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The Vermont State legislature is inconsistent in their pursuit of health care choice for individuals, free from government interference.

Last year, legislators claimed Article 22, the reproductive liberty amendment to the State Constitution, would keep government out of decision-making between patients and their doctors.

This year, S.37 and H.89 propose to codify gender-affirming care as the only type of care for minors experiencing gender dysphoria and incongruence that will be shielded from "abusive litigation" from other states, the only type of care that will be fully funded by insurance companies - making gender-affirming care a priority over all other types of health care - and shields practitioners from increases in malpractice premiums, **while countries in Europe are now re-assessing and changing their standards of care due to negative impacts of exclusively gender-affirming care.**

Pages 2 and 3 of S.37 read as follows:

14 * * * Definitions * * *

15 Sec. 1. 1 V.S.A. § 150 is added to read:

16 § 150. LEGALLY PROTECTED HEALTH CARE ACTIVITY

17 (a) "Gender-affirming health care services" means all supplies, care, and

18 services of a medical, behavioral health, mental health, surgical, psychiatric,

19 therapeutic, diagnostic, preventative, rehabilitative, or supportive nature

1 relating to the treatment of gender dysphoria. "Gender-affirming health care 2 services" does not include conversion therapy as defined by 18 V.S.A. § 8351.

18 V.S.A. § 8351. **(Act 35) applies specifically to minors, making S.37 pertinent to minor protections and parental rights, because it dictates care for minors.**

Please review the submitted Cass Review Interim Report on Gender Dysphoria Services for children and youth initiated by the UK NHS.

Dr. Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for minors at Tavistock

Gender Clinic in 2020. The study came after a lawsuit against Tavistock was filed, and concludes, in part:

- A significant increase in referrals to Tavistock's Gender Identity Development Services (GIDS), especially birth-assigned females presenting gender dysphoria in adolescence.

- Lack of control measures that are typically applied when new treatments are introduced.

- **Lack of discussion and consensus on treatment protocols.**

- Diagnostic overshadowing (healthcare issues other than gender-related distress are overlooked).

- **Pressure on staff to adopt an unquestioning affirmative approach which is at odds with the standard process of clinical assessment and diagnosis.**

In addition, the Summary of the Cass Review Interim Report states:

- **"Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally."**

- **"The Review is not able to provide definitive advice on the use of puberty blockers and feminising/masculinising hormones at this stage, due to gaps in the evidence base."**

See Chart on page 33 of the Cass Review. There is a dramatic change in the case-mix from birth-registered males presenting gender dysphoria in early childhood to birth-registered females presenting in adolescence.

The medical community has not provided evidence-based studies as to why there is a dramatic change in the case-mix. This rush to treat birth-registered females with exclusively gender-affirming treatment, under the dubious NEJM assessment that it is the only way to improve mental health and reduce suicidality, is as trendy as tonsillectomies, except with life-altering consequences.

World Association for Transgender Health is on Version 8 of Standards of Care since 1979, with a dramatic change in 2009.