HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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Public hearing to Continue Discussion on
Appropriate Standards of Care for Minors
Experiencing Gender Dysphoria

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House Health Committee
Subcommittee on Health Care

Irvis Office Building
Room G-50
Harrisburg, Pennsylvania

Monday, September 14, 2020 - 10:00 a.m.

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COMMITTEE MEMBERS PRESENT:

Honorable Paul Schemel, Majority Chairman
Honorable Jim Cox
Honorable Kathy L. Rapp
Honorable Pamela A. DeLissio, Minority Chairwoman
Honorable Mary Jo Daley (virtual)
Honorable Dan Frankel

ALSO PRESENT:

Honorable Aaron D. Kaufer (virtual)
Honorable Jerry Knowles (virtual)
Honorable David H. Zimmerman
Honorable Wendy Ullman (virtual)

INDEX OF TESTIFIERS

SUBMITTED WRITTEN TESTIMONY

(See other submitted testimony and handouts online.)

REPRESENTATIVE RAPP: Good morning. I'm from Warren County, and I am the Majority Chair of the Health Committee.

This morning we are continuing our subcommittee hearing on health care. It's a hearing to continue the discussion on appropriate standards of care for minors experiencing gender dysphoria in Pennsylvania.

This is a committee that's not afraid to take on tough issues. This is a very important subject. It is our duty, as Representatives, to make sure that we are representing our constituents and their safety, and that includes our minor children as well.

This has been a very interesting topic, and I appreciate all of the people who have been willing to testify on this subject. This is our second hearing. And at this time I will ask -- And I want to thank the testifiers, too, from the last time and today as well.

So, at this time I will ask the members to introduce themselves. And after their introduction, I will turn the meeting over to Representative Paul Schemel, who is the Subcommittee Chairman for this hearing. And so,

Paul.

MAJORITY CHAIRMAN SCHEMEL: I'm Representative Paul Schemel from Franklin County.

MINORITY CHAIRWOMAN DeLISSIO: Pam DeLissio. I represent the 194th, parts of Montgomery and Philadelphia counties.

REPRESENTATIVE FRANKEL: Representative Dan Frankel, 23rd District, Allegheny County, City of Pittsburgh, and I'm the Democratic Chair of the Health Committee.

REPRESENTATIVE ZIMMERMAN: Representative Dave Zimmerman, 99th District, northeast Lancaster County.

REPRESENTATIVE COX: Jim Cox, 129th District, Lancaster and Berks counties.

REPRESENTATIVE RAPP: And I think we have some members virtually, if you'd like to introduce yourself.

REPRESENTATIVE KAUFER: I'm Aaron Kaufer, 120th District, Luzerne County.

REPRESENTATIVE DALEY: Mary Joe Daley, the 148th District in Montgomery County.

REPRESENTATIVE ULLMAN: Representative Wendy Ullman, Bucks County, 143rd District.

REPRESENTATIVE RAPP: Thank you,

members. At this time I will turn the gavel over to Representative Paul Schemel.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Chairman Rapp.

Today's meeting is a continuation of the hearing that we began in March at the very outset of COVID when we weren't sure how serious or that it would be very serious. We've had a lengthy bit of delay since then, but we're very grateful for the testifiers to come today.

The genesis of this hearing actually stems from discussion the last time that Medicaid, and Medicaid, for those of you who aren't aware, that's the state insurance program for low-income individuals.

When Medicaid was being reissued, there was a directive that came from the Governor that Medicaid would now cover the full range of transition services for gender dysphoria for our children. There was a bit of confusion amongst a number of the members as to exactly what this sort of treatment was. So, the point of the hearing was to gain information on it. It is an informational hearing, and then we will ultimately issue one or more reports out of committee.

There is no legislation that I'm aware of that would -- that's being circulated currently in Pennsylvania that would make any of the services that are being discussed illegal. I know other states have had those, but that's not what's in discussion in the course of this hearing, and we're not taking any sort of a vote in this committee at the conclusion. So, this is a fact-finding mission.

After this, we may, depending on whether myself and my co-chair, Representative DeLissio, want to have additional hearings or, of course, receive information from various research. So we're very grateful.

I'm gonna -- I will also turn the microphone over to my co-chair, Representative DeLissio.

MINORITY CHAIRWOMAN DeLISSIO: Thank you, Representative Schemel. It's my pleasure to serve as co-chair on this subcommittee with you. The COVID pandemic prevented all four testifiers from testifying back on March 12th, so we're having part 2, as everyone has mentioned here today.

This is relatively a new topic for me. I am not well-informed on this topic. I apologize

if I use any part of any lexicon inappropriately, and very willing to be corrected either during the committee meeting or subsequently. I want to always be as appropriate as possible.

But, with any new topic, just so I can share this personally, I tend to do my homework, and I particularly pay attention to things like footnotes and sources to make sure I am being as well-informed as possible.

So, I look forward to what I'm gonna learn this morning, and thank you so much all for being here.

MAJORITY CHAIRMAN SCHEMEL: Very good. Thank you, Representative DeLissio.

We have the same. I think we expressed this during the first hearing; that this is an emerging area, and sometimes the lexicon of terms can be confusing for many of us. I think that there's a good degree of goodwill and charity among the members of the committee with no intent to offend anyone.

Our testifiers today, we have two eminent doctors who will be testifying in order. The first is Doctor Katharine Dalke. Doctor Dalke is an attending psychiatrist at the Pennsylvania

Psychiatric Institute at the Penn State Milton Hershey Medical Center, which is a phenomenal resource.

People around the world know Hershey, Pennsylvania, for chocolate. I happen to be fortunate enough to live in a community where Hershey and Johns Hopkins are equidistant, and everyone if they have any sort of a malady that requires more that what the local health service can provide wants to go to Hershey because of, really, the phenomenal care that they provide. It's a phenomenal resource for our entire Commonwealth.

Doctor Dalke is the director for the Office of Culturally Responsive Health Care Education. She's Assistant Professor of Psychiatry and Behavioral Health at the Penn State College of Medicine.

Doctor Dalke, I believe that you're with us.

DOCTOR DALKE: Yes, I'm here.

MAJORITY CHAIRMAN SCHEMEL: Very well. Doctor Dalke, please feel free to go ahead.

A VOICE: If I may for a second.

MAJORITY CHAIRMAN SCHEMEL: Yes.

A VOICE: Clinton, could you please turn off your microphone.

(Pause). Okay, we're good. Thank you. You can go.

DOCTOR DALKE: Thank you very much for the introduction. Good morning, Majority Chair Rapp, Minority Chair Frankel, Representative Schemel, and the members of the Subcommittee of Health Committee. Thank you so much for this opportunity to speak with you all today about care models for transgender youth and adolescents.

As our Chairman Schemel said, my name is Katharine Dalke, and I'm a psychiatrist who specializes in mental health care for sexual and gender minority, adolescents and adults. I received my medical degree in psychiatry training at the University of Pennsylvania where I had experience in treating psychiatric illness in inpatient and outpatient settings. I also have additional training in transgender mental health in particular.

As an assistant professor of psychiatry and behavioral health at Penn State College of Medicine, I treat patients in the inpatient and outpatient settings at Pennsylvania Psychiatric

Institute in Harrisburg, and also at the Gender Health Clinic at Penn State Children's Hospital.

In a typical week, I provide mental health services to up to 15 to 20 transgender and gender-diverse adolescents and adult patients. I've also been involved in sexual and gender minority health education and research for 15 years, and I currently serve on health care research committees on the state, national and international levels.

Before I move into my testimony, I'd like to offer a couple of definitions just to ensure that we're all speaking the same language. I really appreciate Representative DeLissio's acknowledgement that this language is complicated and shifting.

For purposes of my testimony, transgender refers to the experience of having a gender identity, which is how we feel about our gender inside, that does not align with the sex that we are assigned at birth. Gender diverse includes people who are transgender, people who have non-binary gender identity, and people whose gender expression, which is how we present our gender to the outside world, does not conform to

societal expectations.

I'd also like to acknowledge, because I'm not transgender, I can't personally speak to what it's like to be transgender. My testimony today, rather, is influenced by a synthesis of the best available medical evidence, my clinical practice in community and academic mental health settings, and input from colleagues who are transgender identified mental health providers and/or physicians.

I would also submit to the subcommittee that caring for transgender youth and their families has been one of the greatest privileges of my life. On a daily basis, my patients and their families teach me about what it means to be resilient and courageous.

As I mention in my testimony, there are five key points I'd like to mention. The first is that trans identity and gender diversity are not mental illnesses, but normal aspects of human diversity.

Second, trans and gender-diverse youth are vulnerable to higher rates of mental health problems, suicidal thoughts and suicidal attempts. And importantly, mental health problems are due to

the combined stress of gender incongruence and social stigma.

Gender-affirming mental health care, which is what my testimony focuses on today, aims to reduce these mental health problems by promoting resilience, helping their support system to accept them, and facilitating connections to medical care, when appropriate.

Withholding gender-affirming care from transgender and gender-diverse youth has been associated with worse well-being and can potentially increase the risks for distress and suicidality.

To highlight these points, I'd like to start with a story from the mouth of the patients that I've treated in Hershey, Harrisburg, and Philadelphia.

Jay is a 15-year old child who was referred to me from an inpatient psychiatric hospital after a series of suicide attempts. While Jay was in the hospital, he told his mother for the first time that although he was assigned female at first, he had felt like a boy for a long time.

When I met with Jay, he told me that until puberty he felt pretty good. His mother was

fine with him wearing boy clothing, doing boy activities, and both of them really thought of him as a tomboy. They were especially delighted that strangers would occasionally call him he or him. He did well in school; had lots of friends, and was involved in extracurricular activities. He was close to his family and cared for his siblings while his mom worked her second job. This was one of his favorite responsibilities.

When puberty started, though, Jay became depressed and anxious, and for a long time he wasn't so alive. He did notice that it was less and less likely that people took him for a boy, and he started to feel anxious every time he was referred to by his female name or female pronouns. He started to be teased at school for being different from other girls, so he stopped going.

Eventually, he realized that his increasingly feminine body was physically uncomfortable for him, and he even began to self-harm by cutting his wrist with a razor blade when he got his period. He told me that the pain distracted him from the stress of having a period as a boy. He eventually became suicidal because he was afraid that he would never be able to be seen

as a man, and he didn't want to live life as a woman. And he only told someone because he realized that he couldn't survive if he didn't.

Much to his relief, his mother was supportive, and she was relieved that he was finally telling her what was going on. She began calling his son, Jay (indiscernible) and he started to feel better. Together they approached school, and the principal and teachers began to respect male pronouns as well.

Over the course of seven months, Jay talked with me and a therapist to learn more about what his options were to feel at home in his body. He began wearing a tight top to flatten his chest and started a birth control injector called Depo-Provera to stop his periods.

Six months after I met Jay, he went through and he was back to his extracurricular activities. He told me he hadn't had any suicidal thoughts or done any self-harm in several months. He was hoping to start testosterone at some point, and his mom said she was going to pay for it, but he really wanted to get a job so he could pay for his own co-pays. His mother told me carefully that she finally felt like she had her child back.

Although Jay's story is not the story of all youth, as you'll hear, there are many things about it that are common.

While roughly 1 to 2 percent of American youth identify as transgender, up to 20 percent of American youth describe diverse-gender expressions.

Trans people, furthermore, have been represented throughout history and literature for thousand of years and in cultures across the world. These experiences of trans identity and gender diversity are recognized as common, normal aspect of nature of human diversity by major medical organizations like the American Academy of Pediatrics.

However, we also know that in the U.S. there is strong evidence that trans and gender-diverse youth are vulnerable to higher rates of mental health problems.

Studies have consistently found over the past 20 years that trans and gender diverse youth support higher rates of depression, anxiety, psychological distress, eating disorders, and substance use problems relative to all youth. We also see significant suicide disparity. And as a psychiatrist, this is extremely concerning for me.

In one study, 94 percent of transgender youth said they wanted to die at the time of the study. In another survey, 5 percent of trans youth reported having attempted suicide in the past year, which was compared to 8 percent among all American youth.

Unsurprisingly, as a result, and we can see this both in the literature and in my clinical practice, trans and gender-diverse youth often receive intensive and expensive levels of mental health care, like multiple inpatient hospitalizations, partial hospitalizations, in terms of outpatient programs, residential treatments, and often extensive psychiatric medication trials.

Sadly, these treatments are really only partly effective at best for the majority of youth because they really fail to address the core issues. However, there is strong evidence when trans youth have family support and affirming mental care, they are just as happy and healthy and successful as any other young person, and in some studies even more so. In other words, these mental health problems are not intrinsic to being transgender, but rather due to a combination of

gender incongruence and social stigma.

So gender incongruence stress is sometimes also referred to as gender dysphoria, or body dysphoria, and it can take a couple of forms. Some youth tell me, like Jay, they are actively distressed by their physical sex traits. The shape of their chest, facial hair, the pitch of their voice, their genitals. Other youth are maybe not so bothered by their bodies, but really feel bad when they're misgendered by other people when something else refers to them by the wrong name or the wrong pronouns.

I see over and over again that this distress can manifest pretty diversely. Some youth have anger outbursts. Other youth express depression or anxiety, and many have suicidal thoughts related to this distress.

It's also common for youth to abuse substances or self-harm to help to ease this distress. However, some people are not aware feeling distress until something changes.

One transgender youth published the following accounts of his experience wearing a binder to flatten his chest. Before I had my binder, I was anxious and uncomfortable wherever I

went. I felt as if my skin was visibly crawling over my bones and sinew, and everyone who looked at me could see it. After I started binding, I felt normal like any other average person on the street. Being glanced at was no longer a humiliating experience. I had no idea that I carried that much dysphoria until I had a way of relieving it.

Socially, like all children, they feel vulnerable to stressors and lack the ability to change their circumstances. We also see clinically in the literature that trans youth are vulnerable to unique stressors because of their gender. In particular, trans youth, especially youth of color, are more likely to experience social isolation, verbal harassment, and physical and sexual abuse both at home and in school.

Because of this rejection and violence, trans youth are also more likely to be kicked out of their homes and to leave school. This, in turn, increases trans youth stress of homelessness, lower educational attainment, placed in the foster care system, incarceration and poverty. All of these stressors combined heighten mental health symptoms and suicidality, just like for any person regardless of their gender identity.

And it turns out that family and social acceptance ultimately has the single greatest impact on keeping kids in school and in their homes which, in turn, can significantly reduce suicidal thoughts and behavior.

So trans and gender-diverse youth are not inherently mentally ill, but if you require affirming mental health care to reduce the impact of social stigma and gender incongruence on their mental health. So literature has shown that gender-affirming mental health care as part of gender-affirming (indiscernible) can significantly improve mental health and well-being.

In my practice, and according to the best practice recommendations, gender-affirming mental health care is part of a comprehensive mental health assessment for all youth, which is designed to evaluate the youth strengths and coping skills, their emotional distress and symptoms, including evaluating whether there are any distress or illnesses or problems that might be ongoing; consistently assessing for and trying to reduce risk factors from problems with safety, and also assessing their support system.

