Neutral Testimony on HB 2791:
Why Kansas is Right to Restrict "Gender Transition" Procedures for Minors

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Chair Landwehr and Members of the Committee,

There are many reasons why legislatures, such as this one in Kansas, are right to protect children from the experimental procedures known euphemistically as "gender affirming care." But sifting the key arguments from the giant mountains of spin and distraction can be challenging for anyone who lacks the time to study the issue in detail.

In what follows, then, I'd like to offer sixteen brief, key reasons defending the wisdom of HB2791. The evidence against so-called "gender affirming" medical interventions on children grow every day. Keeping track of the mounting evidence against this strange chapter in medical history is a full time job.

Almost everything I say here was known a full year ago. There is a reason that, if Kansas passes HB2791, it will join a proud block of almost half of US states that have passed similar bills—most of them in 2023. It will also join most northern European countries, which have rethought the wisdom of these medical interventions.

(1) **HB2792 is not government overreach.** This bill is not a case of the government wrongly limiting parents' rights over their children's health care. The government is not wrongly coming between parents, children, and their doctors. It is protecting parents who are being misinformed of the alternatives, scientific evidence, known benefits, and likely risks of these procedures. In such cases, parents lack truly *informed* consent.[2]

Moreover, no parent has the right to consent to severe harm of their children—leading to infertility and sterility—even if that parent is well-meaning.[3] In a less troubled world, doctors wouldn't conduct severe experiments on teenagers and tell parents it may be their only option. But when some doctors have abandoned their mandate to do no harm, it falls to duly appointed representatives to protect children from them.

(2) **This bill is about protecting youth** who suffer distress over their sexed bodies. The critics' likely claim that this bill "targets trans youth" begs the question. Clinicians have no reliable way of knowing whether the discomfort these children feel with their bodies means they are destined to feel this distress for the rest of their lives.[4] Would interventions not involving drugs and surgery be better? The critics of this legislation

don't know and have no way of knowing. What we do know is adolescents do not yet have the fully mature faculties needed for reliable, long-term decision-making.

(3) **There is no reliable scientific evidence that these procedures improve the long-term mental health of minors who receive them.**[5] The UK, Sweden[6,7] Finland,[8] and Norway[9] practiced this approach—or "affirming a stated "gender identity" rather than a child's actual sex—*until* they noticed the huge increase of teenagers, especially girls with co-existing mental health problems, dominating their clinics. The same trends have been recorded in the United States, according to data published in peer-reviewed journals and by Reuters in October 2022.[10]

Three of these four European nations responded with systematic reviews of the evidence. After finding no evidence that the benefits outweigh the risks, they stepped back and now favor a much more restrictive approach. These countries have reverted to something closer to the original Dutch protocol, which has problems of its own. If used in this state, however, this protocol would screen out many or even most of the minors who are getting cross-sex hormones.[11]

The UK, for its part, closed its pediatric gender clinic—Tavistock[12]—in the wake of a critical review.[13] That review found that an "affirmative mode" of care that "originated in the USA" was responsible for a lack of child "safeguarding."

A German systematic review on puberty blockers and cross-sex hormones published on February 27, 2024, just as I was finishing this testimony. This review updates a 2020 UK systematic review. The researchers confirmed that the evidence for the value of these interventions for the treatment of gender dysphoria in minors is of "very low quality."[14]

(4) **Florida health boards have judged this bad medicine**: After hearings and careful study of systematic reviews of evidence, the health authorities in Florida ruled in 2022 that "gender affirming care" (GAC) had no basis in reliable evidence and prohibited the use of Medicaid funds to pay for these procedures.[15]

(5) **The suicide narrative of the other side distorts the truth.** It exploits a very simple causation-correlation fallacy. While there is evidence that teenagers who reject their sex exhibit high rates of suicidal thoughts and non-lethal forms of self-harm, there is no evidence that their elevated suicidality is *because* of gender issues. Nor is there evidence that gender transition will solve their problems.[16] Put simply, the evidence suggests that teenagers who are suicidal are more likely to adopt an identity incongruent with their sex, not the other way around.[17]

(6) **There is no solid evidence that puberty blockers, cross-sex hormones and surgeries are necessary to prevent suicide**.[18] Health authorities in Sweden, Finland, and the U.K. have examined this claim and found it unreliable. Consider Finland's leading expert on

pediatric medicine, Dr. Riittakerttue Kaltiala. She recently called the "affirm or suicide" narrative "disinformation" and its dissemination by medical professionals "irresponsible." Also consider a 2022 analysis by my colleague Jay Greene, which compared availability of puberty blockers and cross-sex hormones and in US states. He found that teen suicides were *higher* in states in which minors could access these drugs without parental consent, than in more restrictive states.[19]

