Submitter: Ronald Lamberton MD

On Behalf Of: ER Physician

Committee: House Committee On Behavioral Health and Health Care

Measure: HB2458

I have been working with the transgender population since the 1970s-80s, I was the primary care doc for some of the first Stanford transgender patients and I had a reputation for giving my patients good care and was honored to be their PC physician. Then I switched to ER Medicine. One thing I know as a physician is if a patient comes into the ER, I don't let them give themselves their own diagnosis, we do a thorough history and physical, consult with specialists, and always include parental input in diagnosis. Parents know more about their child than more than the examiner. We run tests, consult with other docs, and try to find the best care and most appropriate care for our patients. My point is that self-ID for a pediatric population of post-Covid adolescent teens with gender dysphoria has exploded, and there was a 70% increase in gender clinic referrals from 2020-2021 (see Reuters. Gender dysphoria is complex and my concern as a physician is that there aren't enough trained therapists to work with this population almost 100% of gender-diverse adolescents have psychiatric co-morbidities such as anxiety, and depression, and the latest research does not show psychiatric improvement when these gender dysphoric kids simple referred to a gender clinic for cross-sex hormones, etc. They still have a lot of complex issues that aren't solved by simply giving them a trans ID. There are undoubtedly false positives (trans ID'd kids who aren't actually trans) getting this label which is not safe. As we know from the latest Cass Report, even a social transition is considered a serious psycho-social intervention with unknown pros and cons and should be done with caution.

I am against abusive conversion therapy for anyone who identifies as LGBTQ2SIA+. But we have a correct definition of conversion therapy. Exploratory therapy to address other co-morbidities is now the WPATH 8 SOC (adolescent chapter) they included in the guidelines that there are detranisioners and if they had had appropriate exploratory therapy to address their mental health, they may not have chosen medical interventions which are irreversible. We need to be careful about making every gender-diverse kid a lifelong medical patient. It certainly would be easier for mental health workers to go along with a child's self-diagnosis of trans. Still, it is imperative for clinicians to question how they found this identity...if a 13-year-old comes out post-puberty as a trans boy post online Covid school, a therapist should be allowed be able to ask "how did you come to find this as your identity". If the child says by watching TikTok or Youtube videos...that may imply the trans identity is not congruent.
Instead, what we have right now is many therapists quoting anonymous survey data (done on adults in 2015) that if a parent doesn't go along with the medical interventions for a child's transition their child will have a suicidal attempt. This is

simply not supported by research and each and every gender dysphoric child deserves an individual approach to their mental health care. Doing thorough psych evaluations and addressing additional psychiatric co-morbidities, not conversion therapy. I oppose this bill because I think will lead to some false positives (kids who aren't trans being put on serious hormones and surgery, Reuters).
Please consider every child as a unique individual and not part of a giant one size fits all cohort, if you know a trans kid...you've one trans kid. I'm against abusive tactics to influence a child to "desist" but I also believe that every child deserves to be seen as a whole person and a skilled clinician can help address all mental health issues so gender-diverse kids can thrive. I oppose this bill.