

**IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

JANE DOE et al.,

Plaintiffs,

v.

JOSEPH A. LADAPO et al.,

Defendants.

Civil No. 4:23-cv-00114-RH-MAF

PLAINTIFFS' NOTICE OF FILING TRIAL EXHIBITS

Pursuant to the Court's October 31, 2023 Order Confirming the Deadline to File Exhibits and the Pretrial Stipulation (Dkt. 174), Plaintiffs hereby submit this Notice of Filing Trial Exhibits¹, with copies of each exhibit Plaintiffs expect to or may offer at trial listed on the Exhibit List below and appended hereto.² Plaintiffs reserve the right to use additional documents for purposes of impeachment, and to offer any exhibit identified by Defendants.

¹ Due to the extensive number of documents, Plaintiffs are filing multiple, identical copies of this Notice on the case docket, each attaching a separate set of the below listed exhibits.

² Sealed versions of Plaintiffs' medical records (Doe Pls' Trial Exs. 80-86) have been filed at Dkt. 147.

Plaintiffs' Exhibit List

Trial Ex. No.	Bates No.	Exhibit Description	Will Use	May Use	Stipulated/ Defendants' Objections
<i>Dekker Exhibits</i>		Any exhibit that was entered into evidence in the <i>Dekker</i> trial		X	
Doe Pls' Trial Ex. 1	PL000566 - 000579	Defendants' Response to Pls' First Set of Interrogatories		X	
Doe Pls' Trial Ex. 2	PL000580 - 000625	Expert Report of Dr. Aaron Janssen, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 3	PL000626- 000683	Expert Report of Dr. Brittany Bruggeman, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 4	PL000684- 000735	Expert Report of Dr. Dan H. Karasic, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 5	PL000736 – 000816	Expert Report of Dr. Daniel Shumer, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 6	PL000817 – 000886	Expert Report of Dr. Loren Schechter, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 7	PL000887 - 000910	Expert Report of Dr. Vernon Langford, DNP, APRN-CNP, FNP-C (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 8	PL000911 - 000929	Expert Report of Dr. Kenneth W. Goodman, PhD, FACMI, FACE (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 9	PL000930 - 000938	Expert Rebuttal Report of Dr. Aaron Janssen, M.D. (9.5.2023)		X	Hearsay

Doe Pls' Trial Ex. 10	PL000939 - 000946	Expert Rebuttal Report of Dr. Dan H. Karasic (9.5.2023)		X	Hearsay
Doe Pls' Trial Ex. 11	PL000947	Florida Admin. Code R. 64B8-9.019, <i>Standards of Practice for the Treatment of Gender Dysphoria in Minors</i> (effective 3.16.2023)	X		
Doe Pls' Trial Ex. 12	PL000948	Florida Admin. Code R. 64B15-14.014, <i>Standards of Practice for the Treatment of Gender Dysphoria in Minors</i> (effective 3.28.2023)	X		
Doe Pls' Trial Ex. 13	PL000949	Notice of Change, Fla Admin Code R. 64B15-14.014 (filed 2.10.2023)		X	
Doe Pls' Trial Ex. 14	PL000950	Florida Department of Health Guidance, <i>Treatment of Gender Dysphoria for Children and Adolescents</i> (4.20.22)	X		
Doe Pls' Trial Ex. 15	PL000951	Surgeon General Ladapo Letter to Florida Boards of Medicine (6.2.22)	X		
Doe Pls' Trial Ex. 16	PL000952 - 000959	Florida Department of Health Petition to Initiate Rulemaking Setting the Standard of Care for the Treatment of Gender Dysphoria (7.28.22)	X		
Doe Pls' Trial Ex. 17	PL000960 – 000969	Florida Senate Bill 254 (2023)	X		
Doe Pls' Trial Ex. 18	PL000970 - 000979	Florida House Bill 1421 (2023)	X		

Doe Pls' Trial Ex. 19	PL000980 - 000981	Section 456.001(1)(8) – (9), Florida Statutes (2023)		X	
Doe Pls' Trial Ex. 20	PL000982 - 000983	Section 456.52, Florida Statutes (2023)		X	
Doe Pls' Trial Ex. 21	PL000984 - 001462	Rulemaking Record (Produced by Defendants)	X		
Doe Pls' Trial Ex. 22	PL001463 - 008066	Public Book for 02.10.2023 Joint Hearing (Produced by Defendants)	X		
Doe Pls' Trial Ex. 23	Med Def_001485 - 001622; PL012003 – PL012012	Transcript of Florida Board of Medicine Meeting 08.05.2022	X		
Doe Pls' Trial Ex. 24	Med Def_001058 – 001349	Transcript of Florida Boards' Joint Rule Workshop 10.28.2022	X		
Doe Pls' Trial Ex. 25	Med Def_000876 - 001016	Transcript of Florida Boards' Joint Meeting 11.04.2022	X		
Doe Pls' Trial Ex. 26	Med Def_001017 – 001043; PL012013 - PL012137	Transcript of Florida Boards' Joint Public Hearing 02.10.2023 (*Incomplete at present)	X		
Doe Pls' Trial Ex. 27	Med Def_001350 – 001484	Transcript of Florida House HHS Committee Meeting 02.21.2023	X		
Doe Pls' Trial Ex. 28	Med Def_002232 - 002234	Excerpt from Speech of Governor Ron DeSantis – Joint Session 03.07.2023		X	

Doe Pls' Trial Ex. 29	Med Def_000087 - 000250	Transcript of Florida Senate Health Policy Committee Meeting 03.13.2023		X	
Doe Pls' Trial Ex. 30	Med Def_002235 - 002335	Transcript of Florida House Healthcare Regulation Subcommittee Meeting 03.22.2023		X	
Doe Pls' Trial Ex. 31	Med Def_001913 - 002001	Transcript of Florida Senate Fiscal Policy Committee Meeting 03.23.2023		X	
Doe Pls' Trial Ex. 32	Med Def_002336 - 002461	Transcript of Florida House HHS Committee Meeting 03.27.2023		X	
Doe Pls' Trial Ex. 33	Med Def_002462 - 002571	Transcript of Florida Senate General Session 04.03.2023		X	
Doe Pls' Trial Ex. 34	Med Def_002002 - 002028	Transcript of Florida Senate General Session 04.04.2023		X	
Doe Pls' Trial Ex. 35	Med Def_002029 - 002144	Transcript of Florida House General Session 04.18.2023		X	
Doe Pls' Trial Ex. 36	Med Def_002145	Transcript of Florida House General Session 04.19.2023		X	
Doe Pls' Trial Ex. 37	Med Def_002215 - 002231	Transcript of Florida Senate General Session 05.04.2023		X	
Doe Pls' Trial Ex. 38	Med Def_002193 - 002214	Transcript of Florida House General Session 05.04.2023		X	
Doe Pls' Trial Ex. 39	Med Def_001623 - 001912	Transcript of Florida Boards' Joint Meeting 06.23.2023		X	