Importantly, my job is never to decide

whether or not a person is transgender, or to assume that I know what they want or will need now or in the future. My job instead is to listen to and support young people in exploring their gender identity and expression, and to think with them about what this might mean for their eventual social, legal and medical goals.

The strategies we use to help support in this processing treatment frequently asking for and affirming youth in their chosen name and pronouns, connecting youth with peer support, and they're very fortunate to have a number of local peer support groups for our youth, encouraging exploration with gender expression like hair styles, activities and (indiscernible). Consistently and assiduously to manage suicidal thoughts, social stress, and disclosure of what's going on to other people in their lives. And a big part of gender-affirming mental health care that's often overlooked is providing support and education for families.

In my experience most parents bring their child to mental care because they want to be able to support their children, but they might need some help figuring out how. Part of my job is to

help them understand, with their support of their child, is perhaps the single-most important they can do to protect their child from harm. What I see over and over again is that the majority of parents only come to be able to adapt to and even celebrate their child's gender.

Because many families, importantly, may have trouble accessing mental health care for themselves, and I'm sure you all know that this is a challenge especially for families in more remote or rural parts of the state, and also because they might be shy about discussing this in their communities. These conversations with their child's provider can really be crucial to improving the health of the family as a whole.

Gender-affirming mental health care does also include educating youth about the menu of legal and physical options. You'll hear more from Doctor Dowshen in her testimony about these options. I won't go into them in detail right now. But I will say that in my clinical practice and in the literature, we see over and over again that not all youth want all available intervention, which is why I never assume all people want or need a specific intervention.

It's also important to understand that intervention is considered partly reversible or irreversible are rarely considered until the youth is late in adolescence.

This education is really important for us to provide because all guidelines require that a minor have a letter from a mental health provider before they can start a partly reversible or an irreversible option. For some youth, frankly, this can really be a barrier, if they're not able to find an affirming mental health provider or they don't have people who will take them to an affirming mental health provider.

But when affirming health care is available, accessible, expedient, and efficient, a lot of youth do seem to find this beneficial. It gives us an opportunity to have an in-depth discussion about the potential risks and benefits of a given intervention, which is a decision almost all of my patients take extremely seriously. It also gives them an opportunity to have an affirming and supportive relationship with a medical provider which is often the first experience like that most of them have.

I will also say that expanded access to

mental health during the course of this pandemic has been very important, in particular, for our trans and gender-diverse persons with less supportive families or in rural parts of the state.

The literature and my clinical experience has shown that outcomes, in general, in this approach are very good. You see at the population level that affirmative care reduces psychological distress and suicidality and improves well-being. Many youth end up requiring much less mental health care than they would have otherwise, and a significant proportion of my patients end up needing no mental health care once they are adequately affirmed.

We also see some clinical studies of extremely high rates of satisfactory care. And it's because of this data that gender-affirming care, including mental health care, has been deemed as medically necessary by all of the major medical organizations involved in pediatric medicine, elective medicine, psychiatry and psychology.

Finally, there's evidence that shows that the opposite is true for approaches that refutes gender-affirming care for trans and gender-diverse youth. There's literature to

suggest that it's unlikely that a young person with a gender incongruence distress diagnosis, like gender dysphoria, that presents or persists at or after puberty will not identify as transgender as an adult.

So what this means is that, by the time most youth are coming to us in adolescence with distress, most of them will be identifying trans as an adult. While -- when watched (indiscernible) fails to support a youth gender identity, even socially, they can expose them to significantly more harm. Many of us who work -- who are doing this work on a daily basis really understand this approach that fails to support a youth's gender identity or waits for them to grow out of it, to have the kind of risk than some of the strategies we use to affirm youth.

Finally, there are psychotherapies that seem to change a youth's gender identity. These are sometimes called gender identity change efforts or conversion therapy. There's been good recent evidence that suggests that, overall, these studies -- these approaches really lack evidence of efficacy, and that youth that go through them have higher evidence -- excuse me, have evidence of

higher rates of distress and suicide attempts, including well into adulthood. As a result of this, these particular types of therapies have been decried by SAMHSA and major medical organizations across the U.S.

So, in conclusion, the best available medical evidence shows that gender-affirming mental health and medical care, really significantly improves the health and well-being of trans and gender-diverse youth, just as it has for the scores of transgender and gender-diverse youth in Pennsylvania that I've had the privilege of seeing.

Thank you very much for your attention. I'm happy to answer questions. I will to excuse myself after this to go to clinic. Thank you.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Doctor, for your testimony.

Two things I neglected to reference at the very beginning of the meeting. Number 1, we did receive a request from the Pennsylvania Youth Congress to film or to photo during the hearing, and we appreciate the request, and that request was granted. We welcome you to be here.

And, secondly, Doctor Dalke, I appreciate all of the footnotes that you provided

to evidence in your written remarks. The subcommittee is familiar with a number of these resources, but not all, so we'll be following up with those.

With that, what committee members would like to ask questions?

Chairwoman DeLissio, please.

MINORITY CHAIRWOMAN DeLISSIO: Thank you. I appreciate that. May I refer to you as --

DOCTOR DALKE: Doctor Dalke.

MINORITY CHAIRWOMAN DeLISSIO: I know that very often now when you go into a health care provider's office, any number of screenings are sort of standard, including standards for abuse. As I grow older about, you know, do I feel unsafe in my home, things like that.

Are there routine screenings that are part of pediatric medicine to kind of, I'll use the term suss out, whether this may or may not be an issue? Because, I would imagine -- I have no children of my own, but I have eight nieces and nephews that are near and dear. Sometimes you really have to give children a very comfortable opportunity in order for them to share.

So, is there any type of screening that

has become routine, perhaps, during a wellness visit that would give a provider, a health care provider the opportunity to, perhaps, pursue something a little bit more so they could be as supportive as possible of their patient?

DOCTOR DALKE: Yes. Thank you very much for that question. I appreciate that.

You're reminding me of a statistic I referenced in my testimony, which is, that in one study trans youth reported they had understood their gender identity 10 years before they ever told someone else. That's one of the reason why, actually, many youth will not share this information with other people unless they're asked or unless they feel safe to do so.

In pediatric medicine, in particular with adolescent patients, it is recommended as part of routine screening to ask all patients about how they feel about their gender, just as we ask them how they feel about dating and their interest in other people.

Best practices also, in general, recommend for all patients, regardless of their age, that we ask all patients what name they'd like to be called and what pronouns they use. This is

another way we can indirectly invite people to share this information with us.

So, yes, it is part of routine screening for adolescent patients, and best practices recommend, really, for all patients to be something to consider.

MINORITY CHAIRWOMAN DeLISSIO: One other quick question, and then, Paul, maybe you can just circle back if we have a chance for a second round.

Do you happen to know, Doctor Dalke, how many gender health clinics are in Pennsylvania? I'm aware of the Hershey location; CHOP, obviously. I think there's one out in the Pittsburgh area.

DOCTOR DALKE: Yes. So, to my knowledge, there are three integrated gender health clinics for trans youth, which include young patients before puberty. Those are at the University of Pittsburgh, Children's Hospital of Philadelphia, and Hershey.

There are also individual providers and clinics across the state that will also provide affirming care to trans adolescents, although our younger patients do have difficult accessing care. But there are really excellent programs in the State College area and in northwestern PA -- I'm

sorry. Northeastern PA as well.

MINORITY CHAIRWOMAN DeLISSIO: Thank you. Thank you, Chairman.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Chair DeLissio. Chairman Frankel.

REPRESENTATIVE FRANKEL: Thank you, Chairman Schemel. Thank you, Co-chair or Democratic Chair DeLissio. I appreciate the opportunity to have this testimony today.

I want to thank Doctor Dalke for taking the time to join us. In particular, I'd like to ask you to address some of the misinformation that went unchallenged when the last hearing went forward without the attendance of any experts in the field. So, a couple of things.

The previous testifier argued that puberty blockers are likely to cause negative psychological effects. Can you speak to that?

And also, one of the other testifiers talked about -- argued that pre-homosexual children are being mischaracterized as transgender. Can you discuss the difference between gender and sexuality?

DOCTOR DALKE: Yes. Thank you very much for those questions.

So, to address the first question regarding psychological outcomes with puberty blockers, you know -- So puberty blockers, it's important to know, have been used for a long time for young people with precocious puberty. These are young children. Sometimes they're as young as 4, 5 or 6 years old whose bodies starts to naturally go through puberty on their own.

Medications -- We use -- We use puberty blockers in those young people to help postpone puberty until they go through puberty at a more developmentally usual age. So we do have data from those sets of patients to help inform some of our understanding.

There have been some early concerns about puberty blockers affecting cognitive development. Those concerns are really not well understood. And the other concern that we have about puberty blocks is for bone health. So, if we prevent the body from being exposed to hormones, like sex hormones, it can affect the development of the bones. This is why people, after they go through menopause, have higher risk for osteoporosis.

The really crucial thing, though, to

keep in mind with trans youth is that, when they're taking puberty blockers, it's typically for a very, very short period of time. Usually just a couple of years. And there's good evidence that shows, including some recent evidence that was published even just this year, that when young people have access to puberty blockers, their psychological outcomes, including their risk for suicidal thought or behavior, is lower than it is for trans youth and adults who are not able to access puberty blockers.

This is in the study I'm referencing from earlier this year, we saw those effects even when people had social support. So people who have social support plus puberty blockers did better than people who had social support without puberty blockers.

The other thing that we have to keep in mind is that, we have to weigh the risks of taking a puberty blocker against the risk of not taking puberty blockers. So, when a young person doesn't take a puberty blocker, we certainly see higher risk, as I said, of psychological problems, but we're also exposing them to the hormones that their bodies produce which can lead them to develop

irreversibly sex traits that they may not want later in life, which could put them at risk for needing surgery later in life.

So, one of the things I say all the time is that, in medicine there's nothing that has no risk. It really, ultimately, becomes about weighing the relative risks and benefits for an individual person. And, on balance, we believe, based on the evidence and on clinical outcomes, that the benefits of puberty blockers outweigh those risks.

Regarding the question about pre-homosexual children, I think what you're getting at is some of the literature around what's described as desistance. So, there were a series of studies that were published that suggested that if you take youth who are presenting with gender questions, 80 percent of them will not identify as trans later in life.

It turns out that those studies have some really serious methodological issues. So one of those issues was that, they were including young people who were gender diverse; meaning, they had a gender expression that was diverse in some way, like a tomboy, for example, but not necessarily

youth who were transgender on the basis of a gender incongruence diagnosis, like gender dysphoria or gender identity disorder, which is an older diagnosis used in the psychiatric literature.

When you look at the folks who actually have those diagnoses, it is much, much, much less likely that those young people will desist.

So really, what we see, and without having seen the previous testimony personally, we know that not all youth will want all interventions. And we know that not all youth will identify as trans when they come to us, so the approach is not one-size-fits-all one. It's really youth centered, formally centered and led, and we really work with people over time to help them achieve their individual goals as they come to understand their identity.

REPRESENTATIVE FRANKEL: Thank you.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Chairman Frankel.

Representative Zimmerman.

REPRESENTATIVE ZIMMERMAN: Thank you, Chairman Schemel.

Doctor Dalke, I appreciate your testimony. Just a couple of questions.

One, when did the gender clinic in Hershey open? How many patients are being seen each year, and is that number increasing?

DOCTOR DALKE: So, Hershey has been providing care to trans and gender-diverse youth and adolescents for 15-plus years. Over the past year and a half to two years was when we really formalized the structure of care for trans and gender-diverse youth, so that was really integrated. Our critical program includes a psychiatrist, who is me, a licensed clinical social worker who's our gender therapist and coordinator, an adolescent medicine physician, who's the pediatric endocrinologist. So we've been really working together over the last couple of years to have an integrated program.

I don't off the top of my head know the exact number of families that we're serving, but it is -- at this point is over 100 patients. Probably close to 125 would be my guess. And it's hard to say, really, whether that number is increasing because we are still relatively early in the process of having this integrated program. But we do expect those numbers to increase over time.

REPRESENTATIVE ZIMMERMAN: Also, how

many biological girls versus biological boys, and what is the youngest age that you might treat?

DOCTOR DALKE: So, I don't have the exact breakdown of how many children we take care of who are assigned female at birth versus assigned male at birth, and those numbers vary from clinic to clinic and across countries.

The youngest age of patient that we will see really is as early as (indiscernible) are ready to bring them for care. We do not -- We do not provide any medical care for any young person. The only time we think about medical care is when someone is starting to go through puberty, which is, on average, sometime between 10 and 13 or 14 years old. So while we may take care of some people who are in elementary school, those young people are not receiving any medical care. They're receiving psychological and social support.

REPRESENTATIVE ZIMMERMAN: I appreciate that. And one last final question here is, do most children come before puberty or after puberty to your clinic?

DOCTOR DALKE: So, in our clinic the majority of our patients are presenting during or after puberty. From informal conversations with

other programs, as programs are opened for longer, they do start to see patients younger. But at this point most of our patients are in or after puberty.

REPRESENTATIVE ZIMMERMAN: Okay. Thank you. Thank you, Mr. Chairman.

MAJORITY CHAIRMAN SCHEMEL: Thank you.

Representative Cox.

REPRESENTATIVE COX: Thank you, Mr. Chairman.

Thank you, Doctor Dalke. A few questions came to mind as I'm listening to your testimony.

When you first see a child, that first meeting, do you evaluate in that meeting whether you believe the child is transgender diverse or gender dysphoric? Do you draw that conclusion in the first meeting, or what's your process there?

DOCTOR DALKE: So, I never decide whether a young person is transgender or gender diverse. That's ultimately for the young person to decide.

One of the things I do evaluate in the first meeting is whether someone meets diagnostic criteria or gender incongruence diagnosis, which in my case is gender dysphoria. Sometimes in the

first meeting I am able to identify that with certainty. Sometimes it takes more time than that.

What I will say is that, for young people, we don't make that diagnosis without information from multiple sources, including the young person as well as their family members, and without evaluating for whether there might be something else going on that could better explain why a young person is feeling, for example, depressed or anxious.

REPRESENTATIVE COX: Okay. And so, I want to make sure I understand the distinction. Sounds like you're drawing a little bit of a distinction between diagnosis and recommendation. Is that -- Am I being accurate there?

DOCTOR DALKE: So, what I'm drawing a distinction between is labeling someone distressed and labeling their identity.

I think the problem with labeling identity is really two. One, that's just not for me to decide. That's for the young person to decide.

And number 2, I really, as I said previously never -- I try not to make any assumptions about what a young person is or what

that young person wants. So if someone comes to me and they have, you know, six months of distress that's related to their gender identity. They've got a strong and persistent preference for -- things for activities or clothing or hairstyle that are another gender; this is happening at school and at work, and it doesn't seem like this is related to another mental health problem, then we can give a person a diagnosis of gender dysphoria, but even that is not something you see all the time in the first visit. It really depends on the person's individual circumstances.

