

Good morning, Chairwoman Lee and members of the committee. My name is Mayson Bedient, and I am a family medicine physician in Fargo. I have been providing gender affirming care as well as general primary care for the past 5 years. I am here today in opposition to HB1254.

My colleagues have already given you a lot of information on the science of the care that we provide, but I'd like to speak briefly from the point of view of a primary care provider, someone who gets to take care of the whole patient over the span of a lifetime. I get to have a special relationship with my patients, getting to know the patients and their families in a way that many specialists do not have the opportunity to know them. Because of that relationship, I may be the first medical provider with whom a patient feels comfortable discussing gender identity, either their own or that of their child. I am the one they will look to for guidance and it is critical that I am able to help them in the way that is best for that patient, that family. If that means helping to explore gender identity and ultimately assisting in their transition, I need to be able to do that. The key here is helping, not directing; I am not the only voice in the room, and that is something we all bear in mind when dealing with transgender youths and their families. I have spent many appointments sitting with an adolescent and their parents, answering questions and addressing concerns from both sides, "what if I do" as well as "what if I don't." As a provider, I will sit with that family as long as it takes to reach a consensus on the best next steps. The patient and the parents always get a say; no one is assisting in transition without consent from both of those parties.

In primary care, we deal quite a bit with the care of mental health disorders, particularly anxiety and depression. While it is not uncommon for transgender patients to suffer from these things, anxiety disorders and major depression are very different diagnoses than gender dysphoria, and each individual diagnosis must be treated appropriately in order for the patient to feel better. Gender dysphoria will not be alleviated with antidepressants; it is a problem with the physical body and therefore must be treated with a medication that will change the physical traits that cause the dysphoria. By the same token, depression in a cisgender person would not be solved with hormonal treatment. I have personally been in that position, trying to treat my own gender dysphoria with antidepressants and hoping it goes away, and I can tell you that it does not work. You trust in your doctor to know the difference between a cold virus and a bacterial infection, and to treat either of those appropriately, so trust us to be confident in the difference between gender dysphoria and depression as well.

It is also important to realize how access to care would be affected by the passage of bills such as this one, not only for transgender patients but for all patients. The majority of my practice is general family medicine for all people. Bills like this certainly play a role in determining where we want to practice, for me personally and for many physicians across the country. When the government inserts itself into the doctor-patient relationship, it is a red flag to many providers, who may then decide to practice elsewhere, depriving all patients of their care. You are asking us to choose between practicing in the way that our profession encourages and expects us to practice, to the widely accepted standard of care, or practicing in a way that obeys the law but is not best practice.

Thank you for listening to the doctor who cares for the whole family, the whole community. I urge you to give a DO NOT PASS to HB1254, and I stand ready for questions.