Doe Pls' Trial Ex. 40	Med Def_000251 - 000454	Transcript of Florida Boards' Joint Public Meeting 06.30.2023		X	
Doe Pls' Trial Ex. 41	Med Def_000001 - 000086	Transcript of Florida Boards' Joint Meeting 08.03.2023		X	
Doe Pls' Trial Ex. 42	FDOH_000 0 44095- 000044100; 000044010- 000044014; 000042401- 000043407; 000044022- 000044026; 000044081- 000044086; 000042389- 000042398.	Composite Exhibit - Emails between Board of Osteopathic Medicine Executive Director Danielle Terrell and Vernadette Broyles (Oct. 25-28, 2022)	X		
Doe Pls' Trial Ex. 43	FDOH_000 065015- 000065016	Emails from Board of Osteopathic Medicine Executive Director Terrell (11.07.22)		X	
Doe Pls' Trial Ex. 44	FDOH_000 058615- 000058616	Gender Dysphoria Roundtable (7.8.22)		X	Foundation Hearsay
Doe Pls' Trial Ex. 45	FDOH_002 874150- 002874157	Governor Talking Points		X	Foundation Hearsay
Doe Pls' Trial Ex. 46	FDOH_000 065735- 000065778	Request for Hearing to Board of Medicine		X	Foundation Hearsay

Doe Pls' Trial Ex. 47	FDOH_000 038015- 000038019	Open Letter to the Florida Board of Medicine (9.23.22)	X		Foundation Hearsay
Doe Pls' Trial Ex. 48	EOG_0051 21- 005156	FDOH Updates (4.8.22)		X	Hearsay, as to draft material
Doe Pls' Trial Ex. 49	FDOH_000 064667- 000064671	Emails between Board of Medicine Executive Director Paul Vazquez and Dr. Laidlaw (10.14.22-10.25.22)		X	Foundation Hearsay Objection as to highlights
Doe Pls' Trial Ex. 50	EOG_0008 49-000864	Governor Talking Points (5.13.22)		X	Foundation Hearsay Objection as to highlights
Doe Pls' Trial Ex. 51	FDOH_000 039058	Emails between Board of Medicine Paul Vazquez and Dr. Patrick Hunter (10.16.22)		X	
Doe Pls' Trial Ex. 52	FDOH_001 9000113	Emails between Dr. Van Mol Dr. Patrick Hunter (9.14.22)		X	Foundation Hearsay Objection as to highlights
Doe Pls' Trial Ex. 53	FDOH_000 030412	Email between Vazquez and Hunter (9.14.22)		X	
Doe Pls' Trial Ex. 54	FDOH_000 030376- 000030377	Emails between Vazquez and Hunter (9.13.22)		X	
Doe Pls' Trial Ex. 55	FDOH_000 030366- 30369	Email between Hunter and Vazquez (9.12.22)		X	
Doe Pls' Trial Ex. 56	EOG_0005 19-000520	Gender Affirming Guidance Event		X	
Doe Pls' Trial Ex. 57	EOG_0006 67-000682	Governor DeSantis Interview Transcript (4.28.22)		X	

Doe Pls' Trial Ex. 58	Def_000286709	AHCA Invoice for Dr. Van Meter attendance at Board of Medicine Meeting (8.11.22)	X		
Doe Pls' Trial Ex. 59	EOG_008128-008235	Memo on Gender Dysphoria Legislation	X		Foundation Hearsay
Doe Pls' Trial Ex. 60	EOG_008125-008127	Email from Maureen Furino with attachments (1.06.23)		X	Hearsay
Doe Pls' Trial Ex. 61	EOG_005282-005284	Email from Savannah Kelly Jefferson with attachment (6.29.22)		X	Foundation Hearsay Objection as to drafts
Doe Pls' Trial Ex. 62	EOG_005157 - 005250	Alliance Defending Freedom Binder		X	Foundation Hearsay
Doe Pls' Trial Ex. 63	EOG_004414, 004636-004640, 004487-004492	Briefers – Safeguarding Kids from Gender Surgeries and Drugs		X	
Doe Pls' Trial Ex. 64	FDOH_000035598	Email from Board of Osteopathic Medicine Executive Director Danielle Terrell to Bettye Strickland (10.19.22)		X	
Doe Pls' Trial Ex. 65	FDOH_000040582 – 000040599	Email from Patrick Hunter to Paul Vazquez (10.23.22)		X	
Doe Pls' Trial Ex. 66	FDOH_000045008 - 000045010	Appearance Request Form (11.02.22)		X	
Doe Pls' Trial Ex. 67	FDOH_000034212 – 000034214,	Email from Vazquez to Strickland (9.27.22)		X	

	Att. FDOH_000 034022 - 000034111				
Doe Pls' Trial Ex. 68	FDOH_000 069398 – 000061417	Phillip Penna comment (9.19.22)		X	
Doe Pls' Trial Ex. 69	FDOH_000 017897- 000017908	Email from Jeremy Redford (7.10.22)		X	
Doe Pls' Trial Ex. 70	PL008067 - 010525	Public Book for 8.3.23 Joint Meeting (Produced by Defendants)	X		
Doe Pls' Trial Ex. 71	FDOH_000 040530 - 000040542	Email from Hunter to Vazquez (10.22.22)		X	
Doe Pls' Trial Ex. 72	FDOH_000 039931 – 000039932	Email from Vazquez to Strickland (10.18.22)		X	
Doe Pls' Trial Ex. 73	FDOH_000 037928	September 30, 2022 Rule Workshop Agenda (9.30.22)		X	
Doe Pls' Trial Ex. 74	FDOH_000 040020	Original October 28, 2022 Workshop Agenda (10.28.22)		X	
Doe Pls' Trial Ex. 75	FDOH_000 035446 – 000035448	Email from Vazquez to Diamond (10.14.22)		X	
Doe Pls' Trial Ex. 76	FDOH_000 028162 – 000028163; FDOH_000 064956; and FDOH_000 065030	Emails from Senate Committee on Health Policy (Composite)		X	