REPRESENTATIVE COX: And do you -- As a practitioner, do you practice affirmation during those early meetings?

DOCTOR DALKE: I do, actually. So, in those early meetings the way that I practice affirmation is really, primarily, through asking the young person questions and respecting and validating their answers. So, that might be something as simple as a person tells me that they go by they and them pronouns, and I use they and them pronouns when I talk to the young person.

It might be that a young person tells me they really love Spiderman, and so, we had a

10-minute conversation about Spiderman. For a lot of young people, they may not have those experiences elsewhere in their lives.

For many young people, we do also recommend affirmation socially from the beginning, so we may encourage families to use the child's name and pronouns at home or to allow them -- to encourage them to play with toys at home, for example. Part of the reason that we do that is that, it gives us really important data.

When a young person is feeling significantly better with stress like that, then we know that we're on the right track. If they're not feeling significantly better with stress like that, then it means that we need to be thinking really carefully and clearly about what's going on.

REPRESENTATIVE COX: Okay. Is there a point in there where you feel like you have enough information? Do you ever recommend surgery for these individuals? And if so, how far down the line is it before that recommendation is made?

DOCTOR DALKE: So what I would say is, the only two medical steps that I ever recommend to people would be medication to stop periods or medications to delay puberty. And the only time --

Only reason I recommend those is because, number 1, a lot of young people and their families don't know those are options. And number 2, especially with puberty, puberty is a time-sensitive thing.

And I don't ever recommend by saying, this is something you really need to do or something terrible is gonna happen. It's more along the lines of, hey, this is an option that's available to you. How would you feel about me scheduling you an appointment with a medical provider who can talk to you more about the risks and benefits.

I have never recommended estrogen or testosterone or surgery to a person. If someone comes to me and says they really want to do those things, then we have a conversation about the risks and benefits for that individual person, and really understand how that lines up with what their personal goals are.

The clinical guidelines, in general, recommend that hormones, estrogen, and testosterone not be prescribed before 16. The guidelines also acknowledge there are some circumstances in which that might be appropriate. But in my clinical practice, it's generally not super common.

And similarly, guidelines recommend that surgery not be performed before 18. Again, there's really just one exception where we think about that, and that's for people who have breasts who identify as male, and you need a more masculine appearance for their chest. So sometimes we will consider that surgery in a 15 or 16 or 17 year old. But, again, that is very specific to the person and it's not a common -- it's not a routine practice I would say.

REPRESENTATIVE COX: I want to step back to a prior question I kind of -- that you were finishing up your remarks on the first. I had another question jotted down I wanted to ask, which I just did.

So, you mentioned this Spiderman conversation you have with an individual. We have another member of the subcommittee who wasn't able to be with us today due to an issue with the family. I think there was someone who passed in the family, actually.

She described a scenario where one of her children wanted to be talked to and treated like a puppy, and so, that lasted a while. And, you know, they somewhat treated the child like a

puppy, to the greatest extent possible. I forget how the story ended. It had something to do with a tail, I think.

But, beyond that, it's gonna beg the question with me when you're speaking of Superman. The child likes Superman. Let's say the child believes they are Superman, or Spiderman I think was the reference made. Do you affirm or would you affirm a child saying, I'm Spiderman? Would you affirm a child who came in and said, I want to be treated like a puppy?

How would you handle those types of scenarios where a child is expressing certain things; whether it's the age of 4, 5 and 6, or whether it's a little older? How would you treat that?

DOCTOR DALKE: I think the first thing to say is that, it is really common for children to go through a developmental period that we call magical thinking, as far as, you know, having the magical thought that they could be a puppy.

And the difference often between gender identity and expression is that, gender identity -- When young people come to us and they're talking to us about their gender identity or their gender

expression. It doesn't have that same fantastical or magical quality to it. In fact, most young people feel nervous or anxious about realizing this about themselves because they realize that it's not common in their immediate surroundings for people to feel this way. So, I think that is point number 1 and why this is really different.

I think the other piece of it is that, affirming a child's gender identity does not exclude what that means for the young person. So, I can still say to a young person -- refer to a young person as he or him and have a conversation with that young person about what that means; whether they want to be called he or him at school or whether it's just at home. Whether it means they really just want to play with toys, or they also want to change their hairstyle.

As people become older, magical thinking is much less common as we get into adolescence, so it's very unlikely that we see things like that happen. But the conversations are still similar.

As I mentioned, not all people want all interventions. And so, to me, you can affirm someone's identity without making assumptions about what they want and support them in making that

decision themselves.

We do see this distribution of interest in medical care and surgical care, even well into adulthood. There's plenty of adults who are very interested in surgery, and plenty of adults who are not interested in surgery.

REPRESENTATIVE COX: So prior to that surgery, you mentioned medications. You looked at two medications or two approaches specifically is the way -- is what I recall a moment ago. When you're walking through them with the good and the bad, the risks, and so forth, of those medications, is there an exhaustive discussion with those individuals about preserving function and fertility, and explaining to them that there is a point of no return where they will loose functionality and they will loose their fertility? Those are full-disclosure-type conversations, I would imagine?

DOCTOR DALKE: Yes. Frankly, they're conversations we start having with people when they're very young.

You know, when we talk about puberty blockers, we talk to people about how this might affect their fertility. When we talk about

hormones and testosterone and estrogen, we talk about how that might affect their fertility. And certainly, when we talk about surgery that would remove tissue that's necessary for fertility, we talk about fertility.

In my experience, most people have really thought about this in a lot of detail, and have really thoughtful answers to those questions.

One of the things I think that's actually interesting is that, there's a lot of apprehension about preserving fertility, but that's not a service that's actually covered by most insurers for people in Pennsylvania. So, if a person, for example, wants to be able to freeze sperm or a person wants to be able to freeze eggs, that could be very costly out of pocket for young people.

REPRESENTATIVE COX: Okay. Thank you very much for your answers.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Representative. I understand that Representative Mary Joe Daley has a question. I think she's with us virtually.

REPRESENTATIVE DALEY: I'm with you virtually. I'm going to turn the camera and unmute

myself. So, thank you, Chairman Schemel, for the opportunity to participate in this way in this hearing. I really appreciate it.

Doctor Dalke, it's really fortunate to be able to read through your testimony earlier today, but it's really good to hear it directly from you. I want to go back to what Chairman Schemel talked about with why we're having these hearings, and that the question came up in the state when the Governor made a statement that full health care for transgender youth would be covered by the state's Medicaid.

And so -- And I realize as I was thinking through this and listening to some of the other conversation, the provider is not necessarily the best person to talk to about what kind of insurance a person might have. But I wanted to go back to some of the comments that you made about social stressors that youth are exposed to, and especially kids who -- kids of color, black kids, and that they are potentially getting more stigma attached to them, more isolation, and more possibility that these stressors that you discussed would end up with really negative kinds of outcomes for them as they get older because they just don't

have anyone to talk to.

And so, I guess what I could ask you to talk about is, when you have a population that doesn't or can't get treatment, and we know that there's supposed to be parity in mental health treatment, but I don't think there really is, how this can actually help kids who might be -- have Medicaid as their health care, or CHIP, those programs. It seems like it's really important to give them health care when they need it, because it's more -- it's healthier, quite honestly, as they grow older. If you could talk about that a little.

DOCTOR DALKE: Sure. So I appreciate you recognizing that my skill set is not in policy.

So what I can say from the clinical perspective is that, first of all, part of the reason we see trans youth of color, in particular, experiencing significantly more mental health problems and symptoms is actually exactly related to what you're talking about, which is, what we call intersecting stressors, so people experience not just stress and stigma related to being transgender, but they also experience stress and stigma related to being black, for example,

experiencing race and racial discrimination; people who experience stress or stigma related to having a physical disability or a mental disability. And so, you can see that those stressors intersect to change someone's level of stress and change the burden of mental health problems that they experience.

What I can say, and I didn't include these citations in my testimony, so I'd be happy to share them with the subcommittee. There have been studies that have compared mental health symptoms and behaviors in states that have affirming protective legislation and states that lack affirming or protective legislation.

So there's a big body of work looming before the Supreme Court ruling on marriage equality. There were, at least comparing mental health and suicide in states that had same sex marriage legal, and states that did not. We saw that youth in states with marriage equality have lower rates of psychological distress and suicide, but it wasn't even just LGBTQ people. It was all youth.

There's been similar studies that look at affirming-protective legislation to protect kids

from bullying, including states that name -- that name bullying under a specific identity or sexual orientation exclusively.

So I think from a policy perspective, this is one of those things we say that not covering a particular kind of care for a specific population is a matter of policy becomes a mental stressor which we do see can influence people's mental health situation significantly down the line.

Then the last thing I would say is that, the youth in Pennsylvania, although as a particular (indiscernible) there are programs across the state. Many of our youth have a hard time accessing these programs, either physically or logistically, or wherever they are from. There are many (indiscernible) as well as far as being able to find a mental health provider in communities, and Medicaid has been part of their success.

REPRESENTATIVE DALEY: Thank you very much. And it would be really helpful, I think, for us to see the study of the states that have affirming care and those that don't have affirming care. I think that would be useful.

I think for our Chairman, we should

probably be at some point looking at those individuals who actually can, you know, the health economics kind of side of this would be also interesting for a future hearing. So, just something to think about.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Representative Daley.

Doctor Dalke, I have a few questions.

So, in my own mind I sort of stratify, and I know this is an oversimplification, of the different stages. So affirming is an initial stage as children explore, then puberty-blocking drugs, and then cross-sex hormones. And for some, I think you said, perhaps, a minority, surgery.

But each of those first three stages, affirmation, then puberty-blocking drugs, then cross-sex hormones, in your own clinical experience, how many children -- You say this is a path of exploration. Presumably, some children desist; some children persist. Just approximately, how many children desist after each one? How many would desist after just the social affirmation, would desist to their natal sex; and then, once again, same thing following puberty-blocking drugs or cross-sex hormones.

DOCTOR DALKE: Sure. Thank you for that question. Just to clarify one point.

When I talk about affirming care, I really mean that as including the whole process that you described. It's not -- It's not just the beginning.

I also want it to be clear, too, that for youth, in particular, it is standard care and expected as part of the guidelines that they have gender-affirming mental health care as part of every step along their physical path as well. So it's not --

So people often don't need to see me necessarily as a psychiatrist because they don't need psychiatric medication, but we do expect and want them to have access to a therapist as they continue into this process. And many youth do come back to me, for example, when they're thinking about starting hormones or when they're thinking about having surgery in adolescence or early adulthood.

As far as the question of desistance, what I can say is that, among the scores of patients that I have personally treated, I've had one person later decide that they did -- that they

did not, not identify with their assigned sex. So I say that very intentionally, because this person ultimately decided that they identified as non-binary, but they did not necessarily identify as male which was what their earlier gender identification had been.

And what I learned from that, and what I've learned from talking with other providers and folks in the community and in some of the literature is that, when people are so-called desisting, it's actually not super common for people to desist back to their assigned gender. It's more common for people to say, you know, this is -- I'm understanding my gender identity differently and that has different implications for what my medical care looks like. We also know that the rates of regret for hormones and surgery are very, very low.

But to answer the other part of your question, I -- because I've only had one person, quote unquote, desist, I rarely or never see people who will change their minds after a particular intervention.

What I will see is folks who say, for example, someone who's assigned female at birth,

who identifies as male, who will start this process and maybe they'll wear a chest binder to flatten their chest, and they'll take medication to stop their periods and they'll say, I feel great. I don't need anything else. I am a man and this is what it feels good -- this is how it feels to be a man and I don't need anything else. So that's not someone changing their minds. That's someone just realizing where they are in this spectrum of gender and gender identity as they fall.

Does that help? Does that make sense?

MAJORITY CHAIRMAN SCHEMEL: Yes, it does.

So the first part, especially from prepubertal children, affirmation, you know, that includes acceptance within the family, presentation as transgender in social settings, in school, often changing name and clothing and so forth, and being part of a support group for those able to access that.

I mean, wouldn't you agree that would make it difficult for a child -- They would be experiencing a lot of external pressure to persist. It would be difficult for them to sort of go back after being fully accepted and integrated in that

way. Would you say that's true or not in your experience?

DOCTOR DALKE: So, I think that's a common fear that people have. What I think happens, though, is that, when people -- If someone finds themselves in that situation, which again, happens very infrequently, they don't feel better in the circumstances that they're in, so they don't necessarily feel better being called by a different name or different pronouns or being allowed to use different terms. And so, that becomes pretty clear, and people will try to chart a different course.

I really believe that our children and our young person are extremely resilient and very capable of telling us what they want and need. And so, I think it's very unlikely that someone would, you know, their parents would let they them play with Spiderman toys, again, to use the same example at 6, and then they would feel like they had to take testosterone at 16. I just -- That's very, very unlikely to me, and I personally have never seen that happen.

MAJORITY CHAIRMAN SCHEMEL: Okay. In your testimony you define gender identity as how

someone feels inside. Given that you're diagnosing children, and some children who are very young, do you believe it's likely they have a full understanding of the significance of gender and sex, or is it more likely their feelings sort of evolve as their understandings of those two things evolve?

DOCTOR DALKE: Yes. I'll share, so I have two children myself, and my almost 5 year old is a girl. She was absolutely -- She's thinking it was very all or nothing in a black-and-white way what it means to be a girl. So she decided that if you had long hair, you were a girl and that girls couldn't have short hair. So, I cut my hair very short partly because we had a second child, but also partly to kind of push her on that a little bit. It took her a while, honestly, to kind of open up and recognize that girls could have all different kinds of hair lengths.

So this is something that we see with folks who are very young. The way their cognitive processes work influence the way they talk about and present their gender identity. And as their thinking evolves and their understanding of what this means for them, both individually and socially

evolve, their goals evolve and their priorities evolve. And that's actually what this affirming-care model is doing, and put them in a position to do, is to really meet a person at every single point along their own pathway and say, how are you doing? What is this meaning for you right now, and how are you thinking about this moving forward? So, the model is really designed to be adaptive and dynamic and not to make assumptions or put people on a conveyor belt towards a certain path.

MAJORITY CHAIRMAN SCHEMEL: Thank you. Please understand, I think all of us are trying to understand this better. It's an emerging area for many of us.

But I've read about other dysphoria related to a person's perception of their body, and I'm not aware of any other dysphoria, other than gender dysphoria, that's treated by affirming the individual's perception.

I'm also unaware of any other dysphoria that could potentially be treated by surgery. As a psychiatrist, is that a correct understanding, or am I missing something in my own research?

DOCTOR DALKE: Well, a couple of things. So, first of all, I think while we do -- There

actually are mental health conditions that do involve physical changes.

