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Testimony of Leslie Wolfgang, Director of Public Policy, Family Institute of Connecticut Action in opposition to HB5516, AN ACT CONCERNING REPRODUCTIVE RIGHTS.

My name is Leslie Wolfgang, and I am the Director of Public Policy for the Family Institute of Connecticut. I am testifying in opposition to HB 5516, which would restrict hospitals and other facilities—including pregnancy resource centers—from limiting counseling for abortions or gender-affirming care within their operations.

The premise of this bill is that these services deserve special protection. But that assumption deserves careful scrutiny.

Hospitals and medical facilities that restrict these procedures may in fact be acting responsibly to protect patients from controversial and potentially harmful medical interventions.

What is commonly referred to as “gender-affirming care” includes prescribing puberty blockers, administering cross-sex hormones, and performing complex surgeries such as penile inversion vaginoplasty and free-flap vaginoplasty. These are life-altering and often irreversible procedures used to treat gender dysphoria.

These treatments remain deeply controversial and have been restricted or banned for minors in at least 27 states. Punishing hospitals in Connecticut for exercising caution places institutions in the position of being forced to provide procedures that many physicians and health systems believe carry significant medical risks.

Medical interventions such as puberty blockers and cross-sex hormones can affect fertility, bone density, cardiovascular health, and psychological outcomes. Blocking puberty during adolescence can permanently affect fertility and normal biological development. These are not minor or easily reversible interventions.

Supporters often argue that these treatments are necessary for suicide prevention. But that claim deserves careful examination. Children experiencing gender dysphoria often struggle with complex mental-health challenges. Telling children that they will likely commit suicide if their identity is not medically affirmed is not sound medical practice. Suicide prevention must be grounded in evidence—not rhetoric.

Some long-term studies have shown elevated suicide rates among adults who underwent surgical interventions compared to the general population. At the very least, the evidence does not demonstrate that these irreversible procedures eliminate suicide risk.

Recent developments in the medical community also reflect growing caution.

On February 3, the American Association of Plastic Surgeons formally rejected surgical interventions for minors with gender dysphoria. Shortly thereafter, the American Medical Association affirmed that position. These developments support the judgment of hospitals that have already chosen to restrict such procedures.

International health authorities have reached similar conclusions. On February 20, 2026, the United Kingdom's Department of Health and Social Care announced it was pausing a planned clinical trial of puberty blockers for children due to concerns about safety and participant wellbeing. The UK's Medicines and Healthcare products Regulatory Agency raised serious questions about long-term risks.

HHS also released a peer-reviewed report dismantling pediatric "gender affirming care".

Hospitals therefore have good reason to approach these treatments cautiously.

Even major media outlets have begun questioning the scientific foundations of gender-affirming medicine. Last month, The New York Times reported that some medical organizations adopted their policies through professional consensus influenced by politics rather than rigorous evidence review.

In that context, this bill would restrict hospitals that are attempting to practice cautious and evidence-based medicine.

In fact, it is not clear that gender-affirming care, as currently practiced, would meet the standard defined in this bill for "medically accurate and appropriate information."

That standard requires medical information to be supported by the weight of scientific evidence, derived from accepted scientific methods, and consistent with generally recognized scientific theory.

But major international reviews have concluded that the evidence base is weak.

The Cass Review of gender services in the United Kingdom concluded that *"the evidence base underpinning medical and non-medical interventions in this clinical area is remarkably weak."* (Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People*, 2024.)

Sweden's National Board of Health and Welfare similarly found that *"the scientific evidence for the effects of puberty blockers and gender-affirming hormones is limited and uncertain."* (Socialstyrelsen, 2022.)

Finland's national health authority concluded that psychological support should be the first-line treatment because evidence for medical interventions remains limited. (Finnish Ministry of Health, 2020.)

Individual studies also raise concerns. Puberty blockers have been associated with reduced bone density during treatment (Vlot et al., *Journal of Clinical Endocrinology & Metabolism*, 2017). Fertility impacts remain poorly understood and often irreversible (Nahata et al., *Journal of Adolescent Health*, 2017). Mental-health outcomes involve many factors beyond medical treatment alone (Singh et al., *Frontiers in Psychiatry*, 2021).

Many studies in this field rely heavily on observational data rather than randomized controlled trials, often with small sample sizes and significant loss to follow-up. Researchers have also noted the difficulty of separating treatment effects from the benefits of psychological support or social affirmation. (Hruz, Mayer & McHugh, *The New Atlantis*, 2017; Biggs, *Archives of Sexual Behavior*, 2020.)

Finally, the underlying causes of gender dysphoria remain the subject of active scientific debate, with competing psychological, developmental, and biological explanations. Several European health systems have therefore adopted psychotherapy-first treatment models rather than routine medicalization.

Given these uncertainties, hospitals that restrict these procedures may simply be exercising appropriate medical caution.

HB 5516 would punish those institutions for doing exactly that.

For these reasons, I respectfully urge the committee to reject this bill.

Learn more about Family Institute of Connecticut Action by visiting ctfamily.org or contacting Leslie Wolfgang at ppdirector@ ctfamily.org.

New York Times on medical "consensus": https://www.nytimes.com/2026/02/24/opinion/medical-associations-youth-gender-care.html

Plastic surgeon statement on surgical interventions for minors https://www.plasticsurgery.org/for-medical-professionals/health-policy/position-statements and AMA https://www.theatlantic.com/ideas/2026/02/ama-asps-gender-surgery-minors/685961/?utm_source=chatgpt.com

Implications for long term health: https://pubmed.ncbi.nlm.nih.gov/28945902/

Puberty blocker trial paused: https://www.theguardian.com/science/2026/feb/20/uk-clinical-trial-into-puberty-blockers-paused-after-medicines-regulator-raises-concerns; https://assets.publishing.service.gov.uk/media/6998b06d047739fe61889efb/Sponsor-letter110226.pdf

Suicide and gender affirming treatment. https://pmc.ncbi.nlm.nih.gov/articles/PMC10027312/?utm_source=chatgpt.com#abstract1

Penile inversion techniques: https://rumergendersurgery.com/gender-reassignment-surgery/vaginoplasty-techniques/#:~:text=During%20the%20Penile%20Inversion%20procedure%2C,penis%20and%20testes%20are%20removed.