Doe Pls' Trial Ex. 77	FDOH_000 039513 - 000039516	Emails between Dr. Dayton and Paul Vazquez (10.18.22)		X	
Doe Pls' Trial Ex. 78	FDOH_000 035604- 000035604	Email from Board of Osteopathic Medicine Danielle Terrell (10.19.22)		X	Completeness
Doe Pls' Trial Ex. 79	FDOH_000 039521 - 000039522	Email from Paul Vazquez to Danielle Terrell (10.18.22)		X	
Doe Pls' Trial Ex. 80	PL000022- 000048	Plaintiff Susan Doe Medical Records (SEALED)	X		
Doe Pls' Trial Ex. 81	PL000001 - 000015	Plaintiff Gavin Goe Medical Records (SEALED)	X		
Doe Pls' Trial Ex. 82	PL000366- 408; 000509-565	Plaintiff Lucien Hamel Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 83	PL000418 - 000483	Plaintiff Olivia Noel Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 84	PL000016 - 000021	Plaintiff Lisa Loe Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 85	PL000409- 417; 000484-508	Plaintiff Kai Pope Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 86	PL000049 - 000365	Plaintiff Rebeca Cruz Evia Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 87	FDOH_000 035423 - 000035428	Emails between Hunter, Diamond, and Vazquez (10.04.22)		X	

Doe Pls’ Trial Ex. 88	FDOH_000 062034 - 000062035	Emails between Hunter and Vazquez (9.23.22)		X	
Doe Pls’ Trial Ex. 89	FDOH_000 061277 - 000061279	Emails between Hunter, Vazquez and Biggs (9.19.22)		X	
Doe Pls’ Trial Ex. 90	FDOH_000 030412	Email from Hunter to Vazquez (9.14.22)		X	
Doe Pls’ Trial Ex. 91	PL010526 – 010528	Governor Ron DeSantis Appoints Four to the Board of Medicine (6.17.22)		X	
Doe Pls’ Trial Ex. 92	PL010529- 010530	Dr. Hunter article “Political Issues Surrounding Gender- Affirming Care for Transgender Youth” (JAMA Pediatr., December 20, 2021, doi:10.1001/jamapediatrics.2 021.5348)		X	Hearsay
Doe Pls’ Trial Ex. 93	PL010531- 011801	<i>Eknes-Tucker v. Ivey</i> , 2:22- cv-00184, ECF 69-6 (5.02.22)		X	Relevance Foundation Hearsay
Doe Pls’ Trial Ex. 94	PL011802- 011804	Catholic Medical Association Resolutions 8-7 through 8-14		X	Authentication Foundation Hearsay
Doe Pls’ Trial Ex. 95	PL011805 - 001806	Catholic Medical Association 92 nd Annual Education Conference (9.18.23)		X	Authentication Foundation Hearsay
Doe Pls’ Trial Ex. 96	EOG_0081 25 - 008127	Email from Furino with texts attached (1.06.23)		X	Foundation Hearsay
Doe Pls’ Trial Ex. 97	PL011807 - 011811	AAP Resolution # 27		X	Authentication Foundation Hearsay

Doe Pls' Trial Ex. 98	PL011812 - 011817	WSJ article "Youth Gender Transition Is Pushed Without Evidence" by Hunter, Roman, Kaltiala, Malone, etc. (7.13.23)	X	Hearsay
Doe Pls' Trial Ex. 99	PL011818 - 011819	U.S. EO 12866 Meeting 0945-AA17 (4.25.22)	X	Foundation Hearsay
Doe Pls' Trial Ex. 100	PL011820 - PL011825	SEGM "About Us" Page	X	Foundation Hearsay
Doe Pls' Trial Ex. 101	PL011826 - 011827	"Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents" (de Vries, 7.14.20)		Hearsay
Doe Pls' Trial Ex. 102	PL011828 - 011830	Governor Ron DeSantis Appoints Three to the Board of Osteopathic Medicine (12.06.22)		
Doe Pls' Trial Ex. 103	PL011831 - 011833	Governor Ron DeSantis Appoints Two to the Board of Medicine (12.28.22)		
Doe Pls' Trial Ex. 104	PL011834 - 011857	NYT Article, Dr. Benson quoted (11.14.22)	X	Hearsay
Doe Pls' Trial Ex. 105	PL011858 - 011866	Smalley, et al., <i>Improving Global Access to Transgender Health Care</i> , Transgender Health, Vol. 7, No. 2 (2022)	X	Hearsay
Doe Pls' Trial Ex. 106	PL011867	Fla. Admin R. 64B8-30.008	X	

Doe Pls' Trial Ex. 107	PL011868	Fla. Admin. R. 64B8-30.012		X	
Doe Pls' Trial Ex. 108	PL011869 - 011871	Fla. Stat. 464.0123		X	
Doe Pls' Trial Ex. 109	PL011872 - 011874	Fla. Stat. 464.012		X	
Doe Pls' Trial Ex. 110	PL011875 - 011880	Fla. Stat. 458.347		X	
Doe Pls' Trial Ex. 111	PL011881	20 CFR 10.310		X	
Doe Pls' Trial Ex. 112	PL011882 - 011888	A Letter to Christian Physicians_CMDA Today		X	Hearsay
Doe Pls' Trial Ex. 113	PL011889 - 0011890	Composite Exhibit (Jonathan Clemens Tweets)		X	Hearsay
Doe Pls' Trial Ex. 114	PL011891 - 011938	FSU Student Handbook 2022-2023		X	Hearsay
Doe Pls' Trial Ex. 115	PL011939 - 011948	Detransitioners in Your Church Doorway		X	Hearsay
Doe Pls' Trial Ex. 116	PL011949 - 011973	Composite Exhibit – Tweets from Defendants and Lawmakers		X	Foundation Relevance Hearsay
Doe Pls' Trial Ex. 117	PL01974 - 011975	SB 254 Amendment (350064 - Failed)		X	