So, for example, if you have severe depression, I can validate how depressed you feel, as much as I want to, but it's unlikely that you'll feel less depressed unless I give you medication. Some people might need another kind of physical treatment; for example, transcranial magnets, magnetic stimulation which uses magnets to stimulate different parts of the brain to help treat their depression.

So, this kind of divide between physical and psychological I think is not as keen as we sometimes think it is. I think that's kind of point number 1.

I think point number 2 is, there are folks that have something called body dysphoric disorder. This is a scenario in which someone is extremely distressed by a significant part of their body. Frankly, this is something that I wonder about every time I see a person who's presenting with gender dysphoria. I ask myself, is this possible? Is this something that could be going on for this person?

What helps us to feel confident that's

not body dysphoric disorder is that, body dysphoric disorder is usually very specific to one part of the body. So it might be someone's nose, it might be their skin. It might be their calves, whatever the case may be. And socially affirming them otherwise does not take away that distress.

For a young person with gender dysphoria, socially affirming their gender identity may not take away everything, but often will really help reduce a lot of the stress, especially for our younger patients.

Also, similarly, with body dysphoric disorder, these folks are adults. They may go to a plastic surgeon and have treatment, and they still continue to experience this stress either about the outcome of that particular surgery or something else.

So the other difference is that, again, people don't feel better when they have had that kind of treatment if their body dysphoric disorder, their social gender dysphoria do feel better to access (indiscernible) confirms their body goals.

MAJORITY CHAIRMAN SCHEMEL: Okay. Last question, a lot simpler.

Do you follow up with your patients

especially after they are no longer pediatric patients, 5, 10, 20 years down the road just to see how they're doing?

DOCTOR DALKE: So we do stay in contact with patients. Patients are seen regularly, by -- especially by the medical team, as they move through care. If someone is taking testosterone, they need to be seen, for example, every 3 to 6 months or once a year to get their prescriptions they need and have laboratory monitoring. So, yes, longitudinal follow-up is a routine part of care.

MAJORITY CHAIRMAN SCHEMEL: Okay. I know we've gone a little bit over time as we have Doctor Dowshen waiting in the wings. I think one or more members have additional questions. Doctor Dalke, would you be willing, if we submitted those in writing, to take a look at those?

I think that Representative Daley and Representative DeLissio, I think, had questions. Would that be acceptable to you if we sent them via e-mail?

DOCTOR DALKE: Absolutely. I would be honored to do that. Thank you.

MAJORITY CHAIRMAN SCHEMEL: Thank you. We're grateful for your time today. Thank you so

much, Doctor Dalke.

DOCTOR DALKE: Thank you.

MAJORITY CHAIRMAN SCHEMEL: Then our next testifier is Doctor Dowshen. Doctor Dowshen, I think is -- There you are. We can see you.

Doctor Dowshen is the Co-Founder and Medical Director of the Gender and Sexuality Development Clinic and the Director of the Adolescent HIV Service, and Associate Professor of Pediatrics to the University of Pennsylvania School of Medicine. She works out of the Children's Hospital of Philadelphia. That's a phenomenal hospital treating many young children with either new and emergent care.

We're grateful to have you today, Doctor Dowshen, and you may go ahead with your testimony.

DOCTOR DOWSHEN: Thank you. I'd like to start off by thanking Chairwoman Rapp, Chairman Schemel, Minority Chair Frankel, and members of this committee for the opportunity to testify at today's hearing on this important issue.

It's a pleasure to speak with you today in my capacity as a pediatrician and an adolescent medicine specialist. I am a physician and researcher who has been responsible for the care of

nearly 2,000 transgender and gender-diverse children, adolescents and young adults.

My goals for today are to provide information to the Committee about:

Okay. One, development of gender identity in children and adolescents.

Describe the gender-affirming care that is provided at multidisciplinary clinics like ours at CHOP and at Hershey and Pittsburgh as well, and the evidence and support for this care by major professional associations.

And finally, to share with you the personal experiences of my patients and their caregivers. How this care has benefited them and why is this essential.

First, I want to review some basic concepts to ensure that we are all on the same page. First, we often refer to the concept of sex or sex assigned at birth. If you think about it, what is the first thing that people say when a child is born. It's a boy. It's a girl. And how do they decide that? It's based on the identification of a child's genitals by the nurse or doctor in the delivery room.

Second, the term gender expression

refers to how we signal our gender to the world; what clothes or hairstyle we wear or what toys we play with, masculine or feminine, early in the concept of gender identity. For most children, they will grow up to have a gender identity, the internal sense of being male or female, boy or girl, that is the same as their birth assigned sex, on their birth certificate gender, and we refer to this as cisgender.

This sense of being a boy or a girl begins to develop as early as ages 1 or 2 when kids first become conscious of physical differences between sexes. At age 3, most children can label themselves as boy or girl. At age 4, most children will have a stable gender identity and recognize it as constant.

However, for a significant number of people, they will not identify their gender the same as their sex assigned at birth, and we refer to this as transgender. There are also many other terms for gender identity that fall across the spectrum, including those individuals who identify as non-binary, who feel that they are not a boy or a girl or that they are both.

It is also important that we distinguish

these concepts for sex orientation and behavior. How we see ourselves as male or female, or boy or girl, is different from whom we are attracted to.

So, while the majority of the children and adolescents identify as cisgender as much as one percent or more of the U.S. population may identify as transgender, totaling millions of Americans. Initial reports of the number of people who are transgender were much lower than today, but there is evidence in societies across the world that people have always identified as transgender.

The reason for lower reports in the past are that there was great stigma towards this identity, and supportive psychological services and affirming medical care simply were not available. Today, now that there is better understanding and acceptance of having transgender identity and supports are available, many who may have suffered in silence are now openly able to live as their true selves. In recent surveys of adolescents, up to 2 percent or more identify as transgender or non-binary.

For young people whose gender expression or identity is different from their sex assigned at birth, issues may arise around early school age

when most children's gender identity is solidifying, or it may not appear until later in life. For many of these children, they will experience significant distress about not having the physical characteristics of the gender that they identify as. This is a concept that we call gender dysphoria. As you can imagine, if when body parts began to change and secondary sex characteristics develop during puberty, this can be extremely distressing for trans youth who do not identify with those body parts.

The research shows us that transgender youth who are not supported in their identities have poor health outcomes for both their physical and mental health. They have extremely high rates of anxiety and depression, and more than 40 percent of trans individuals who are not formed in their identities report having attempted suicide in their lifetime. Trans individuals are also at higher risk for medical conditions such as eating disorders, HIV, and other chronic diseases.

It is extremely important to understand that these poor outcomes are not due to one's gender identity, but rather due to the shame and stigma they face from society because of their

identity. Trans individuals often are not accepted by their families, friends, community, and schools, and experience extremely high rates of bullying, violence, and other forms of victimization and harassment.

On the flip side, we see that when young people who identify as trans are supported by their loved ones, communities, and institutions, and have access to gender-affirming medical and mental health care, their physical and mental health outcomes are greatly improved. This clear evidence of benefit have led all of the major medical and mental health professional associations, including the American Academy of Pediatrics, the Endocrine Society, the Society for Adolescent Health and Medicine, the World Professional Association of Transgender Health, and the American Medical Association, which together represents the vast majority of physicians to recommend gender-affirming medical care for children and adolescents.

This evidence and clinical guidelines and recommendations from organizations like the AAP and Endocrine Society drive the care provided at clinics now found at most major pediatric medical

centers. Myself and Doctor Linda Hawkins founded the CHOP Gender and Sexuality Development Clinic almost 7 years ago now, with the goal of providing medical care and psychosocial support to transgender and gender-diverse children and adolescents.

Our multidisciplinary team, including mental health gender experts, adolescent medicine specialists, endocrinologists, and social work and educational support specialists have now provided care for over 1600 youths and their families ranging in age from ages 4 to 24.

Interactions with the clinic begin with a brief telephone call with our intake and education specialist who can help to triage any immediate needs or concerns. The young person and their caregivers will then have a series of meetings together with the gender mental health care specialist to understand the child's gender expression and identity. What happens next very much depends on the child's age, development, and the child and family needs, and any decisions are made together by the multi- disciplinary care team, parents, and child.

When it comes to treatment for gender

dysphoria, there are multiple stages or categories. There are treatments that are considered fully reversible, those that are considered partially reversible, and those that are irreversible.

Fully reversible treatments include non-medical interventions, such as allowing a child to wear their clothes and hair they want, to use preferred names and pronouns, to play with the toys they would like to. This is often referred to as social transition. These non-medical interventions in addition to therapy and creating more supportive environments are the only recommended treatments for younger, school-aged or prepubertal children. These fully reversible interventions have been shown to have great benefit.

For example, in a large study published in the journal Pediatrics of prepubertal children with gender dysphoria, they were followed over time and compared with youth who were not allowed to transition, and to their cisgender peers. Those who are allowed to socially transition had much lower levels of anxiety and depression than their counterparts who were not allowed to socially transition, and they had similar outcomes to their cisgender peers.

Another recent study showed that trans youth who were called by their preferred names at school were significantly less likely to consider suicide because of this validation of their identity.

The major medical intervention that is considered fully reversible is puberty-blocking medication. These medications are only given when a child has already started puberty, a time which can be extremely distressing to youth with gender dysphoria, and in a child who has displayed insistence, consistence and persistence in their gender identity. Again, these decisions are made together by the care team, youth, and parents.

This is a very safe medication that has been used for many decades, previously for children who are starting puberty too early or what is referred to as precocious puberty. We now also have a great deal of experience with using it to put a pause button on puberty for youth with gender dysphoria. This helps to give time for parents, youth, and providers to consider less reversible options and allows the youth to not have to deal with going through the puberty that is wrong for them and, therefore, decreases distress.

For example, for a youth born assigned as female who identify as male, if they start puberty blockers just as puberty is beginning, they will stop any breast development from ever happening, relieve potential chest dysphoria, and avoid the need for surgery later. We have multiple studies now showing the (indiscernible) and psychosocial benefits of these medications for gender dysphoria, including similar psychosocial outcomes in young adults to cisgender youth, and rates of suicidality up to three times lower than in youth who did not have access to puberty-blocking medications.

Decisions may be made in early to mid-adolescence to consider hormone therapy, particularly estrogen or testosterone, which are the major partially reversible options for treatment. This allows for a child to essentially then go through the puberty that aligns with their gender identity, together with their peers. It's important to note that these changes occur over a period of several years, similar to the natural puberty process. Again, there is strong evidence that these hormones are safe and provide psychosocial benefit to youth experiencing gender

dysphoria.

For many trans and non-binary individuals their chest and genitals may be a significant cause of distress, and they may choose to have a variety of gender-affirming medical procedures to achieve alignment of their body and their gender identity. It is also important to note that many trans individuals do not want to or are not able to have gender-affirming surgeries for a variety of reasons.

In general, these surgeries are offered after the age of 18. The most common surgical procedure, as Doctor Dalke mentioned, that may occur among adolescents is masculinizing chest surgery or bilateral reduction mammoplasty, which is also referred to as top surgery.

For those transmasculine youth who are born assigned female, but have already developed breast tissue when they present for treatment, they frequently experience severe distress related to their chest, almost universally wearing painful chest binders to flatten the appearance of the chest and experience significant functional impairment.

Top surgery, which involves removing

breast tissue to create a masculine chest appearance, has been shown to have tremendous social and psychological benefit for transmasculine adolescents and young adults. Typically, any other gender-affirming medical procedures, such as genital reassignment surgery, if desired and appropriate for an individual happens after age 18, and these procedures have been shown to have similar benefit as well.

As you can image, it's often challenging for youth and family to navigate this treatment path, including social and medical transition, and they often feel alone in the process or their identity and don't know who to turn to.

One of the most important things we did shortly after starting our clinic was to form a support group for patients and families. We now have over 150 people attending a support group each month, many traveling from far away, and it includes groups for the younger kids, the younger school-age kids who call themselves the mighty's, the tweens, the teens, the siblings, the parents, and recently we added grandparents as well.

So, many of my patients and their families have found this incredibly important to

learn from each other as they face so many unique challenges in a society that often does not support or understand them. Some of the youth tell me that it is the one day of the month that they look forward to the most.

Now I want to share with you some words from my own patients and from parents of transgender youth about how essential gender-affirming care is to them.

First, a study completed by my research team and led by my colleague, Doctor Jamie Mehringer that was just recently provisionally accepted for publication in the journal Pediatrics, highlights the suffering that occurs for a transmasculine youth who experienced chest dysphoria, and then the tremendous benefits from masculinizing chest surgery or top surgery.

The young people who participated in this study wanted us to share their words and gave permission for them to be used for educational purposes. First, there's a series of quotes from youth about their experience of chest dysphoria.

The first youth says: It was really hard every day waking up and having to go to school. For me, at least it was impossible to feel

like a man, especially in an environment like school with a very large chest, and I didn't want to be seen. I would miss a lot of school sometimes because I just couldn't get myself together.

The second youth says: Little things would definitely tip me off the edge where I would feel too overwhelmed. I couldn't manage very simple tasks like just doing school work.

The third youth says: I've been suicidal quite a few times over just looking at myself in the mirror and seeing it. That's not something that I should have been born with.

The next youth says: Even if it's not the prettiest surgery, I will be comfortable. I don't have to limit my activities or limit the most ridiculous things because of my breasts. More freedom. I'll get to live. I'm not living now. I feel like I'm just getting by.

Next are a series of quotes by youth who actually had top surgery. The first youth says: It's been a relief. Now that the problem is basically solved, I can basically focus on the energy that I was focusing on that and redirect it somewhere way more productive. I can now do actual exercise for the first time in my life.

The next youth says: I think I really didn't realize how much it was affecting my life until I was able to start going out and doing things again without constant worry and fear. I just felt more confident as a person. I was able to talk to people. A lot of things that I wasn't able to do because that was holding me back.

And the last youth says: It was liberating because I could finally live a normal life like the rest of the kids my age. I'm a lot easier to talk to people because I'm not as uptight or I don't come off as rigid as I was. So it's made me a lot more relatable to people because I could actually -- I don't have to worry about my chest dysphoria.

When laws were recently proposed in other states to criminalize gender-affirming care, our clinic was flooded with calls from patients and their parents concerned for their children's safety and well-being if they would no longer be able to receive this care. My colleague at Children's Hospital Pittsburgh, Doctor Casey Kidd, myself and others, decided to do a survey of parents of transgender children who were receiving gender-affirming care across the country. We were flooded

with over 300 responses from parents in just 24 hours from 43 states across the U.S.

The most salient theme in their responses, which appeared 85 percent of the time, described parent and caregiver fears that these laws would lead to worsening mental health and suicide for their transgender children. The resulting manuscript from the survey was recently accepted for publications in the Journal of Adolescent Health.

Please listen carefully to what I have to say next. Here is what your constituents, parents of transgender children in Pennsylvania who participated in this study had to say. They were asked, what do laws like this mean to you as the parent or caregiver of a gender-diverse child? How do you think that laws like this would have impacted or could impact your child?