(7) **The number of minors ages 6 – 17 diagnosed with gender dysphoria increased 300% between 2017 and 2021, according to data published by Reuters last year.**[20] This includes a spike of 80% between 2020 and 2021 alone. The percentage of youth rejecting their sex has increased even more dramatically. In the DSM-5 (2013), prevalence of gender dysphoria was reported as being between 0.002 and 0.014 percent. A peer-reviewed study from 2018 found that 9.2 percent of students at a school district in Pittsburgh rejected their sex.

Data obtained through a Freedom of Information Act in Davis, California, found that at least 6 percent of students there identified as transgender. This represents a six-fold increase from the previous generation and a sixty-fold increase from the generation before that. Even the World Professional Association for Transgender Health and its activist president, Dr. Marci Bowers, have recognized that social influences may be driving some transgender identification in youth. [21] In short, there is strong evidence that gender confusion is a social contagion among youth.[22]

(8) In recent years, there has been a **huge spike in gender surgeries for minors**. Data published in the *Annals of Plastic Surgery* found a thirteen-fold increases in "gender affirming" mastectomies between 2013 and 2020.[23] This strongly suggests social contagion.

(9) Studies over the decades have consistently shown that almost all children with gender distress resolve that distress while passing through puberty.[24] In contrast, one study by a gender activist-researcher from last year inadvertently showed that if you socially transition children, almost all of them will persist in their confusion, and many will want hormones.[25] If correct, this means that starting a child down the path of gender transition tends to lock in their confusion rather than resolving it.

(10) **Contrary to claims from the other side, puberty blockers given to minors are not reversible**.[26] That claim is based on studies done on a very different condition called precocious puberty, in which puberty starts too early but is always allowed to resume at a developmentally normal time. When used for minors with gender distress, over 95 percent will continue on to cross-sex hormones and never go through natural puberty. Even when puberty blockers are discontinued, their harms on social and psychological development cannot be reversed. That is why New Zealand's ministry of health recently scrubbed the words "reversible" from its website when discussing puberty blockers.

(11) **The number and percent of detransitioners is unknown.**[27] Studies claiming to find rates of regret and detransition below two percent were done on adults who transitioned as adults. A few were done on minors who transitioned under the Dutch protocol—which is far more conservative than the affirmation model practiced in the US. None of these studies were done on minors who transitioned under the affirmative protocol used in American clinics. Limited evidence from the affirmative cohort suggests the percentage might be as high as 30 percent. A 2021 study found that 75% of detransitioners never reported their regret and detransition to their doctors. That means doctors could mistakenly believe that all their patients were satisfied with their transition.

(12) Unlike European health authorities, **American medical organizations have not conducted systematic reviews of evidence**.[28] The guidelines published by the American Academy of Pediatrics, for example, are based on a single, non-peer-reviewed, highly flawed policy statement by an inexperienced doctor who was finishing his residency at the time of publication. The Endocrine Society has rated the quality of evidence behind its own recommendations as "low" or "very low." The AAP has finally agreed to conduct its own review. Nevertheless, both organizations continue to push these interventions.

(13) "Medical" organizations pushing "gender-affirming care" are really a**dvocacy groups that have been captured by a fashionable ideology**.[29] If their representatives testify against this bill, they should be asked to cite the long-term studies and randomized control trials on which their guidelines are based. They should be asked to explain what the health authorities in the UK, Finland, Sweden, Norway, and Florida have gotten wrong. They should be asked to predict, on the record, that gender troubled teens in these countries and in Florida will have worse long-term outcomes than American teens who receive puberty blockers, cross sex hormones, and surgery. And they should be asked to explain their guidelines for treating de-transitioners and challenged if they try to dismiss or explain away the experiences of detransitioners.

(14) Gender ideology has infiltrated many of our educational and medical organizations—including medical schools and professional societies who claim to speak for science and medicine.[30] Legislators should keep this in mind when evaluating claims from these groups.

(15) The obscure notion of "gender identity" has **nothing to do with genuine disorders of sexual development,** which have clear biological definitions and evidence. Very few individuals who cite a "gender identity" incongruent with their biological sex have a physical disorder of sexual development. Biologically, almost all these individuals, prior to undergoing "gender transition," are unambiguously male or female.