Doe Pls' Trial Ex. 118	PL011976 – 011977	SB 254 Amendment (299002 – Failed)		X	
Doe Pls' Trial Ex. 119	PL011978 - 011979	SB 254 Amendment (212692 - Failed)		X	
Doe Pls' Trial Ex. 120	PL011980 - 011981	SB 254 Amendment (374289 - Failed)		X	
Doe Pls' Trial Ex. 121	PL011982 - 011996	SB 254 Amendment (256341) (and Failed Amndts to Amndt)		X	
Doe Pls' Trial Ex. 122	PL011997	SB 254 Amendment (388571 - Failed)		X	
Doe Pls' Trial Ex. 123	PL011998 - 012000	Dr. Hunter Letter to the Editor, JACCP, DOI: 10.1002/jac5.1691 (6.06.22)		X	Hearsay
Doe Pls' Trial Ex. 124	Def_000177 905 - 000177906	Email from Jeremy Redfern re: Surgeon General Ladapo Meeting (7.10.22)		X	
Doe Pls' Trial Ex. 125	PL012001 - 012002	ALEC Legislative Membership List		X	Authentication Foundation Relevance Hearsay
Doe Pls' Trial Ex. 126	PL012138 – PL012143	Notice of Emergency Rules 64B8ER23-11 and 64B15ER23-12	X		

Dated: November 6, 2023

LOWENSTEIN SANDLER LLP

By: /s/ Thomas Redburn, Jr.

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CERTIFICATE OF SERVICE

I hereby certify that, on November 6, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system.

By: /s/ Thomas Redburn, Jr.

Jane Doe

vs.

Joseph Ladapo

Taped Transcription

Tab 26 and 39



Med Def_001485

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAP0,

6 Defendant.

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11

12

TRANSCRIPTION OF AUDIO RECORDING

13

FLORIDA BOARD OF MEDICINE

14

TAB 26 AND 39

15

GENDER DYSPHORIA DISCUSSION AND

16

PETITION TO INITIATE RULEMAKING

17

18

19

20

21

22

TRANSCRIBED AUDIO RECORDING BY:

23

Julie Thompson, CET

24

25

Job No.: 322529

1 Thereupon,
2 The following proceeding was transcribed from an
3 audio recording:

4 *****

5 CHAIRMAN DIAMOND: All right. At this
6 point I'd like to go to tab number 26 and tab number
7 39. We'll be handling both of these together. Tab
8 number 26 is entitled Discussion on Letter from
9 Dr. Joseph Ladapo, MD, PhD, State Surgeon General,
10 dated June 2, 2000 -- I'm sorry -- 2022, Related to
11 Gender Dysphoria in Children and Adolescents.

12 And tab 39 is Petition to Initiate
13 Rulemaking Setting, the Standard of Care for
14 Treatment of Gender Dysphoria.

15 To begin with, I'm going to turn this over
16 to Mr. Vasquez for some statements.

17 EXECUTIVE DIRECTOR VASQUEZ: Thank you.
18 Good afternoon.

19 Again, my name is Paul Vasquez. I'm the
20 executive director of the Florida Board of Medicine,
21 and this is a duly noticed meeting of the Board.
22 It's a public meeting, and it's being recorded.
23 There's a court reporter in the meeting, so
24 understand that if you speak to the Board, it's
25 important that you speak in a way that's clear

1 enough for the court reporter to take it down and
2 capture all the information for the record.

3 The Chair will ask for public comment at
4 the appropriate time, so please refrain from
5 speaking out during the meeting until that appointed
6 time. Remember, it is a public meeting that's being
7 recorded, and side conversations may become part of
8 the record.

9 And at this time we ask, again, that you
10 please silence all electronic devices.

11 In terms of how the meeting will be
12 organized, the Florida Board of Medicine invites and
13 encourages all interested parties to provide
14 comments on matters before the Board. The following
15 guidelines will apply to public comments.

16 Interested parties will be given an
17 opportunity to provide comment on matters before the
18 Board after an agenda item is introduced.

19 Interested parties may provide comments on
20 the record during the meeting, or they can waive
21 speaking and indicate their position on the issue,
22 which will also become part of the record.

23 Appearance forms are being provided to
24 facilitate that process. If you have interest in
25 making desires known on the record or speaking at

1 the meeting, you need to make sure you fill out a
2 speaker's card and that we've received it.

3 Interested parties will be limited to three
4 minutes to provide comment, which may only be
5 extended by the Chair if time permits, based on the
6 number of proposed speakers.

7 If an interested party is part of a larger
8 group of persons, we do request that you identify an
9 individual to speak on behalf of the group, if
10 possible.

11 Interested parties may use pseudonyms if
12 they do not wish to identify themselves on the
13 record.

14 Our expectation is that we'll have a civil
15 discourse. And in that regard, we ask that you
16 refrain from profane language and understand that we
17 are going to be controlling the audience to the
18 extent that we want to have a highly calm and --
19 meeting with high decorum. So just understand that
20 we are going to be monitoring the progress of the
21 meeting, and please conduct yourselves accordingly.

22 CHAIRMAN DIAMOND: Thank you, Mr. Vasquez.
23 So I thought I'd give a little bit of an over line
24 how we thought we would address these issues.

25 First, I want to welcome all of our guests

1 here today, and I'd like to just provide a little
2 bit of background.

3 The Board of Medicine is vociferously
4 apolitical. We are here to protect the people of
5 the State of Florida. I've asked all the members of
6 the Board to put their personal feelings aside and
7 approach these contentious issues openly, focusing
8 on the science and the standard of care.

9 I'm going to start by just asking a very
10 simple question of each member of the Board. Has
11 any member of this board been improperly contacted
12 by a member of the State, and in any way pressured
13 on how this meeting ought to be conducted or how
14 that person ought to respond?

15 Dr. Carnes (phonetic)?

16 DR. CARNES: No.

17 CHAIRMAN DIAMOND: Dr. Ackerman?

18 CHAIRMAN ACKERMAN: No.

19 CHAIRMAN DIAMOND: Ms. Justice?

20 MS. JUSTICE: No.

21 CHAIRMAN DIAMOND: Dr. Wasylik?

22 DR. WASYLIK: No.

23 CHAIRMAN DIAMOND: Dr. Vila?

24 DR. VILA: No.

25 CHAIRMAN DIAMOND: Dr. Chandra?

1 DR. CHANDRA: No.

2 CHAIRMAN DIAMOND: Dr. Pimentel.

3 DR. PIMENTEL: No.

4 CHAIRMAN DIAMOND: Dr. Pages?

5 DR. PAGES: No.

6 CHAIRMAN DIAMOND: Dr. Derick?

7 DR. DERICK: No.

8 CHAIRMAN DIAMOND: Dr. Hunter?

9 DR. HUNTER: No.

10 CHAIRMAN DIAMOND: Thank you. What we're
11 going to do is we're very pleased that our State
12 Surgeon General, Dr. Ladapo has decided to speak
13 with us today. We're going to first listen to
14 Dr. Ladapo's remarks. I believe then the State is
15 going to present the petition.