The first parent says: My child was suicidal and depressed. After starting hormones at 16, the suicidal ideologies were gone and his depression had eased tremendously. The gender-affirming care received saved his life, and he was accepted at an Ivy league and high-achieving universities. He is now on the Dean's, high honors

list, at the university he chose. He had not had this care -- Had he not had this care, he most likely would not have lived to age 19, let alone achieve what he has done. Mother of a transgender son.

This law would add to the already rising teenage suicide rate. Transgender children need to know that their lives matter. They want hope for a better tomorrow. Do not marginalize them. Do not minimize the pain they feel or the ridicule they endure. Mother of a transgender daughter.

Laws like this would take away life-saving medicines from kids like mine and ones across the country. Trans kids are already so vulnerable and oftentimes subjected to violence. To take away something that could make them feel closer to their true selves is just cruel. Mother of a transgender daughter.

My child is only 5, but every year she gets closer to puberty, we worry about what would happen if we weren't able to get blockers and her body started to change and present in a more masculine way. No one desires to have their body betray them like that. No one should be allowed to tell me what is right for my child's body other

than our doctor. I know that without puberty blockers, my child would forever be subjected to a life of torment, less acceptance, and self-loathing. She would no longer be considered passing which would put her in danger every single day of the rest of her life. Mother of a transgender daughter.

They would make our lives hell, especially my son. He's an honor student now that he started his transition. He's happier than ever, well-adjusted, thoughtful, many friends, and great in school. Before the start of transitioning, he was horrible. Acted out in the worse ways, cut himself, lied, et cetera. Now he's a well-adjusted respectful child. The difference is astounding. Take this trans care away, he will probably be suicidal, and knowing him, he'd succeed. Removing his trans care would be the same as signing his death warrant, and that's not overstating. Mother of a transgender son.

I'm terrified of these laws. He will end up dead, probably through suicide, or I will end up in jail buying his testosterone illegally. Mother of a transgender son.

My son would be forced to go through

female puberty, causing unwanted and some not completely irreversible changes to happen to his body against his wishes and consent. He would have to then go through more extensive and expensive and medically complicated treatments and surgeries, knowing that there was a better way; that inert blockers and testosterone would have been made things safer, cheaper, and easier. His risk of depression and suicidality would increase exponentially. I fear for my son's mental health if these laws were passed in my state. I fear for his life. Mother of a transgender son.

And finally, my assigned female at birth son was in total crisis when he started testosterone. I worried for a year while he was in therapy and had a supportive family and medical team that he would attempt to hurt himself. He was so depressed and anxious. The testosterone and ensuing top surgery were medically necessary intervention that helped my child immensely. Without these treatments, which are recommended by a team of mental health professionals that specialize in adolescent gender issues, a pediatric endocrinologist, and one of the foremost plastic surgeons in the region, my child may not be alive

today.

Access to this care currently is a privilege for those who have the health care coverage, and in many cases, the intellectual and emotional resources and time to fight a health care system that does not, in most cases, just accept that trans kids have legitimate medical needs that should be treated so they can live.

All any parent wants is for their child to grow up to be happy and healthy and realize their full potential. Being able to get the care my child needs means he gets to do those things. He will always be a member of a marginalized group, so he will likely have to deal with discrimination his whole life, in addition to the dysphoria that is part of being trans, but his access to medical care is the difference between him being able to simply live his life and him being in hell.

Laws that would restrict or eliminate his access to care are tantamount to a life of misery, or even no life at all. Denying care to a vulnerable population means actively endorsing that their lives are unimportant. I assure you as a parents that nothing could be farther from the truth. Look at statistics on suicide attempts and

completions for trans kids versus LGB youth, and you'd see that they are exponentially more at risk than LGB youths. Ask yourself why this is okay for kids with other chronic health concerns to get treatment, but not for our kids. If you or someone you know has a child with a chronic medical condition, ask yourself how you would feel if you knew that lawmakers were considering making their care illegal.

My son is bright, kind, and has a lot to offer the world. I love him, and caring for him is something that his family and his doctors, not legislators should be in charge of. You don't know my son, but if you did, you wouldn't want to write him off. Mother of a transgender son.

So, unfortunately, at the beginning of COVID pandemic, we, our patients, and their parents worried about whether they would be able to continue to receive this vital care. Hospitals quickly clamped down on in-person visits in the outpatient setting in order to conserve resources like PPE and to reduce exposure among patients and providers to the virus. Across the country, appointments to start or stop puberty blockers or hormones were canceled. And again, we received

many calls from parents concerned about their children's access to care and their safety if they could not continue the care.

However, one of the silver linings of this pandemic for me and for many others has been the proliferation of telemedicine. Thankfully, at CHOP we were able to immediately spring into action, and within a week we were seeing all of our patients via telemedicine. One of the amazing benefits of this care has been that we have been able to increase access for children living in areas or circumstances where this life-saving care is not available, and we still have been able to deliver this care with the highest quality.

My take home message to you today as a pediatrician and a mother, is that gender-affirming care stays effective, medically necessary, and recommended by all major medical professional organizations. We need to find ways, like telemedicine, to provide more of this care and not less. Access to this care is a matter of life and death. I assure you, our children's lives and well-being depends on it.

Again, I thank you for your time and attention, and I'm happy to take any questions at

this time.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Doctor Dowshen, for your testimony. And one point of clarification, you may not have heard from the very beginning of the testimony today, I'm not aware of the legislature in Pennsylvania is currently circulating any legislation which would outlaw the transgender care that you provide at your clinic.

The purview of this subcommittee is really just to explore what that care is in light of the fact that the Governor has made that accessible through Medicaid. So in that way the Commonwealth or the taxpayers of Pennsylvania are consumers. They're paying for the service.

Also, the last I knew from my discussions with the Secretary of Health, I'm not aware that actually any Medicaid patient has requested that care. It may have changed. That's a few years old.

With that, if you're willing to take some questions, I'll see what subcommittee members have.

Chairman DeLissio. Chairwoman, sorry.

MINORITY CHAIRWOMAN DeLISSIO: That's

okay. I'll answer.

Good morning, Doctor Dowshen. Thank you for being here today. A couple of quick questions, and I'll save my comment or two for when we close.

Are the referrals -- The children that are referred to the clinic, are those a combination of self-referrals? Are those referrals made from those individual children's pediatricians? Where do -- How do those folks find their way to your door?

DOCTOR DOWSHEN: Yeah, that's a great question. I'll tell you that when we first opened the clinic seven years ago, and Doctor Hawkins and I were on local radio talking about it, we had 24 calls from parents within 24 hours because there was no care like this available, and people were just waiting to get their children into somewhere where they could find the appropriate support.

Since then, we've had consistently over the last six and a half years approximately three to five referrals per week, and they're coming from a variety of places. Many, as you mentioned, are coming from the child's pediatrician. And like Doctor Dalke talked about, it is now standard practice that pediatricians, in general, should be

asking patients and families about this. And, particularly, for adolescents they should be spending confidential time with adolescents to ask them about things like their gender and sexuality.

And so, the more that pediatricians are becoming comfortable with talking about these topics with patients and families, the more that they are getting comfortable with them saying, okay. Well, if the young person says they have these concerns or the parents have these concerns, we'll make this referral onto the, you know, CHOP Gender and Sexuality Development Clinic.

We also have a lot of parents and children who are coming to us directly, and specifically to address the question that came up with before, we are seeing kids at a variety of ages, and we're definitely seeing large numbers now of kids coming in that sort of, or at least school-age time, where they're expressing their gender differently than parents expect.

When parents are supportive or they're confused about what's going on with their child, they will contact us directly. As I said, as Doctor Dalke talked about in the beginning, that care is really just to do assessments and provide

support. There's no medical intervention at this point.

But, yes, we're really getting referrals from a variety of resources.

We're also getting a lot more referrals from other institutions and other youth-serving professionals who are working with youth in other capacities, sometimes from within the foster care system or the mental health system; through homeless shelters for youth who are in need of support.

MINORITY CHAIRWOMAN DeLISSIO: Thank you. I appreciate that.

It just kind -- Oh. Again, if I -- I said when we started this hearing today, this is a new body of knowledge for me. Certainly, my awareness was there, but it's there much more. So I'm actually very grateful to Rep Schemel for suggesting this as a topic and suggesting that we take this opportunity while there is not any legislation to educate ourselves because there was quite a bit of discussion when the real authorization bill went through.

So, my one take-away has been, after these two hearings is that, this is highly nuance.

This is not a liner event where you check this box, check this box. You know, we've done A, and now we move onto B, and now we move onto C, with the end result being, you know, a sex-change operation.

I have heard clearly from Doctor Dalke today, as well as yourself, that this is a -- as one would imagine in a situation like this, a very thoughtful process where -- My sister happens to be a mental health professional, and she's always advised me that -- I come out of long-term care. But if you want to get somebody from point A to point B, better start where they are at point A in order to help them get to wherever they need to be, which may or may not be point B, actually.

Am I wrong to characterize that in this way; that this is highly nuance? This is individualized as these children are, and what their particular needs are depending on where they're at in the process.

DOCTOR DOWSHEN: Yes. Your characterization is a hundred percent spot on.

We're in this era where folks have recognized that in the field of medicine, we need to provide individualized and tailored care. You'll hear terms like personalized or precision

medicine, and that's exactly what we're doing here. We're certainly using a standard set of guidelines from these major professional organizations with evidence behind them. But which parts of those guidelines comply to each child may be different, right?

And so, as Doctor Dalke talked about and as I referred to in my testimony, many young people are coming to us where they may want no medical support, and they may only want psychosocial support. Others may want medical support and surgical intervention and others may want just medical intervention. So, we really are tailoring the care to what the needs of the child and family are and to what's developmentally appropriate and recommended for that child.

MINORITY CHAIRWOMAN DeLISSIO: Thank you. Thank you, Representative Schemel.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Madam Chair.

Chairman Frankel.

REPRESENTATIVE FRANKEL: Thank you, Chairman Schemel.

And thank you, Doctor Dowshen. It's really very informative, very helpful. The stories

you told us about your patients were very moving. I would hope -- I know there was great interest for this hearing to have actual families and transgender youth have an opportunity to speak to us. I hope at some point we'll be able to hear from them directly. But, nevertheless, very moving testimony that you provided us as well.

And I want to say, I'm very grateful to our Governor to having extended this about four years ago, Medicaid coverage for transgender care. I think that that was a meaningful move for us, and certainly one that is consistent with the standard of care that ought to be accessible to every person in this state no matter what their gender identity or expression.

I want to ask you, and I know you touched on this and so did Doctor Dalke. Can you tell us exactly -- We talked about the standard of care and where the medical profession is and the organizations that, basically, the American Academy of Pediatrics, the Endocrine Society, the American Medical Association, where do they stand on this standard of care?

DOCTOR DOWSHEN: Yeah, absolutely. Thank you for that question. First, I want to say

that I'm so glad to be here today to provide information to the Committee.

I included statements specifically about those laws that were being proposed in other states. I think the point of my sharing that information was to let folks know how important this care is to our patients, our families, even if legislation like that is not being proposed in Pennsylvania.

As far as the major medical professional associations, as both Doctor Dalke and I talked about in our testimony, it's both all of the major mental health professional organizations, as well as all of the major medical professional organizations that support the model of care that our clinics are providing. It's very clearly outlined in the Endocrine Society guidelines and the WPATH standards of care, the World Professional Association of Transgender Health standards of care, as well in the American Academy of Pediatrics' statement on transgender and gender-diverse youth and their clinical practice guidelines.

So all of the things that we are talking about today and the way in which our clinics are

providing care are consistent with those sets of guidelines from these organizations that represent almost all of pediatricians and mental health providers who were involved in this care.

REPRESENTATIVE FRANKEL: Thank you very much. Really appreciate, again, your testimony today and -- I think it gave us all a much better understanding of gender-affirming care that I think would be so necessary for our youth, particularly that -- they're so much at risk without this care. So thank you very much.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Chairman.

Representative Zimmerman.

REPRESENTATIVE ZIMMERMAN: Thank you, Chairman Schemel.

And thank you, Doctor Dowshen. Several questions. Let me start with the question, at CHOP, how many patients that are biological girls versus boys are taking place right now? What does that percentage look like?

DOCTOR DOWSHEN: I don't have the exact numbers for you. And I think what you're referring to is, how many individuals who are born assigned female sex versus who are born assigned male sex,

you know, and generally, we have probably close to two-thirds of individuals who are born assigned female sex who are presenting to care. But that, as Doctor Dalke mentioned, also varies across the country.

REPRESENTATIVE ZIMMERMAN: What's the youngest that you would treat a child?

DOCTOR DOWSHEN: Also, as Doctor Dalke mentioned, and as I referred to in my testimony, I think the youngest child that we've seen in our clinic is age 4. But at that age what we're doing is, if a parent is bringing their child because they have a concern or a question about what's going on with that child's gender expression or gender identity; or if they are understanding their child's gender identity and want to know how to be supportive, in any of those scenarios they may contact our clinic or their pediatrician may refer them to us.

So, first, we'll sort of start off by giving them some resources and support, and we will also have a meeting with the mental health gender specialist who will try to understand what's going on with the child's gender identity and expression, like Doctor Dalke talked about, and then making

recommendations for how they can support their child which, you know, the main recommendation that we're always making is that, you should love your child for who they are, and that will be what's best for them.

And then like Doctor Dalke said, it will often involve saying, okay, well, if the child seems more comfortable with being called this name or wearing this type of clothing, let's let them do that and let's see how they're feeling when they're allowed to do that. And again, like Doctor Dalke said, if we see that the child is feeling better and persisting in that identity, then we know we're on the right track.

REPRESENTATIVE ZIMMERMAN: So, what percent -- Again, children coming to CHOP would be before puberty. Did I understand most of them are after? What percent might be before puberty?

DOCTOR DOWSHEN: Yes. The majority are still coming to us after puberty, but we do have increasing numbers of -- and then we've had significant numbers of kids from the beginning of the clinic who are coming during early school age, around age 4 or 5, or other times before puberty. For those kids who are coming before they hit

puberty, again, we're only recommending psychosocial support and nonmedical intervention.

REPRESENTATIVE ZIMMERMAN: When it comes to puberty blockers, what age do they generally start? What about cross-sex hormones? What age do those things start?

DOCTOR DOWSHEN: Sure. Great question.

A lot of this is done based on a child's natural puberty, and then also what's appropriate based on their developmental contacts, their family and school situations, and their specific needs.

So, for puberty blockers, you know, as Doctor Dalke mentioned in her testimony, there's a wide range of ages in which a young person can begin to go through puberty and it be normal. So some kids have used the puberty-blocking medication because they were going through it in a stage that was too early for them.

For kids who are going through puberty at normal ages, that could start as early as 8 or 9. For a child who is born an assigned female sex and could go up to age 14 for folks who were born assigned male sex. So there's a real range there, and we're making a decision to start the blocker based on when that child hits puberty.