(16) **Toxic gender ideology is behind this craze.** Gender ideology reduces biological sex to "sex assigned at birth" and reduces the person to a subjective notion of "gender identity" for which there can be no verifiable evidence.[31] Those seized by this ideology tend to dismiss or ignore the social pressures on teenagers—especially girls—to try to escape the naturally distressing phase of puberty. Lawmakers should understand this clearly and notice that the other side avoids language that would imply the reality of biological sex, opting instead for references to "sex assigned at birth." This reflects the fact that gender ideology contradicts basic biology.

There is, and can be, no scientific confirmation of this thing called gender identity that is independent of the sexed body. What we know, from scientific study and common sense, is that humans, like all mammals, are sexually binary. There are two sexes, corresponding in normal development to two body plans organized for sexual reproduction, with two corresponding gametes. There is no third gamete.

It is well within the authority of the Kansas legislature to protect the children and parents of their state from these medical travesties. Indeed, with **HB2791**, it has an opportunity to act while it still takes some moral courage to do so. It will soon be obvious to all objective observers that children should never have been subjected to these experiments in the first place.

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[1] I would like to think Leor Sapir for his help and insights with this document. The opinions in this testimony, however, should not be attributed to him.

[2] Chad Terhune, et al., "As More Transgender Children Seek Medical Care Families Confront Many Unknown," Reuters (Oct. 6, 2022), at: https://www.reuters.com/investigates/special-report/usa-transyouth-care/.

[3] Children's Hospital Los Angeles Assent/Consent Forms to Participate in Research Study: "The Impact of Early Medical Treatment in Transgender Youth" (2016). Obtained Apr 17, 2020 via HHS Appeal 19-0093-AA; NIH FOIA Request 51365. https://drive.google.com/file/d/1Q-zJCivH-QW7hL25idXT_jITfJZUUm1w/view.

[4]W. Bockting, "Chapter 24: Transgender Identity Development," in D. Tolman & L. Diamond, Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology* (2 volumes). Washington D.C.: American Psychological Association 1: 744.

[5] Leor Sapir, "The Distortions in Jack Turban's Psychology Today Article on 'Gender Affirming Care,'" Reality's Last Stand (Oct. 7, 2022*),* at: https://www.realityslastand.com/p/the-distortions-in-jack-turbans-psychology.

[6] The National Board of Health and Welfare (Sweden), "Care of children and adolescents with gender dysphoria" (2022), at: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf.

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https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/.

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[9] Jennifer Block, "Norway's guidance on paediatric gender treatment is unsafe, says review," *British Medical Journal* 380 (2023), at: https://www.bmj.com/content/380/bmj.p697.

[10] Chad Terhune, et al., "As More Transgender Children Seek Medical Care, Families Confront Many Unknowns," Reuters (Oct 6, 2022), at: https://www.reuters.com/investigates/special-report/usa-transyouth-care/.

[11]Michael Biggs, "The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence," *Journal of Sex & Marital Therapy* (2022), at: DOI: 10.1080/0092623X.2022.2121238.

[12] Jasmine Andersson & Andre Rhoden-Paul, "NHS to close Tavistock child gender identity clinic," *BBC News* (July 28, 2022), available at: https://www.bbc.com/news/uk-62335665.

[13] The Cass Review: Independent review of gender identity services for children and young people: Interim report (February 2022), available at: https://cass.independent-review.uk/publications/interim-report/.

[14] Florian D. Zepf, Laura König, Anna Kaiser, Carolin Ligges, Marc Ligges, Veit Roessner, Tobias Banaschewski, and Martin Holtmann, Beyond NICE: "Aktualisierte systematische Übersicht zur Evidenzlage der Pubertätsblockade und Hormongabe bei Minderjährigen mit Geschlechtsdysphorie," Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie (2024), 1–21.

[15] "Let Kids Be Kids," A Report of the Florida Agency for Health Care Administration (June 2022), at: https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf.

[16]Polly Carmichael, Gary Butler, et al., "Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK," *medRxiv* 2020.12.01.20241653, at: doi: https://doi.org/10.1101/2020.12.01.20241653

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[18] Michael Biggs, "Suicide by Clinic Referred Transgender Adolescents in the United Kingdom," *Archives of Sexual Behavior* (2022), at: https://pubmed.ncbi.nlm.nih.gov/35043256.

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