16 At that point, I've invited Dr. Michael
17 Haller, who's the chief of UF Pediatric
18 Endocrinology, to say a few words. I'm going to ask
19 some questions using my prerogative of both parties.
20 Then I'm going to open it up to the Board of
21 Medicine to ask some questions.

22 After that time, we're going to open it up
23 to the floor for public discussion. And what we've
24 done is we've invited the members of the public to
25 fill out speaker statements, and we've segregated

1 them into essentially opposition and support of the
2 petition. And what will happen is that names or
3 speaker cards will be selected at random and handed
4 to me AB order so that we can do this as fairly, as
5 impartially as possible.

6 It is essential that the people of the
7 state of Florida recognize we are approaching this
8 in a methodical, appropriate way. There is no way
9 that everyone is going to be able to speak today.
10 We've got in probably 150 speaker requests, so
11 that's not going to happen. Probably we'll end
12 speaker comments at 4:45 p.m.

13 The basic question for us today is whether
14 or not to accept a petition for rulemaking. Now,
15 this board is statutorily authorized to address
16 these issues. And if we're asked to accept this
17 petition, it's really incumbent upon us to do this.
18 It's not an issue or where you can just shirk our
19 responsibilities and say, no, thank you.

20 But I want to be very, very clear that if
21 this board decides to accept the petition for
22 rulemaking, nothing is going to happen today. This
23 will begin a series of publicly-noticed workshops,
24 where we can go and invite the public, where we can
25 invite experts to discuss these matters in an

1 appropriate way. And of course, these will all be
2 publicly-noticed and done with a focus on science.

3 As Mr. Vasquez says, we're going to limit
4 the public comments to three minutes each. There is
5 going to be no outbursts. There is going to be no
6 inappropriate behavior. If you do that, you'll be
7 escorted out of the building.

8 At this point, I think we should commence.

9 And, Dr. Ladapo, I'd like to turn it over
10 to you for your comments, and thank you for being
11 here, sir.

12 SURGEON GENERAL LADAP0: Thank you. I'm
13 going to see if I can stand up. Sometimes being
14 tall can be a disadvantage in terms of distance.
15 But can you hear me?

16 CHAIRMAN DIAMOND: Do you want to use the
17 -- do you want to take the mic off the stand?

18 SURGEON GENERAL LADAP0: Oh, great. Thank
19 you. Thank you all for all of your work in the past
20 few days.

21 UNIDENTIFIED FEMALE: We can't hear.

22 UNIDENTIFIED FEMALE: We can't hear you.

23 CHAIRMAN DIAMOND: Is the mic on, sir?

24 SURGEON GENERAL LADAP0: Okay. All right.

25 Okay.

1 So first I want to thank you, members of
2 the Board for all of your work over the past two
3 days. I know that you guys have been busy and
4 working hard and taking on a number of issues. And
5 I know that that's pretty routine that the -- that
6 your roles here on the Board require, you know, a
7 lot of energy, not to mention travel and a lot of
8 time.

9 Today, you're taking on something
10 additional. And I want to acknowledge that context,
11 because it's an important context, and it's
12 important to acknowledge it. And that context is
13 around us. It's behind us. It's the strong
14 feelings about the issue that you guys are taking on
15 today.

16 So with that in mind, I think it's
17 important, especially during these situations where
18 there just is a lot of outside external pressure and
19 influence, to remember what you all know, which is
20 what our duty is as clinicians and as members of a
21 society that set standards of care and evaluates
22 standards of care. And ultimately, that's what is
23 important in terms of your roles as members of the
24 Board of Medicine, as you know, and all of our roles
25 as clinicians.

1 And in terms of standard of care, the
2 reason that the Department of Health, our Governor,
3 DeSantis, and the Agency for Healthcare
4 Administration have been focused on this issue is
5 because there is a substantial departure. And I say
6 this from a very -- from an objective perspective,
7 not from a perspective that is influenced by, you
8 know, any favoritism for or against any particular
9 outcome, but rather an objective perspective about
10 the level of evidence and the data surrounding this
11 particular issue.

12 And I've spent a lot of time -- I've
13 actually evolved in my perspective on this
14 particular issue, so the comments I'm making today,
15 if you had spoken with me six months ago, I could
16 not have made them. The comments I'm making today
17 are based on my review of the evidence and my
18 discussion and evaluation of data presented by
19 individuals of all different perspectives on this
20 particular issue.

21 And when you go through that process, and
22 if you can go through that process with an unbiased
23 eye, it is very clear that in terms of the
24 effectiveness of what we're discussing today, the
25 petition that Mr. Wilson will present, the

1 effectiveness is completely uncertain. I mean,
2 maybe it is effective, but the scientific studies
3 that have shown -- been published to date do not
4 support that. They're just -- you know, they happen
5 to be entirely observational studies. There are
6 issues with confounding. It is impossible to
7 conclude that there is a benefit from the scientific
8 studies that have been published.

9 This is not to take away from any
10 particular individual's experience, you know, having
11 gone through or not gone through some of the
12 therapies that we'll be discussing today, but it
13 does have to do with what exists currently in the
14 scientific literature.

15 You look beyond the effectiveness and you
16 look at the safety. On the safety, again, it is
17 incontrovertible. There clearly is a level of risk
18 with these procedures, both the hormone therapies
19 and the hormone blockers for individual who are in
20 puberty and for the surgical interventions that are
21 obvious.

22 With the hormonal therapies -- puberty is
23 such an elaborate and confusing time. I mean, from
24 a scientific perspective, we don't understand all
25 the changes that happen in individuals. We do know

1 that hormones that are active and changing during
2 puberty affect brain development and other parts of
3 the human body, physiology. The effects of that in
4 terms of these therapies is completely unknown. It
5 is a huge question mark.

6 On the surgery side, we don't know the
7 effects in terms of sterility, fertility in the
8 future, in addition to the usual risk of surgery
9 that we're familiar with, such as infection, you
10 know, bleeding, and potentially death.