We have a series of tests that we do, as well as the main thing being our physical exam to understand when a child is starting to have, for example, testicular development or breast development to clue us in to when they're starting puberty. And we would start the puberty-blocking medications at that time.

REPRESENTATIVE ZIMMERMAN: Okay. Thanks.

And just kind of a final question, again, revolving around age. When there's breast removal or top surgery, as it's called, what age does that generally happen? And also, what about bottom surgery? What ages are we looking at?

DOCTOR DOWSHEN: Sure. I realize I also didn't address part of your previous question, which was about what ages we start hormones. Generally, that's around age 16, but sometimes we're starting somewhat earlier than that, again, to have that puberty that a child is going to go through aligned with their peers, and when it's again decided on to be developmentally appropriate for that child with their family and their care team.

I think that there isn't really a strict

number, but it's really more about when it's developmentally and socially and medically appropriate for that child.

And then in terms of surgeries, as I mentioned, top surgery is the only surgery at this point that the major medical professional organizations are recommending that there be no lower age limit for that surgery. And so, in general, though, most youth who are having top surgery are over the age of 16.

I provided two references in my testimony to published studies which were about the benefits of top surgery, and both had youth who are on average age 17. So, the majority of youth were having top surgery are having that surgery if it's before age 18 just in the couple years before that.

And we're seeing, like I said, youth are having tremendous benefit from that because a lot of them have been now for many years, after having developed breast tissue, because they weren't able to come to us early enough for puberty blockers, they've been wearing these either chest binders, which are really helpful and essential for them, but also are really limiting. So, once they are able to have the surgery, universally are able to

just be socially engaged in ways they weren't before.

And then when it comes to bottom surgery, which, you know, some people will refer to as sex reassignment surgery or gender reassignment surgery, I refer to it as genital reassignment surgery. As we talk about people can have a variety of different feelings about certain parts of their bodies when they have gender dysphoria.

And for some people their genitals do not necessarily define their gender, and some people who, you know, are a trans woman, for example, who will live their life -- their entire life as a woman may not choose to have any surgery on -- any bottom surgery. The same could be true for a trans masculine individual. However, for many people it would be really important to have this surgery.

These genital reassignment surgeries generally almost always occur after the age of 18. These surgeries, particularly vaginoplasty and orchiectomy, the surgeries for a transgender woman, are complicated surgeries that require quite a bit of, sort of preparation and support for healing. And so, you know, this is not something that we

make the decision lightly with a young person and their family, again, after the age of 18 if that is the right option for them.

REPRESENTATIVE ZIMMERMAN: Just a final question. What would be the youngest that you would have referred a patient for either of those surgeries?

DOCTOR DOWSHEN: For top surgery, we have referred -- Again, we don't recommend the surgery. This is based on, over time, working with the young person and their family and what decision seems right and developmentally appropriate for them, that they would be sometimes receiving a letter of support or a referral to a surgeon as young as age 14 is probably -- sometime between 14 and 15 is the youngest. Again, like I said, the majority are happening closer to 18; more between 16 to 18.

Again, I think it's really important to remember that age is a number. But as an adolescent medicine and developmental specialist, we know that where a child is cognitively and socially is more important than that exact number of their age.

REPRESENTATIVE ZIMMERMAN: Good. I

appreciate that. Just another real quick question and I'll end with that.

What would have been the youngest that you would have recommended this cross-sex hormones? What might that number have been or age been?

DOCTOR DOWSHEN: Yeah. So, that is also highly dependent on the individual situation. We're talking about sort of two different groups of individuals, those who have come to us when they're really young and who started on puberty blockers, and those of us who are coming to us later after they've already gone through most of or all of puberty. Then we sort of see what we call bi-mobile distribution.

For the kids who are coming to us much younger who have been on puberty blockers since the beginning of puberty, for some of them, for a variety of reasons, it's appropriate to start earlier on the hormones. But, generally, not before the age of 14.

REPRESENTATIVE ZIMMERMAN: Okay. Thank you.

MAJORITY CHAIRMAN SCHEMEL: Thank you. Representative Cox.

REPRESENTATIVE COX: Thank you, Mr.

Chairman.

Thank you, Doctor Dowshen. I understand that puberty-blocking drugs can slow down or stop a child's growth and can result in under-developed bones. When you have these discussions regarding the use of those particular drugs, do you caution the patient?

I'm hearing some of the -- I guess I heard 8 or 9 years old as some of the puberty-blocking drugs going into use. So, kind of a wrapped-up question, are parents -- First of all, are parents in those meetings with the 8- or 9-year-old children?

(No audible answer).

REPRESENTATIVE COX: Okay. And so, the discussion that you have with parents regarding the risk of potentially utilizing puberty-blocking drugs, what does that sound like? What does that discussion entail?

DOCTOR DOWSHEN: Yeah. Thanks very much for this important question.

So, first, I want to mention as the context for this care overall, you may be familiar with the fact that adolescents are able to receive some types of care confidentially. This is

actually not one of them. So for any medical treatment for gender- affirming care, parents have to be fully involved and fully consenting to the care for their child, so they're involved in all discussions about any treatment decisions.

In terms of the consent for care, we have very extensive consent forms, which I'm happy to share with you, that are pages and pages long that detail sort of all of the risks and benefits, side effects, expectations, for these medical -- medications or medical interventions.

As Doctor Dalke referred to, there is no medication that comes without a risk or a side effect, right, but it's all about weighing the potential benefit and what that ratio of risk to benefit is. It's very clear that, you know, these medications provide much more benefit than they do risk based on multiple studies.

I do want to address specifically your question about growth and about bones because these are real ones. These are ones that parents ask us. These are ones that providers worry about.

So, in terms of growth, with the puberty blockers what happens is, just think of it, as I mentioned in my testimony, is like you're putting a

pause button on puberty. So, in puberty you know that the growth velocity accelerates, so how fast someone grows starts to increase. You may have been going only one or two inches a year. You may have started puberty and you start to grow 3 or 4 inches a year. So when we say that we are putting a pause button on puberty, we're not preventing the child from growing. We're just having them grow at a prepubertal rate.

And then, as soon as we start cross-sex hormones, we go into puberty as they're assigned sex, they would grow normally during that time for puberty. So, we generally, also, once we start hormones are then going to have an impact on height with that.

So, once we're starting female hormones, we will -- or estrogen, we will fuse the growth plates so the child will then end up potentially being shorter than they would have if they didn't have that medication. So for most trans women, that's actually a good thing. They do not necessarily want to be the tallest person in the room. But we're also talking about relatively small effect on height, which is more determined by the gene, by your parents' height.

So we have a discussion with them. They often want to know, is this going to make me shorter, is this going to make me taller? We don't know for sure that it's not going to be a big difference than what you would have been otherwise if we didn't give you these medications.

REPRESENTATIVE ZIMMERMAN: Okay.

DOCTOR DOWSHEN: Then in terms of the issue about bone, I think it's important that, again, we recognize the fact that kids are on these medications for a relatively brief period of time. We have many, many years over your lifetime to lay down bone and to increase your bone density.

So we are talking about, you know, potentially having a few extra years where you don't have hormones on board to promote that same level of bone, bone mineral development and bone strength.

However, in infant studies it has been shown that some kids will have a decrease of their bone density during the time that they're on these puberty-blocking medications. So youth truly have taken it because they went through puberty too early, we see that their bones fully density fully recovers when they come off of those medications.

For some transgender youth, there's been multiple studies with somewhat conflicting evidence. Some kids will have decreases and they won't fully recover from those decreases with their bone mineral density. Others will not have any decrease.

A good thing is that, part of our care for these youth is to monitor their bone mineral density, and here we do a scan to make sure that their bone density is in the normal range. If it's not, then we can make different decisions about treatments based on that.

REPRESENTATIVE COX: Okay. Thank you.

So, the individuals you see, the children who come in, have they been down the road of social affirmation where they've been undergoing that type of discussion with doctors like Doctor Dalke and others? Is it safe to assume they've all gone through that affirmation process, if you will, at least for a period of time before they arrive in your office, or are those going on at the same time?

DOCTOR DOWSHEN: So, as Doctor Dalke mentioned previously, this is sort of a spectrum of coordinated care, so we're all kind of working

together. But, yes, before there's any medical intervention recommended, which is when they're coming to see me, they've already been working with a mental health gender specialist for some time. It could be, depending on the age of the child, a series of months versus years in that situation.

REPRESENTATIVE COX: Okay. So it's going to depend on the patient, the child, and the background there as far as the discussion of the risks --

Do you discuss puberty-blocking drugs typically that first visit? I'm assuming because they come to some point of medical intervention, and puberty- blocking drugs being kind of that first step, do you step right in and say, okay, you heard about puberty-blocking drugs, let's talk more about that and the risks? Is that kind of the usual process, or am I making assumptions?

DOCTOR DOWSHEN: Yeah, I think that's a pretty good characterization. The young person usually will have been followed by their pediatrician and by a mental health gender specialist. And then, at the point where they actually start to show signs that they're going through puberty, that's when they'll see me, and

we'll confirm that they're actually going through puberty and we'll have a discussion about whether this is the right option for them.

You know, for some kids and parents, we end up having the discussion and they decide not to start it because, maybe they're actually a little bit later in puberty than we thought, and the different treatment would be most appropriate, or maybe they decided this is not what they need to do at all.

For the most part, yes, once they're coming to me they've already been followed by their general pediatrician and their mental health gender specialist, and then we're having that discussion as well.

REPRESENTATIVE COX: So once they're on the puberty-blocking drugs -- I know every patient is different. That's clearly a common answer we're hearing. And I have five children and none of them are the same in any way.

DOCTOR DOWSHEN: I assume they're very different also.

REPRESENTATIVE COX: But with that said, so different children are on puberty-blocking drugs for different periods of time, I get that. But is

there kind of a window time you normally see? Again, I say set period of time very loosely, but is there kind of a standard, if you will, of how long you're on puberty-blocking drugs before they transition or before they begin cross-sex hormones?

DOCTOR DOWSHEN: Yeah. So, as I mentioned before, because it's natural puberty process can start at a very wide range of ages, we're talking also about a very wide range of when it would be appropriate for kids to be on the blockers. But, you know, generally we don't want the kids to be on them for too long either because we do want them to start to go through the puberty of the gender they identify as together with their peers.

And so, generally, some kids may only -- And it depends on when they come to us as well. So, some kids may be on them for a year. Some kids may be on them for four years. It just depends.

REPRESENTATIVE COX: Okay. A few more questions about, I want to make sure I understand the full range here.

So puberty-blocking drugs, followed by the cross-sex hormones, it's my understanding they can prevent the full development of the penis and

the breasts, and can even result in loss of fertility, or in the ability to experience the physical pleasure that would accompany intercourse.

Is that something -- Am I accurate in that statement just to make sure I'm starting from the right point?

DOCTOR DOWSHEN: You were --

REPRESENTATIVE COX: I'm basing that on prior testimony we heard and some research that I've done in --

DOCTOR DOWSHEN: I think you're asking about two issues. One is, what are the effects of these medications on the genitals? Another is, what about their impact on fertility?

First, in terms of the effects on genitals, again, that will depend on when the child comes to us. But, yes, if we do begin puberty-blocking medications, they will -- or individuals who are born assigned female sex, if they come to us just as they're beginning puberty, they will not develop breast tissue. Now, should they ever stop those medications, they would develop breast tissue normally.

For those who are born assigned male sex who identify as female, if they come to us early,

they will have, yes, less testicular and penile development. However, for many of these children, their genitals are an area of significant distress for them, and so, this is a positive impact.

Also, in terms of how folks will experience sexual pleasure, that is something that we have discussions with our patients about as they -- as they get older, and when it's developmentally appropriate, and young people in all of these different scenarios can find ways of having -- of having sexual pleasure.

When it comes to -- And just to be also clear, the medications, again, will not change any child's genitals, even though they may not grow beyond that prepubertal level. That would then happen if they had surgery, which again, would not be until after the age of 18.

When it comes to the questions about fertility, these are important ones, that we discuss with patients and families early on and often. So, we certainly have discussions prior to starting puberty blockers and prior to starting gender for many hormones, testosterone or estrogen.

What's interesting is that, the field of assistant reproductive technologically is rapidly

evolving, and our understanding of the impact of these medications on biological fertility is also evolving.

I also want to take a step back for a second to say that, you know, transgender youth and their families, just like everyone else, may -- are aware of the fact there are other ways to build families beyond having a child biologically, right? Folks can adopt as well, and many transgender children and adolescents are interesting in having biological children and many are not interested in having children at all or interested in adopting.

I think that we come from a place of having a discussion to say, this is how these interventions may impact your fertility, and there are steps that you may be able to take if biological fertility is something that's really important to you.

So, it's important to note that until someone has surgery, if they were to have genital surgery, or surgery of their other reproductive organs, which would not happen until after the age of 18; if they were to have any intervention before that, there is still a possibility of biological fertility.

The thing that's important to know, for those youth who are going onto the puberty-blocking medications, there are -- most of what we know about fertility preservation comes from the pediatric oncology literature and experience. So kids with cancer who are going to be taking medication that may impact their fertility, what we have learned from that is that there are potentially experimental ways in kids who are prepubertal to obtain tissue from the testicles or from the ovaries that can be saved and may be able to use -- able to use these later, to grow it, and to then have it be used. As I said, this is still very much experimental.

When you talk about the less reversible options, like estrogen and testosterone, we do actually see larger and larger numbers of trans individuals, if they were to stop hormones later in life, particularly testosterone, may be able to have children -- many are able to have children biologically. But, if we want to be certain, if they are going to take those medications and they're coming to us as teenagers who have already partly gone through puberty, we can have them bank sperm or preserve eggs, and some patients will take

that option. We've had several patients do that, for both banking sperm or eggs.

So, we have this conversation with all of our patients and families. And I think it's also, again, really important to say that, while we don't fully know the impact of these medications on fertility, there are many options for biological fertility and other ways to build families, and delaying treatment because of that could lead to much worse outcomes, right? So we would have to think about what the alternatives are.

REPRESENTATIVE COX: Okay. And so -- I think this is my last question. So -- And it's kind of a blended -- You said it earlier, parents are in the meetings. Are parents in every single meeting all the way up through -- You know, every meeting you have with them, there is a child and at least one parents that -- Okay. You're nodding your head, so I'm assuming that's --

DOCTOR DOWSHEN: That's right. That's correct. There are parts of the visit where the parents may not be present because there may be certain issues that the youth are more comfortable talking about alone with the provider, and that we may be checking into other things not related to

their gender. But when it comes to making any decisions about treatment, the parents are always present.

REPRESENTATIVE COX: Okay. And when are the parents asked to leave during certain times that you just described, or is that --

DOCTOR DOWSHEN: Yes.

REPRESENTATIVE COX: At what point do the parents leave for that type of scenario?

