Texas Pediatric Society
The Texas Chapter of the American Academy of Pediatrics
INCORPORATED IN TEXAS

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August 16, 2021

The Honorable Jaime Masters Via email: jaime.masters@dfps.texas.gov
Commissioner
Texas Department of Family and Protective Services
701 West 51st Street
Austin, Texas 78751

Dear Commissioner Masters:

On behalf of the 4,600 pediatrician, pediatric subspecialist and medical student members of the Texas Pediatric Society, the Texas Chapter of the American Academy of Pediatrics, we write to implore you to review the full range of evidence and the current recommendations developed by the American Academy of Pediatrics[i] and affirmed by every major American medical association before providing a response to the August 12th letter submitted to you by Representative Bryan Slaton. We believe that doing so will make it absolutely clear that providing gender affirming care to transgender children and adolescents unequivocally does not constitute child abuse.

Over the past several years, state legislatures across the country have been pursuing bills that have the effect of threatening the health and well-being of transgender children and adolescents and criminalizing the care provided to them by pediatricians and other specialists. In fact, an Arkansas law which bans gender-affirming health care for transgender children and adolescents was recently temporarily enjoined[ii]. An amicus brief submitted by the American Academy of Pediatrics and additional national and state medical, mental health, and education organizations outlines the risk of suffering and irreparable harm the law would have on transgender children and adolescents.[iii]

Legislation filed in the 87th Texas Legislature which would have gone even further to criminalize gender affirming care by classifying it as child abuse failed to pass. The Texas Pediatric Society has unequivocally opposed this legislation as it would have criminalized best practice standards of care for transgender children and adolescents and stigmatized their life experience. Transgender children and adolescents are first and foremost children and adolescents, and our Society's goals of protecting all children and adolescents from harm does not falter in this circumstance. We expect the Texas Department of Family and Protective Services – similarly charged with ensuring the safety and well-being of our state's most vulnerable children and adolescents – to take the same stance.

1.8% of children and adolescents identify as transgender, and an additional 1.6% are questioning or gender diverse.[iv] Transgender children and adolescents are particularly at risk of feeling unsafe and reporting suicidal ideations – over 50 percent have suicidal ideations and one third attempt suicide.[v] We know that when children and adolescents are provided with appropriate gender affirming care, including puberty suppressors, the risk of lifetime suicidal ideation falls dramatically.[vi]

Medical care for transgender children and adolescents is evidence-based and has proven effectiveness. Guidelines for appropriate treatment have been carefully developed and endorsed by the American Academy of Pediatrics[vii], the American College of Obstetrics and Gynecology[viii], the Pediatric Endocrine Society[ix], the American College of Physicians[x], World Professional Association for Transgender Health[xi], and the American Psychological Association.[xii]

The decision of whether and when to initiate gender-affirmative treatment is personal and involves careful consideration of risks, benefits, and other factors unique to each patient and family. These are medical decisions reached in consultation between the patients and their parents. The process involves repeated psychological and medical evaluation, with the participation and consent of a child's or adolescent's parents. Gender-affirming care for children and adolescents with gender diversity or gender dysphoria begins with social affirmation. Before puberty, there is no medical or surgical treatment that is used at all. Care for these children and adolescents includes allowing them to express themselves for who they are – including living with the name, pronouns that are true for them. We know that social transitioning alone reduces the risk of suicide for transgender children and adolescents.[xiii]

Only after the onset of puberty is medical treatment used, and only in some patients – again, with complete consent of the child's or adolescent's parents. Treatment with medications to temporarily suppress puberty is reversible and allows the patient and their family time, with the ongoing medical supervision of their doctor, to explore their gender identity, access psychosocial supports, and further determine their treatment goals. Puberty-suppressing medications delay the development of secondary sex characteristics that often spark intense distress for transgender patients. Data shows that puberty suppression leads to improved mental health and decreases suicidal ideations for transgender children and adolescents. These same medications are commonly prescribed for other conditions, such as early puberty in children and prostate conditions in men, and their safety is well documented.

Later, teenagers can elect to receive hormonal therapy, if it is indicated, generally after the age of 16 and after living in their authentic gender for some time. Again, this treatment is safe, evidence-based, and only occurs after extensive discussion with the patient, family, and health care team. Fewer than one quarter of transgender patients ever have surgical procedures, and these are generally recommended after the age of 18.

As physicians, we must be able to practice medicine that is informed by our years of medical education, training, experience, and available evidence, freely and without threat of punishment. Providing patient care that helps rather than harms is our duty according to the oaths we took as doctors. Gender-affirming care is part of the comprehensive primary care we provide to our patients and should not be criminalized or stigmatized.

Sincerely,

Seth D. Kaplan, MD, FAAP
President

Copy to: Trevor Wood, DFPS Associate Commissioner trevor.wood@dfps.texas.gov
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[i] Rafferty J. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Gay, Lesbian, Bisexual and Transgender Health and Wellness. *Pediatrics.* Oct 2018, 142 (4) e20182162; DOI: https://doi.org/10.1542/peds.2018-2162. Retrieved from: https://pediatrics.aappublications.org/content/142/4/e20182162

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[v] Ibid.

[vi] Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics.* Feb 2020;145(2)doi:10.1542/peds.2019-1725

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[viii] Care for Transgender Adolescents. Committee on Adolescent Health Care, American College of Obstetricians and Gynecologists. Committee opinion, January 2017 number 685 (Reaffirmed 2020). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/care-for-transgender-adolescents

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[x] Safer J, Tangpricha V. Care of the Transgender Patient. *Annals of Internal Medicine*. July 2, 2019. https://doi.org/10.7326/AITC201907020

[xi] Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People. The World Professional Association for Transgender Health. 2011. https://www.wpath.org/publications/soc, Accessed January 9 2021.

[xii] Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. American Psychological Association. *American Psychologist,* December 2015. Vol. 70, No. 9, 832–864 http://dx.doi.org/10.1037/a0039906

[xiii] Ibid.