11 So when you combine those two and, you
12 know, you look at standards of care, these
13 procedures clearly fall into an area that is outside
14 what we generally conduct and consider part of the
15 standard of care for medical and surgical therapies.
16 There is no question about that based on the
17 available data. Could that change in the future?
18 It's possible. I think it is very unlikely
19 considering what I've reviewed, but it's possible.
20 But based on what we know today, it clearly falls
21 outside of the standard of care.

22 On top of that, one has to consider the
23 ability of a minor to provide consent for something
24 that is beyond the complexity of most adults to even
25 competently provide consent. And this just adds an

1 enormous ethical issue that, again, as clinicians,
2 we have training that tells us how to navigate
3 issues where we don't feel that we can be confident
4 that the patient in front of us is actually
5 providing informed consent for the therapy that he
6 or she is about to undergo.

7 So I want to -- I just wanted to share that
8 with you because that's been the conclusion of the
9 data that I've reviewed. Again, I want to
10 acknowledge the context that you all are working
11 men, and I want to thank you for your service here
12 on the Board of Medicine. And I have full
13 confidence that you all will provide, as Dr. Diamond
14 has shared, just a scientific and unbiased
15 assessment of this issue.

16 Okay. Thank you.

17 CHAIRMAN DIAMOND: Thank you so much,
18 Dr. Ladapo.

19 At this point I'd like to recognize
20 Mr. John Wilson, general counsel of the Florida
21 Department of Health. We'd like you to go ahead and
22 present the petition please.

23 ATTORNEY WILSON: Thank you, Mr. Chair.
24 Good afternoon, Board members. And thank you,
25 Dr. Ladapo, for that introduction.

1 My name is John Wilson. I'm the general
2 counsel for the Florida Department of Health, and
3 I'm here to present the Department's Petition to
4 initiate rulemaking, setting the standard of care
5 for gender dysphoria in Florida.

6 In April of this year, the Department
7 issued a recommendation and guidance recommending
8 against the use of puberty blockers, hormone
9 therapies, and sexual reassignment surgery in
10 children for the treatment of gender dysphoria.
11 After the release of that report, our sister agency,
12 the Agency for Healthcare Administration, began a
13 study to determine whether such treatments are
14 consistent with generally accepted medical
15 standards.

16 AHCA has concluded their report, and they
17 have determined that these treatments do not conform
18 with generally accepted medical standards. That
19 report is attached to the motion and is part of your
20 materials.

21 I will let the keen clinical minds of both
22 the Board and your public commenters reach into the
23 research and explain that to you, but the
24 Department's position at the end of the day is that
25 there simply is not evidence that these experimental

1 and irreversible treatments are effective for the
2 treatment of gender dysphoria.

3 Because of this, the Department recommends
4 that the Board adopt a standard of care by rule that
5 prohibits puberty blockers, hormone therapies, and
6 sexual reassignment surgeries for the treatment of
7 gender dysphoria in children that requires a robust
8 informed consent process for any of those therapies
9 in adults and provides guidance to physicians that
10 may find themselves caring for a patient that is
11 currently undergoing hormone therapy at the time of
12 the adoption of this rule or the patient's entry
13 into the state.

14 Now, before I turn over the floor, I'd like
15 to mirror some of the comments and expand on them of
16 Chair Diamond.

17 What we are asking you to do today is not
18 adopt a rule. It is to initiate the rulemaking
19 process. If granted, the Board would simply kick
20 off the normal process that is part of the
21 Administrative Procedures Act. This would give
22 plenty of time, as you stated, for public comment,
23 investigation, and research.

24 The Department has made a recommendation
25 today, and that is for two reasons. One, we do

1 believe that this is the only rational
2 recommendation, considering all of the available
3 evidence going towards the use of these procedures
4 to treat gender dysphoria. And number two, because
5 the Florida statutes require that a petitioner
6 asking the Board to initiate rulemaking provide
7 their proposed resolution for the rulemaking
8 process. Our request today, as you highlighted, is
9 simply to begin this process. By doing that, the
10 Board will not have legally bound itself to any
11 particular outcome.

12 I'd also like to answer a couple questions
13 that I believe might be in the forefront of Board
14 members' minds when discussing this petition. And
15 the first one is, why now? I have served before the
16 Board for the last several years in various
17 capacities, and I know your usual rulemaking process
18 is responsive. It's responsive to a set of
19 disciplinary cases, an ongoing dialogue with a trade
20 association or professional association, or after
21 the Legislature's mandated you to engage in
22 rulemaking. And I understand this is different, and
23 the Department has brought this petition directly to
24 you. And the answer to that question, why now, is
25 that the Department of Health believes that the

1 Board and Florida should be ahead of this issue and
2 not behind it.

3 I expect that there will be a great deal of
4 disagreement about where the public and potentially
5 even Board members believe this discussion should
6 end. But I also expect that there will be a great
7 deal of agreement that this is an important issue
8 for Florida healthcare, for our citizens, and our
9 citizen's children, and it is worthy of your
10 attention, time, and resolution.

11 The Department at this point is not willing
12 to wait for others to lead, and it is not willing to
13 wait for a neatly tied controversy to naturally come
14 before you and force this issue. That is why the
15 Department has brought you this petition today.

16 We respectfully request that you join the
17 Department in this urgency because I'm sure you all
18 understand that there is someone out there right now
19 that tomorrow is too late, and it is time for the
20 Board to take up this issue.

21 The second question I want to touch on, why
22 you? Why the Board of Medicine?" And I thank you,
23 Chair Diamond, for your comments. The Legislature
24 has delegated this duty to you, not to the
25 Department, not necessarily reserved it for itself.

1 The Legislature created the Board for this exact
2 type of purpose, to gather some of the brightest
3 medical minds in our state, get them together so
4 when such a controversy presents itself, it can be
5 decided by physicians, not politicians, not
6 bureaucrats at the agency, but a group of keenly
7 minded physicians that can exercise due diligence in
8 the research that goes into such an important
9 decision.

10 The Department and the Board share a common
11 goal, obviously, of safeguarding the health and
12 welfare of our Florida citizens. We are always
13 partners in this. But at the end of the day, the
14 Board and the Department of Health are legally
15 distinct agencies, and the authority to set a
16 standard of care, the Legislature has unequivocally
17 delegated that to this body. And the Department has
18 absolute full faith in this Board's ability to deal
19 with the issue we have brought it today.

20 And with those questions answered, I again
21 respectfully request that the Board grant the
22 Department's petition and initiate the rulemaking
23 process to set a standard of care for the treatment
24 of gender dysphoria in Florida. Thank you.