DOCTOR DOWSHEN: So that's the standard for adolescent and pediatric care in general. That once the child reaches, you know, the teenage years, it's a time for us to be able to talk to youth confidentially about things like, you know, like their mental health, like their illusion tips of other teens; about what's going on in school in terms of drug use, and things like that.

We know that kids will give us more honest answers and feel more comfortable if they can do that confidentially. And sometimes parents -- Sometimes kids don't want to disappoint their parents, and so, they may want to tell the provider about those things. We then always, of course, are working with adolescents to have them involve their parents in those discussions.

However, again, when it comes to any decisions about treatment or gender dysphoria, that's being made altogether with the family.

For example, you know, there might be something that, because of the hormones, is happening with their body, to their private parts, they don't want to discuss in front of their parents. We'll offer at that time to discuss that alone. Some of the kids will say, I still want my parents to be part of the conversation. They know everything about that, and other kids will say no. But, in the end, as I mentioned, if we're making any decisions about treatment, then the parents are always part of that conversation.

REPRESENTATIVE COX: Do the parents -- Sounds like the child can ask the parent to be there. Does a parent have the right to say, if you're going to be talking to them about mental health issues and otherwise, I would like to be in here to know where they're at mentally and so forth? Do the parents have the right to say, you know, what I'm going to go ahead and stay in here?

DOCTOR DOWSHEN: As I mentioned, we present this to parents as we recommend having this confidential time with adolescents because it's not

about us trying to talk to your kids about things that you don't know about, but it's about providing that forum for them -- for them to start to learn how to take care of their own health care and to have conversations with a provider one on one. We may ask about things, certain things, and the youth does have that right to keep that confidential. A parent can always say they don't want that to happen, but that rarely ever happens.

REPRESENTATIVE COX: Okay.

DOCTOR DOWSHEN: Most parents understand that their kids benefit from having that conversation with the medical provider.

REPRESENTATIVE COX: So I promise this will be my last question.

What age, ultimately, do you believe that a child can fully appreciate the impact of these potentially permanent conditions you describe them as less reversible options? What is that age that you typically see as when they can fully understand the type of the decision that --

I mean, their parents can weigh in, but ultimately, the child has to live with it for the rest of their life or until something else occurs. What is that age or range if I could ask you?

DOCTOR DOWSHEN: You're starting to predict already that I'm not going to be able to give you an exact age because every child's situation is different, and it's about where they are at developmentally; whether they cognitively understand things. You know, we won't make recommendations unless we know that a child is socially and cognitively ready for that. And again, the decision is being made together with the parents, the youth themselves, and our multi-disciplinary care team.

REPRESENTATIVE COX: Okay. Thank you very much.

MAJORITY CHAIRMAN SCHEMEL: Thank you. I believe that Representative Daley has a question.

REPRESENTATIVE DALEY: Yes, I do, Mr. Chairman. I am going to make this very short, however, because I do have another meeting that I've been waiting.

I want to say -- I wanted to ask, you mentioned two different articles, one in Pediatrics and one in the Journal of Adolescent Health that you have articles in with your colleagues. It would be really helpful for us, I think, to have them if we totally don't understand the abstract of

them. It sounds like they may be useful to us, so I would really love to get copies of those, and probably the Chairman would want you to send them to him so he can disperse them.

But the other thing, I really -- I did stick around because I just wanted to let you know, that in getting -- prepping for the hearing we had in March, I have a friend -- well, he's a former work colleague, and I had learned a few months before that when I asked him how his daughter was and he told me, well, my son is doing really well. And so, I learned about his son.

Then in prepping for our last hearing, he and I got together for coffee, and he just explained his family story and how concerned they were about, at that point, their daughter because she was just really, really having a difficult time, and they got an alert from a teacher at her school that she was potentially suicidal and they followed through. They're patients at the CHOP clinic, and their life, he told me, is so much better, and their son is just flourishing with the care that he has received, and they are so grateful for the work that you and your colleagues are doing at CHOP.

I was really glad that you brought in the stories from patients and people in Pennsylvania because I think it's really important for us to hear them. The whole idea that what you tell people is, what you should do is love your kids for who they are. I think that's just really important in a human sense for us to hear you say.

I appreciate all of the information that you have provided to us. It's clearly not a one size fits all. It's just really taking each person as they come to you, and then working with them to find what the best path is. I feel so appreciative because this is a topic I really didn't know much about prior to these hearings. So, I'm grateful for you and Doctor Dalke to be testifiers, to really inform us. I wanted to be able to personally say thank you so much.

Just because, you know, when you don't know something about some thing, it really helps to listen to physicians who are really looking at the needs of their patients. I'm sure you're all learning things yourselves as you move forward, because it's a topic that doesn't seem like it's that old in some ways, but it's been there, because I remember hearing about a cousin who had a baby

and there was not -- they weren't really sure what gender the baby was, and I completely lost touch with that cousin. But, that's a whole different story.

Anyway, I wanted to make sure I got to say thank you to you. And if you'll send us those papers, that would be great.

DOCTOR DOWSHEN: Absolutely. Thank you so much for inviting me today.

I've been to Harrisburg before to talk with various members about these issues. I'm very happy to come and provide education and information any time you all would like.

As the story that you talked about, we have 1,650 kids now who have similar stories, and I feel so privileged to be able to be part of their care.

In terms of the articles, those two articles are actually just accepted for publication, so they aren't actually available yet. But as soon as they are available, I will make sure to send them to you all. And any other references or information that you might need, please feel free to call on me any time for that.

REPRESENTATIVE DALEY: Thank you so

much. Thank you so much.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Representative Daley.

A few questions of my own, Doctor.

So a natal male who uses puberty blockers, they will end up with a child-like genitalia. Do you believe that that will then sort of contribute to their desire to subsequently have surgery? Otherwise, they would go through life as a trans woman with a child-like penis?

DOCTOR DOWSHEN: I'm sorry. You're asking about somebody who was born assigned male, but who identifies as female?

MAJORITY CHAIRMAN SCHEMEL: Correct. And they've gone through the regimen of puberty blockers, therefore, their genitalia is not developed, so they would have a prepubertal genitalia. Do you believe that that then contributes to their desire later to have surgical intervention?

DOCTOR DOWSHEN: No. No, there is -- As far as I'm aware, there's no evidence and I haven't experienced it at all clinically that that has impacted one's decisions. As I mentioned, many of these youth are dysphoric about that body part to

begin with, and even prior to starting puberty blockers, you know, they would be wanting to have that surgery. And for others they are okay with the genitalia that they have.

But, again, as I mentioned before, for many individuals, their genitalia does not necessarily -- does not necessarily correlate with their gender or define their gender for them. We are always there to support young people in building a safe and healthy relationship as they -- as they get older. But there's a real variety of what people look like and what their -- what their body parts are. To the average person, these children will -- will look, you know, physically not look different.

MAJORITY CHAIRMAN SCHEMEL: Okay.

A previous testifier, Doctor Stephen Levine, had testified that children -- the young children who go through facilities like the gender clinic, they will find themselves in a very supportive environment, a celebratory environment, and that corresponds to that age in life when they're in school and so forth. So he said it's no surprise that they have happy outcomes at that point.

He asserted that it's actually later in life that individuals who transitioned young end up feeling sort of isolated and alone. They've lost that support group and they find it difficult to have close relationships. Are you aware of any research that details the outcomes for children treated with blockers, testosterone -- hormones, rather, and so forth, 10 or more years after the administration of those drugs?

DOCTOR DOWSHEN: Yes. The main, sort of long-term outcome data that we have, is actually from the Dutch who were doing -- providing this care earlier than we were in the U.S. That's one of the articles that I referenced in Pediatrics, which was a longitudinal study of kids who had puberty blockers, hormones, and surgeries, and then they were followed into their -- into their -- well into their young adulthood, up into their mid to late 20s, and these folks had excellent psychosocial outcome.

And also, now I've been doing this -- I'm dating myself, but I've been doing this care long enough, for about 15 years, that I have seen what has happened to my patients over time. And I, you know, I have generally not experienced -- I

have not experienced a single patient who has regret over all of that time.

MAJORITY CHAIRMAN SCHEMEL: What percentage of your patients have you followed up with for the full 15 years?

DOCTOR DOWSHEN: There's no -- I'm not able to actively follow them because I'm a pediatrician once they're 24 and beyond. But, as long as they stay in our clinic, they're young people I have taken care of now for almost 10 years just within the confines of our clinic, and then we often stay in touch.

If they're ever concerned or complaints about our care, folks will come to us. We have not received any instances of individuals who have regret of the care that they received.

MAJORITY CHAIRMAN SCHEMEL: You explained in your testimony, at least at CHOP, two-thirds of the children who present are natal females, or you would say child whose sex is assigned at birth as females. I've seen other research that says this is a growing trend; that there are more natal females that are seeking gender care at gender clinics than there are natal males. You've obviously observed this in your own

clinic. What do you think explains that disparity?

DOCTOR DOWSHEN: I don't -- I don't think that it's a growing trend. This has been something that we have seen from the beginning of providing this type of care. And, most likely, the reason for that is that, for trans feminine youth, for those individuals who are born assigned male who identify as female, that they are less likely to be accepted in their gender and society. Therefore, they're less likely to present for care, and will be more likely to come later in life rather than earlier in life to seek treatment.

But, the actual numbers of people who are transgender based on the sex they were assigned at birth, we -- from all the data that's there, the numbers are equal. It's just a matter of who feels in our society and who has access to care.

MAJORITY CHAIRMAN SCHEMEL: One final question. This is actually very similar.

Some research I've seen indicates that there is a -- individuals on the autism spectrum are over-represented amongst those who present at gender clinics. Have you found that to be true in your own practice? If so, what do you think would explain that?

DOCTOR DOWSHEN: This is something that there is ongoing research to understand sort of the intersection between individuals who have a transgender identity and those who are on the autism spectrum. Whether there's actually a higher rate of a transgender identity in that population is really of individuals who have atypical low development isn't really known. We are seeing larger numbers of kids than their representation in the population.

Some of that may be having to do with how kids who are on the autism spectrum identify anything in their lives. They're often more likely to be persistent about how they feel about something regardless of what others, you know, regardless of how others feel or what others say. And so, oftentimes, they think that when a young person is not really socially swayed in the same way by their peers or their family, and they're just telling people who they are, then their family who loves them is gonna bring them for attention and for support. I think that's why we may be seeing higher numbers of youth with autism spectrum disorder.

In the end, the numbers are not what's

important. What's important is that, you know, we again tailor our treatment for those youth to meet their specific needs.

MAJORITY CHAIRMAN SCHEMEL: Okay. Thank you. I know your time is probably growing limited.

DOCTOR DOWSHEN: I'm going to have to leave, actually.

MAJORITY CHAIRMAN SCHEMEL: Okay, Doctor. I think that you are probably aware that, initially, we did envision this as a full day. We have all four testifiers and then a panel discussion. We have the opportunity for a panel discussion here at the end. However, two of the other testifiers are not available. And my understanding is that you are not as well; that you have clinical things.

DOCTOR DOWSHEN: Yes.

MAJORITY CHAIRMAN SCHEMEL: In light of that, you can certainly follow any further discussion we have and present any additional testimony. Like I said, we are not taking a vote any time soon. And I would ask you, if you have any additional testimony or anything, or if we have any additional questions, if you would be willing to allow us to send them by e-mail for a response?

DOCTOR DOWSHEN: Absolutely. I will be very happy to answer any additional questions. Thanks again for this opportunity to share information about the kids and families that I care for.

MAJORITY CHAIRMAN SCHEMEL: Very well. Thank you so much, Doctor Dowshen.

DOCTOR DOWSHEN: Take care. Bye.

MAJORITY CHAIRMAN SCHEMEL: And I share this to my colleagues, if any of them have follow-up questions just let me know. We can kind of put those together in one package to Doctor Dowshen.

The last -- The last part or phase of this hearing would be the panel discussion. The only panelist that we have who was available to return was Doctor Quentin Van Meter. I understand that he is there. I see you, Doctor Van Meter.

DOCTOR VAN METER: Hi.

MAJORITY CHAIRMAN SCHEMEL: Good to see you. I understand that you would be willing to maybe take a few questions or if you had any follow-up comments on any of the testimony that you might have heard, either from the first hearing or through to today.

DOCTOR VAN METER: Thank you for the opportunity to be back. I really had -- had hoped we would actually have a panel discussion where the four of us would be together in the room, and we could sort of cross-question each other and get some clarification for the hearing panel, because that's very important that that happen. Obviously, it's not gonna allow -- this format is not gonna allow us to do that, and I understand the limitations of that.

I did have a chance to review the testimony that was presented to you on the committee by Doctor Dalke and by Doctor Dowshen in advance. Then their speeches to you really followed that very, very closely, so I made notes along the way.

I don't want this to be viewed as an attack on the individuals, but the concepts are based on a profound lack of true science. It was represented that many, many studies show many, many things that justify their particular opinions and their ways of approaching it. But I think it's very telling that Doctor Dalke had not one patient in her practice that ever came to her with issues of transgender and gender incongruence who was --

who went back to resist and return to their biological sex identity.

The use of words is very important. Birth assigned at sex is really a tragic way to look at that because it sort of starts with the person's biologic identity at the moment of birth and not really in utero where so much happens to essentially make the body and the brain and all the organs respond in a particular way based on biologic sex. And there are only two sexes, sex is truly binary. Doctor Dalke seemed to think it was not. But, there are only two sexes.

And so, it's important for you on the committee to understand true science that gender is a social concept; not a biologic one. There is no test other than the opinion of a child that would verify that someone is transgender or not. We don't practice medicine, in general, that way on any other subject.

The appeal of pediatric endocrinology is very interesting, because up until two years ago, all of us in pediatric endocrinology, the majority of our patients came to us because of problems with not achieving appropriate growth and stature or being delayed in puberty, and puberty not happening

on time, and a smaller subset of those patients that we see who actually were having adverse effects, physical effects of what their hormones that did not belong to their biologic sex was doing to their bodies.

We worked very vociferously, and still do, when you see female patients who are being virilized as they appear more masculine through hair growth and muscle mass and acne. When those kinds of things are happening, we work tooth and nail to get down to the bottom of why this is happening because there are so adverse things that happen to these low levels of hormones that happen in biology when it doesn't match the biologic sex.

So here we are spending our entire life and in our training working on these problems that the majority of people have, and all of a sudden we throw out all of what we know in the way of science and knowledge of what cross-sex hormones can do to the physical body that damages it irreparably, and pretend like it's okay. We are basically be blackmailed, if you will, by the concept that these kids would kill themselves.

Now, the quotes for how many people attempt suicide are up to 90 percent in one of the

studies that Doctor Dalke mentioned. In truth, when an LGB activist flow group at the Williams Institute at UCLA did the research on actual suicide attempts or thoughts; not completion. They found that the transgender population had about 22 percent of the patients who had actually, by not because the questions were asked incorrectly, but they delve into it and found that suicide attempts were 22 percent of the population. They compared that with autism and found out that 22 percent of autistic patients also had attempted suicide in their lifetime, and these are all the patients that they saw. These are not selected convenient samples.

