Senate Human Services Committee
3/15/23
HB 1254

Chair Lee, members of the committee,

My name is Rachel Peterson. I am a board-certified OB/Gyn who has been practicing in Bismarck since 2017. I grew up in Mandan and completed my college and medical school at the University of North Dakota. I then moved to Nebraska for 4 years to complete my residency in Ob/Gyn.

I am here today to testify against House Bill 1254. I strongly encourage a do not pass vote.

As part of my practice, I provide gender affirming care for patients. This usually is in the form of medication although on occasion I do provide gender affirming surgery in the form of hysterectomy or removal of the uterus, as well as removal of the ovaries. I do not perform these surgeries on anyone under the age of 18. I have been performing this care for the 5 years I have been in Bismarck as well as in my residency training. As part of my practice, I do treat patients under the age of 18 who have gender dysphoria.

I follow guidelines set out by National organizations including WPATH (World Professional Association of Transgender Heath) and ACOG (Association of Obstetrics and Gynecology). These guidelines are evidence based and go through rigorous review before they are released. The WPATH guidelines alone are 260 pages that go through all treatment aspects for gender affirming care.

ACOG's position is that all transgender and gender diverse individuals have access to respectful, equitable, and evidence based care free from discrimination and political interference.

I want to outline what this treatment and counseling looks like, in particular for those under 18 because I feel that there are some misconceptions on what these visits look like and what the treatment involves.

When I first meet a patient, we spend time getting to know each other. They have usually been referred to me by their mental health provider. I usually sit down with them and their support person, who is usually a parent. I ask their pronouns and their name. I discuss with them how long have they felt their gender did not align with their assigned sex at birth. We discuss what their support system is including friends, parents, teachers, and other family members. I discuss with them any medical problems, surgical history, their mental health history and what resources they have in regards to their mental health and if they have a counselor or psychiatrist. We review their family history, discuss any substance use. We discuss their sexual history and plans for future biological children. I discuss their understanding of the treatment as well as their goals.

I then review with them what treatment looks like including any risks of the medication, when to expect the changes and how significant those changes will be. We talk about long term use of these medications, what additional health screening they may need. We talk about what changes are considered permanent and how this may affect their ability for fertility in the future. We talk about financial cost of the medications. We also review what would happen if they want to stop these medications. I answer any questions they have. Typically, these visits take 30-60 minutes. At this point I will have the patient go home with the information and think everything over. I encourage them to discuss more with their support system and decide if they want to start these medications. They then return and we go over all the information again. I review their prior work with their counselor or mental health provider and ensure they meet criteria for hormonal medications.

After obtaining consent from them and their parents, we start the medications. I closely monitor my patients every 3 months for the first 1-2 years and then slowly space out to 6 months then yearly. I encourage these patients to reach out with any side effects, medication changes they wish to make, or other concerns.

There are many transgender and gender diverse individuals who never start medications. We may manage dysphoria in a patient by working to safely stop their period, set them up with counseling or support groups. Often times, my clinic is simply a safe place to get care where they know they are respected and heard. Not every person who is transgender or non-binary will use hormones or get surgery. It is very much an individual decision.

With any procedure or treatment there are risk of regret or desire to stop treatment. Detransition does happen. As medical providers of this care we want to make sure we are ready to manage this as well. It is also absolutely essential that we continue to work closely with our patients so they have a safe place to come if they desire to pause or stop treatment.

Multiple studies have been completed on this topic for both adults and adolescents.

A study done in Amsterdam from 1972 to 2015 looked at 6793 patients. Of those 70% started gender affirming medications (and of those 78% underwent gender affirming surgery). They found a rate of 0.6% regret for transwomen and 0.3% regret for transmen. Of those 7 out of 6793 reported true regret. The remainder (5 patients) reported their regret was due to social acceptance issues and 2 were non binary. They still considered themselves transgender or non-binary. An additional study out of Spain that looked at 796 patients from 2008-2018 showed only 8 cases where detransition was desired.

A survey done in the US in 2015 looked at regret and desire for detransition or completed detransition. 27, 715 people answered this survey. Eight percent reported either temporarily or permanently detransitioning. Most of these people reported their detransition was temporary and was related to parental pressure (36%), the process of transition was too difficult (33%), harassment/discrimination (31%), and difficulty getting a job (26%). Again, these patients still considered themselves transgender however they stopped medications

related to social pressures. Other potential reasons for stopping medication may including cost, medication shortages, satisfaction with most changes but discomfort with others (happy with voice changes, unhappy with facial hair), and inability to access safe care. Medical issues may also prevent use of hormonal medications.

In adolescents there was a large study done in Amsterdam regarding their protocols which are very consistent with US protocols for treatment. They looked at 1766 adolescents. Those who started with the clinic prior to age 10, about half started puberty blockers and those that started after age 10 about 2/3 started puberty blockers. Of note, these puberty blockers were not started at age 10, the patients just established at the clinic at those ages. Once started 1.4% decided to stop puberty blockers, of those most were due to resolved gender dysphoria while the rest stopped due to medical, social, or compliance issues. Of those in the clinic over these years, 707 patients were eligible to start gender affirming medications and 93% did go on to start these medications. This study really illustrates how puberty blockers can work well for those who are working through gender dysphoria vs other mental health issues. These adolescents were given a pause on puberty and were able to safely work with their medical providers to identify if they had gender dysphoria. When these patients were noted to have resolution of their gender dysphoria the medication was stopped and puberty was allowed to continue on as expected.

To compare to other common medical/surgical treatment, specifically in my scope as a gynecologist, rates of regret for permanent sterilization in form of tubal ligation or bilateral salpingectomy are between 1-26%. For vasectomy the rate of regret is around 6%. For hysterectomy, commonly used to treat heavy periods, pelvic pain, endometriosis, and prolapse, the rate of regret is between 7-13%. Salpingectomy and hysterectomy are irreversible procedures that are often performed with 1-4 pre surgery visits and do not require any mental health evaluation. Follow up varies but is usually 1-2 visits after surgery. This is opposed to gender affirming care which involves significant counseling, involvement of mental health providers, and is closely monitored lifelong. Gender affirming genital surgeries and removal of the uterus, ovaries, and testicles are not done under age 18.

If these house bills pass this state becomes a very dangerous place for transgender and gender diverse people. Multiple studies have shown that gender affirming care is lifesaving. People who receive this care report lifelong improvements in their mental health and a significantly reduced risk of suicide. This is especially noted in patient under the age of 18. Supportive family, friends, and community makes a difference in their mental health and prevents suicide. This is Lifesaving care.

From my personal experience working with transgender and gender diverse youth, I can tell you it makes such a difference for them to have access to this care. Once they start care they truly open up. Their personalities shine and its truly humbling to witness. They are so happy to be living as their true selves. Most report significant improvement in their mental health. They do better in school and at home. It is lifesaving care.

I would strongly encourage you to reach out to transgender and gender diverse youth to see their side prior to creating these bills. In the creation of these bills it was even discussed on the house floor that no provider of gender affirming care was consulted prior to writing the bill.

In summary, I cannot recommend strongly enough a DO NOT pass on HB 1254. Please tell the transgender and gender diverse people in our state that they matter and they are valued and important in our communities.

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