25 CHAIRMAN DIAMOND: Thank you, Mr. Wilson.

1 And just to elaborate a little bit, I want
2 to be very, very clear. If this board elects to
3 enter the rulemaking process, it does not behoove us
4 to promulgate a rule. There is a possibility that
5 we may not be able to come to agreement.

6 Further, if we do promulgate a rule, we do
7 not have to, in any way, necessarily mirror the
8 recommendations that have been presented. We have
9 latitude and leeway. Our job is to approach this in
10 a open mind, and we are going to accept the task
11 presented to us as faithfully as we can.

12 At this time, is Dr. Haller with us right
13 now? Thank you.

14 So what I'm going to do is I've invited
15 Dr. Mike Haller, chief of Pediatric Endocrinology,
16 University of Florida, to say a few words. And the
17 reason I'm doing this is that it is essential, as I
18 said before, that we are making it clear that we are
19 giving full voice to some different opinions.

20 So, Dr. Haller, I'd like to invite you to
21 say a few words. Go Gators.

22 DR. HALLER: Thank you for the opportunity
23 to speak today. Esteemed members of the Board of
24 Medicine, my name is Dr. Michael Haller. I am a
25 graduate of the University of Florida College of

1 Medicine, the University of Florida Pediatric
2 Residency, and the University of Florida Pediatric
3 Endocrinology Fellowship. I hold a master's degree
4 in clinical investigation, and I currently serve as
5 the professor and chief of pediatric endocrinology
6 at the university. I've trained thousands of
7 medical providers, participated in the development
8 of national, international guidelines, and have
9 treated tens of thousands of children. I hold
10 numerous NIH grants and have published more than 200
11 peer-reviewed papers.

12 I provide this background with full
13 humility but also to establish myself as an expert,
14 both in pediatric endocrinology and in the review
15 and analysis of the scientific literature.

16 Respectfully, the Department of Health's
17 petition for rulemaking and the proposed prohibition
18 of pubertal blockers, hormone therapy, and surgery
19 for gender dysphoric patients under 18 is in direct
20 conflict with guidelines from the American Academy
21 of Pediatrics, the Endocrine Society, the American
22 Psychological Association, and the World
23 Professional Association for Transgender Health.

24 The association's guidelines have
25 established gender-affirming care as the standard of

1 care. Importantly, the quality of evidence used to
2 establish standards for other less politicized
3 diagnoses is far weaker than the data supporting
4 gender-affirming care. As such, the assertion that
5 gender-affirming care is not adequately data-driven
6 is at best a double standard, and at worst
7 discriminatory political theater.

8 Sadly, less than 20 -- excuse me, less than
9 48 hours ago, the governor gave public comments in
10 which he called for doctors who provide gender-
11 affirming care to be sued and criminally prosecuted.

12 Similarly, his press secretary, Ms. Pushaw,
13 and the general surgeon's press Secretary,
14 Mr. Redfern, regularly promote falsehoods about
15 gender-affirming care and willfully encourage
16 personal attacks on physicians and patients who
17 provide and receive gender-affirming care. While
18 you as the Board are, thankfully, apolitical, each
19 of you are appointed by and serve at the pleasure of
20 the governor.

21 As such, in order to have meaningful
22 conversations regarding gender care in Florida, we
23 must acknowledge the highly unusual political nature
24 of the State's petition. We must admit that the
25 State's recent actions to remove Medicaid coverage

1 for both adolescents and adults with gender
2 dysphoria are indeed politically motivated. We must
3 recognize that the state-supported AHCA report on
4 gender medicine makes numerous false claims, uses a
5 highly biased review of the literature, and relies
6 on discredited pseudo experts.

7 While there are numerous flaws with the
8 AHCA or GAPMS' report and the State's proposed rule,
9 the following issues deserve some specific
10 commentary.

11 First, the State's primary assertion that
12 gender-affirming therapy has not demonstrated
13 efficacy and safety is patently false. Nearly every
14 major medical organization that provides care for
15 children is supportive of gender-affirming care, and
16 the State is either unaware of or willfully chooses
17 to ignore the totality of the evidence in support of
18 gender-affirming care.

19 Second, the State's use of anti-trans
20 pseudo experts as external advisors, seeking to
21 discredit the standard of care is frankly absurd.
22 At least one of the State's so-called experts has
23 been disqualified from testing and testifying in
24 cases regarding gender-affirming care by Texas
25 judges. Several others have never provided gender-

1 related care to any child or adult.

2 Third, the State's ongoing implication that
3 the overwhelming majority of children resolve their
4 gender dysphoria is a gross misrepresentation of the
5 data. While a majority of pre-pubertal children who
6 express transgender identities do return to their
7 original gender assignment, more than 90 percent of
8 those with a transgender identity following puberty
9 persist with that trans identity indefinitely.

10 With all that as background, I'd like to
11 remind the Board what the established standard of
12 care actually recommends.

13 First of all, evaluation by
14 multidisciplinary groups of providers with expertise
15 in psychology, pediatrics, and endocrinology is
16 recommended.

17 Secondly, adolescents who present to gender
18 care clinics must have co-morbid mental health
19 issues diagnosed and treated before confirming their
20 gender dysphoria or identity.

21 Third, when gender dysphoria persists and
22 when the patient starts puberty, endocrinologists
23 can then offer pubertal blockers. This is never
24 done in pre-pubertal children. In addition, the
25 overwhelming majority of side effects associated

1 with the use of pubertal blockers are, in fact,
2 reversible.

3 Fourth, only when gender identity continues
4 to be well-established are patients offered gender-
5 affirming hormones.

6 Fifth, mastectomy is considered only after
7 the age of 16 in trans men and most often occurs
8 after age 18.

9 And, sixth, genital surgeries are
10 considered only after age 18. That is the standard
11 of care.

12 Importantly, while the State would like to
13 have you think otherwise, surgeries in transgender
14 adolescents are appropriately uncommon. When
15 considering the three largest youth gender clinics
16 in Florida, where more than a thousand children are
17 currently followed, less than 100 patients have been
18 referred for breast surgery in the last 5 years with
19 the majority of those being referred over 18, and
20 100 percent of those from our center being referred
21 after the age of 16 and with full parental consent.
22 Similarly, not a single patient followed by any of
23 our centers has been referred for genital surgery
24 before the age of 18.