Most of the research that they -- that you were quoted today by Doctor Dalke and by Doctor Dowshen are convenient samples. That is to say, it's not everybody in the study. It's patients who are willing to answer questionnaires when surveyed or when given an opportunity.

I'll just bring up those two papers that Doctor Dalke is so proud of having been accepted. Neither of those papers, the way they are designed, have control group. Neither of them have the full hundred percent. We don't even know how many

patients there are in the entire population they're studying. They're only the people that came to them and volunteered. This automatically bias the study.

Journals that we published in, that we have been published in for the past four decades in my case, would not accept a study that way because it's inherently biases and statistically invalid. And yet, these two papers will be published, and it will be published because this is becoming a social issue, sort of a social justice issue. You're taking a medical condition, a mental health condition, and we are turning it, tragically, into something that it should not be.

My problem with the trans clinics in this country is that what needs to be done, what should be done to essentially put these questions to rest involving people, in my particular opinion, as well as people with Doctor Dalke's and Doctor Dowshen's opinion is that, every single patient that enters the door of th transgender clinic needs to have an evaluation that's standardized in terms of mental health.

The concept that the mental health issues of depression and anxiety are due to gender

dysphoria and societal redaction is patent nonsense. That has been discussed at length in Doctor Colin Hughes (phonetic) extensive treatise on the subject, and it clearly makes absolutely no sense when you compare it to other people with stigma from their identity or their sexual practice. It doesn't pan out. It is not true.

The vast majority of these patients actually have under-current anxiety and depression. They have not been screened in their pediatric offices for the adverse childhood experiences such as divorce, death, incarceration, drug abuse, sexual abuse in particular. They're not screened for that. And yet, these kids that come in through the transgender clinic, they often have these things in their background, and they're using the transgender escape route to find some way to justify how to feel better, and they go online, the Internet presence, the like of which we have not seen previously, and they get counseling from individuals, be sure that you mention you're going to kill yourself, and that's how you get things done.

If you prep a population of adolescents, who all have access to the Internet, with that kind

of information, and then you do a survey of those who want to answer questionnaires, not all people, but all of those who want to answer the questionnaire, it's not surprising that there are higher numbers who say, I was thinking about killing myself because they knew they had to say that in order to get their medicines and their top surgeries and, eventually, their bottom surgeries.

No adolescent is capable in early puberty of making a decision in the form of consent, nor are the parents capable of making informed consent about what that adolescent is going to feel like when they're an adult and they are infertile and their genitalia don't work, and they cannot have sexual pleasure the way the biologic anatomy was intended to do. They are handicapped. They've been created as a handicapped population by the activity and the proclivity of those people who are trans activist.

MAJORITY CHAIRMAN SCHEMEL: Doctor, because we have limited time, we might have some members who have questions. Would you be willing to take a few questions?

DOCTOR VAN METER: I sure would. And I didn't mean to go on.

MAJORITY CHAIRMAN SCHEMEL: That's okay.

DOCTOR VAN METER: I'm happy to entertain the questions.

MAJORITY CHAIRMAN SCHEMEL: Sure. Thank you. I have just a few that I wrote down.

Specifically in regard to your wheelhouse and expertise as an endocrinologist, the puberty blockers that are used, what happens if you stop? Like, if you have a puberty blocker used on a pubescent child, you know, we heard testimony saying, well, they can always be stopped. Obviously, they can.

But what actually happens? Do the genitalia and the breasts, will they then grow to normal adult size or not? Or what does happen?

DOCTOR VAN METER: In our experience that we know of in pediatric endocrinology is from the kids with precocious puberty. We do know that when we stop the drug, about 18 months to two years later, they will begin to resume what their normal physiologic process could be at age appropriate time. That's why it's done. And I agree that we treat these kids for a couple of years. Probably the longest span would be about four years.

It's interesting that the math doesn't

work out in terms of the processes that they talk about, both Doctor Dalke and Doctor Dowshen, about stopping puberty with a couple of years of puberty blockers and then beginning cross-sex hormones so you don't have any adverse effects over the long term from puberty blockers. Well, that leaves a gap of about four years where between stopping puberty blockers and cross-sex hormones, and the real truth is these clinics do cross-sex hormones at age 10, 11 and 12.

What you heard was a profession of idealist concepts that are in -- in -- sort of incoordinates with the guidelines that are presented. But what happens in truth in these clinics is that, it is truly a conveyor belt. It is on the puberty blockers, immediately on the cross-sex hormones, immediately then as soon as the child expresses the need to have breast cut off, and they do wait for genital reconstruction surgery until 18, in general, Oregon is trying to move that back to age 16.

So, this is a misrepresentation of what really goes on. What needs to happen is, those clinics need to have the doors open wide, and all patients, 100 percent of the patients who go

through those doors, we need to know exactly how long the drugs are used, exactly when they are started, and what these patients are told, and we're not getting that. We're getting a story-book thing. And then we're also getting the anecdotal cases, which are heart rendering.

And it's interesting that all of the patients, a mother of a transgender child who wrote the comments, and they presented those. Where's the father of the transgender child, are both parents speaking together? These families are most often completely dysfunctional families. That's most often, very commonly, the root of why this child is struggling to emotionally survive, and choose transgender as the answer.

MAJORITY CHAIRMAN SCHEMEL: Now, in regard to -- There was some testimony today in regard to puberty blockers and their impacts on -- the long-term impacts on bone density. There seemed to be conflicting testimony, some that there was no long-term impacts on bone density or other interventions could be taken later, and some said there were sometimes long-term impacts on bone density.

So from, at least from the professional

experience you have, when someone is on puberty blockers for a prolonged period, and I guess you would say that would maybe over 18 months, is there a long-term impact on bone density, and is that treatable in any other ways that is almost always effective?

DOCTOR VAN METER: It is widely published that by age 25, regardless of when puberty started, the average female stops accruing calcium into the skeleton as a reserve to prevent osteoporosis and osteopenia in later years. And so, if you delay that onset where there's no data to show that you get to go to age 27 to recoup that, the years that you need are years you never get back.

So, if you're taking away estrogen in females, you basically take their skeleton and it's devoid of the bone mineral density it needs all the way through the puberty-blocking, and then you immediately throw in testosterone, although some of the testosterone is converted to estrogen, there is no general estrogen-banking system to recover that bone density. It's very important that they do the Dexacen scan to look at bone density, but it's not recoverable. You have the window. And when it

closes, it's closed.

So, to say there is no adverse effect or there is -- puberty blockers are completely irreversible, the answer is absolutely not, particularly during the age of puberty. The brain needs the onset of puberty and the hormones of puberty that are correct for the biologic body to make the brain and the body organs function appropriately. And when you block that, you lose that. You're interrupting that, and that is not retrievable.

Infertility is 100 percent in the population of those who do puberty blocking and the cross-sex hormones. And, of course, when you move the ovaries and testicles, you've completely eliminated the natural reproductive process as well.

MAJORITY CHAIRMAN SCHEMEL: So it's with --

DOCTOR VAN METER: The important sentence that she talked about for many pages tells the patients all of these things. It's like a real estate contract. When you're trying just to initial here, initial there, and sign there, you know, it isn't just, you know, it says that, but

that never happened. In terms of the cross-sex hormones adverse effects, it always happens.

MAJORITY CHAIRMAN SCHEMEL: Okay. I think that actually answers my last question.

Any of my colleagues have questions?

REPRESENTATIVE FRANKEL: Just a comment.

MAJORITY CHAIRMAN SCHEMEL: Chairman Frankel.

REPRESENTATIVE FRANKEL: I just suggest that we heard from two professionals who are, you know, inured in research and actually treating these patients. And we have validation as a standard of care from the American Academy of Pediatrics, from the American Medical Association, Endocrine Society, as well as this, you know, this testimony isn't validated at all except by, I think this gentleman's own organization, which the American -- so-called American College of Pediatrics, which is an outlier with respect to, you know, research commentary, whatever, on these issues. So I think --

What we heard today was standard of care for treatment of folks who are transgender adolescents, and a humane approach to it that has proved to be successful. I think it'd be very good

to listen directly, as we heard from Doctor Dowshen testimony that she related to us about patients and their families who have valued this treatment; who have saved their children, and have had compassionate care provided to them.

I would suggest to you that we have validation from the most -- most respected medical organizations in terms of the standard of care that we heard about this morning from the two other testifiers. Thank you.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Chairman.

DOCTOR VAN METER: I --

MAJORITY CHAIRMAN SCHEMEL: I didn't have the advantage of being at the first hearing, actually, both Doctor Stephen Levine and Doctor Van Meter testified as to that point about how they believe the scientific method wasn't followed and very few people were involved. You may dispute that. And I think we'll analyze the evidence as the subcommittee works -- does its work.

They testified as to why they tend to be marginalized in their opinion and how their original opinions are not -- are not given any voice in the -- in science. So I believe that this

subcommittee is -- been at great lengths to try to give parity and give voice to all opinions, and then we can evaluate.

Chairman Rapp has a comment or question.

REPRESENTATIVE RAPP: And you stated that very well. The purpose of this subcommittee was really to look at both sides of the issue, and I think that you reached out to people who could give us a good balance on both sides of this issue. I've listened to testimony from both sides, and it is up to the legislators sitting here to do their due diligence and evaluate the information that we have received from both sides.

These are professional people, and, obviously, there's differing opinions on both sides of this subject. So, as Representative Schemel stated to -- one of the -- or both of the presenters here today, we do not have a bill in front of us to drive out any type of legislation. The purpose of this meeting today is still to gather information, and then it is up to this committee to decide whether or not we even want to have legislation from this committee to address any issues presented to us. But I think it is --

Representative Schemel has done a great

job of reaching out to both sides of this issue, and we should not be shutting anybody out in hearing their opinions on either side. And I think when I say we try to look at controversial issues here, this certainly is one, but we deserve -- the people of Pennsylvania who are tuning in deserve to hear both sides of this issue, and I think that's what Chairman Schemel has succeeded in doing. So, thank you.

MAJORITY CHAIRMAN SCHEMEL: Thank you.

I know we only have a few more minutes. Do any of my colleagues have any additional questions? And then, I think Chair DeLissio will probably have just an opportunity for any closing remarks from you and I?

(No response).

MAJORITY CHAIRMAN SCHEMEL: None? Very well.

Doctor Van Meter, as with other testifiers, I'll ask if there's anything else that you might have? You certainly are fully able to notify the subcommittee, and I would hope if any of the members of the subcommittee have any follow-up to entertain those by e-mail form.

DOCTOR VANMETER: I will do that.

There's a recent article that was just resolved, published out of Europe experience by a transgender clinic, which proved unequivocally that there was no medical or no emotional benefit for medical intervention through adolescence, childhood, and adulthood in the long run, and absolutely no benefit at all from surgical intervention in the transgender patient population.

It was originally published to just show that medical treatment did not have any benefit to mental health. But when it was criticized, the Journal retracted the article and had it that the authors comment that, indeed, this proved that there was absolutely no benefit whatsoever for mental health with intervening medically or surgically in these transgender patients over the long run. And that is the American Journal of Psychiatry and the retraction, revision came out just last month. So that's a pretty definitive study from a group that was actually actively practicing those things.

One final statement in regard to the guidelines that were set up from the Endocrine Society and American Academy of Pediatrics, those were personal opinions. They were not stated as

standards of care. The only group that's actually built standards of care for transgender individuals is the World Professional Association of Transgender Health, WPATH, and they are not scientists. They are political activists.

The standards of care that were mentioned here are actually not standards of care at all by any other criteria in the field of medicine, but they are touted as such, and they don't represent the opinions of the majority of the membership of any of those organizations.

So, I just wanted to clarify that for the gentleman who thought otherwise.

MAJORITY CHAIRMAN SCHEMEL: Very good, Doctor Van Meter, and thank you for your time.

Madam Chair DeLissio, do you have any closing remarks?

MINORITY CHAIRWOMAN DeLISSIO: Yeah, actually, thank you. I do.

First of all, thank you for the opportunity to hear about affirming gender care. I want to thank the two institutions that testified today. They are, in fact, well-respected institutions in the Commonwealth of Pennsylvania. And, perhaps, I misheard, this was to be a Q and A

section; not additional testimony, as I understood it. I have to mention this comment. I don't usually do this. And I will re-listen to the tape and I apologize in advance if I heard incorrectly.

To describe the other two testifiers as a lack of true science is not in the spirit in which testimony is usually heard here in this Capitol, at least between Chairman Schemel and myself. Nobody made any comments about testimony made on March 12th. So, you know, that's my only comment.

But I would like to, if we have the opportunity to continue to hear, I'm always interested in the consumer perspective, as you will. So we have been talking about transgender youth and affirming gender care. None of us are youthful. We may be youthful in spirit, but we're not youth.

As far as I'm aware. None of us are, in fact, transgender, so we do not have that lived experience. I'll be talking to my co-Chair Rep Schemel to see if, in fact, it would be appropriate to have, perhaps, a part 3 that would include individuals who have -- can cite this as a lived experience now that we have heard various medical

views for this.

So, that was my closing comment. Thank you, sir.

MAJORITY CHAIRMAN SCHEMEL: Thank you, Madam Chair.

I will respond with the words of my wife. I might not be young, but I identify as young.

Yes, we want the work of the subcommittee to go on. I appreciate the attention. I know this is a difficult and complex issue and an emerging issue, as I said at the outset. I appreciate your patience; patience, in particular, to hear the opinions of professionals who have diversion opinions. I think that's critical in analyzing this issue.

All of us care about children. Certainly all of us do, and that's why we're interested in this. And we certainly don't want to be punitive or hateful or anything like that with anyone, any child. We only want the best for children.

So in the interest of that, I do want the work of the subcommittee to continue. I am grateful for the two-parent committee, board

chairs, Chairman Franklin and Chairman Rapp, for giving the subcommittee the ability to do, um, and a little bit of leash to do this. I think we'll analyze the documents, and then Chair DeLissio and I can talk about any subsequent hearings, and so forth.

We certainly appreciate all of your attention, all of those who have come again to the Capitol to watch this. We look forward to continuing it. Thank you.

(At 1:01 p.m., the public hearing concluded).

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C E R T I F I C A T E

I, Karen J. Meister, Reporter, Notary Public, duly commissioned and qualified in and for the County of York, Commonwealth of Pennsylvania, hereby certify that the foregoing is a true and accurate transcript, to the best of my ability, of a public hearing taken from a videotape recording and reduced to computer printout under my supervision.

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Dated this 18th day of October, 2020.

Karen J. Meister

Karen J. Meister – Reporter
Notary Public

Commonwealth of Pennsylvania - Notary Seal
Karen J. Meister, Notary Public
York County
My commission expires July 25, 2024
Commission number 1109844