25 So while the State has used exceptional

1 cases of poor care provided outside the State of
2 Florida to support their positions, I am not aware
3 of a single complaint made to this Board of Medicine
4 by a patient in Florida regarding their gender-
5 affirming care.

6 As all of you are practicing physicians
7 from different backgrounds, I'd like you to consider
8 the following analogy.

9 Dr. Diamond, how would you respond if the
10 State of Florida suggested a standard of care that
11 was in conflict with the recommendations of your
12 American Society for Radiation Oncology Society?

13 Doctors Barsoum and Wasylik, what would you
14 say if the State suggested that the standard of care
15 according to your American Academy of Orthopedic
16 Surgeons was unacceptable, and you could no longer
17 perform surgeries in line with your association's
18 recommendation?

19 Dr. Zachariah, would you support the State
20 if they refuse to let you practice according to the
21 standard of care as defined by the American College
22 of Cardiology?

23 I ask each of you to consider the same for
24 your specific practice of medicine.

25 In closing, I ask you to uphold the

1 sanctity of the doctor-patient relationship. I ask
2 each of you to vote against the State's petition and
3 to let doctors and patients continue to have the
4 freedom to access the care they need. Thank you
5 very much.

6 CHAIRMAN DIAMOND: Thank you so much. I
7 understand -- no, no, no.

8 No, no, no. Not again. Not acceptable,
9 please.

10 I understand that Dr. Quentin Van Meter is
11 with us today as well.

12 Sir, if you could please come to the front.
13 Dr. Diamond.

14 UNIDENTIFIED MALE: Dr. Diamond, do we need
15 to have a motion to accept the petition so we can
16 have discussion on this?

17 CHAIRMAN DIAMOND: Mr. Tellechea says no.

18 UNIDENTIFIED MALE: Okay.

19 ATTORNEY TELLECHEA: Not yet.

20 CHAIRMAN DIAMOND: Sir, could you please
21 introduce yourself?

22 DR. VAN METER: Yes. My name is Quentin
23 Van Meter. I'm a board-certified pediatric
24 endocrinologist in private practice in Atlanta,
25 Georgia. I have a 42 years' experience in dealing

1 with what was originally called transsexual patients
2 and which currently are called transgender patients
3 in the vernacular.

4 My background comes from Johns Hopkins
5 Hospital where Dr. John Money was one of my faculty
6 professors, and he is the person who coined the term
7 gender identity as the concept of the internal sex
8 to self. It was a social concept.

9 I would like to explain to the Board --
10 first of all, thank you for having me here. I'm
11 very, very appreciative of the opportunity to speak.

12 There is no biologic basis for one's gender
13 identity. It is a purely social construct. There
14 have been studies that are limited, looking at MRI,
15 the best studies of the brain, looking at genetic
16 markers, but the quality of those studies in terms
17 of the numbers and the explanation of what their
18 findings are very limited and of no statistical
19 value.

20 So if a person is found -- remains are
21 found some 200 years after the -- they have passed
22 away and they're exhumed and examined, there is no
23 way that anyone has an opportunity or a way to say
24 what one's -- that body's gender identity was. They
25 certainly can tell the biologic sex without any

1 hesitation whatsoever. So the basis of gender
2 identity is a social concept that has been developed
3 and was first coined by Dr. Money in the 1970s.

4 The problem with proceeding with procedures
5 to socially, medically, and surgically affirm
6 children in their incongruent gender is that there
7 is no long-term data outcome from the United States
8 or actually worldwide that proves its safety and
9 efficacy.

10 What has happened in the United States is
11 that before 2007, there was not a transgender clinic
12 in existence in this country, at least not
13 officially. Between 2007 and the present time,
14 there have erupted 66 different university-based
15 transgender centers and then a host of additional
16 places where transgender identified individuals can
17 find medical treatment through Planned Parenthood
18 and through several online services, to get hormone
19 treatments and to have puberty blocked and then to
20 be referred to surgical procedures.

21 So in this past number of years, we have
22 seen a burgeoning of these clinics, and we have also
23 seen an incredible increase in the number of
24 patients presenting with transgender complaints or
25 morbidity. The reason that we are told this has

1 happened is because society is now more open and
2 accepting of these individuals, and that they have
3 always been there throughout history.

4 Well, I have been practicing pediatric
5 endocrinology and as a board-certified pediatric
6 endocrinologist from 1980 forward, and I found no
7 patients in practice, one patient -- except for one
8 patient that came to me in 1993. It was a boy,
9 biologic boy who came to me for hormone therapy.

10 At that point in time, I was flabbergasted
11 as to what to do because there was no place to go,
12 no advice. I canvassed all of my colleagues in
13 pediatric endocrinology from coast to coast, north
14 to south, and said, what would you recommend?
15 Nobody had an idea of what to do because there was
16 no standard of care established for this kind of
17 problem.

18 So what happens then between 2007 and the
19 present day is that the internet has allowed access
20 for these patients to learn about the concept of
21 gender identity and apply it to their own lives.
22 We've seen an absolutely incredible increase over
23 the past two years because of the restrictions of
24 not going to school with COVID and people being held
25 in their homes, that they lived an internet life.

1 My most recent transgender patient, who
2 actually came in to see me yesterday exactly, had
3 had that problem where there was no concept of
4 gender problems before until COVID hit. The child
5 was kept home for two years by their parents, and it
6 was during those two years that this child assumed
7 that there was a problem that would be answered by
8 changing to a different -- the appearance of a
9 different biologic sex than the actual biologic sex
10 of the patient.

11 So this is what we are dealing with. We're
12 dealing with a monumental epidemic of increased
13 proportions. And in Europe, who started these
14 treatments about 10 years before we did in the
15 United States, in Europe, they have come to the
16 conclusion, after looking at their 20 years of data,
17 that there is no way that it is safe or appropriate
18 to treat a minor child with any kind of hormonal
19 intervention or surgical intervention until the age
20 of consent.

21 Now, that is the European experience. They
22 were pioneers in doing these kind of things 10 years
23 before we began in the United States. They have a
24 smaller number of patients because, technically, in
25 the United States, we are supposed to have 120,000

1 transgender children in the United States at this
2 very moment in time. But in Europe, they saw this
3 same phenomenal increase, and they called to
4 question what was going on. And they evaluated the
5 data, and they found that there was far more harm
6 than any benefit in allowing these children to
7 receive any kind of medical or surgical treatment.

8 And the government of Sweden, the
9 government of Finland, and most recently in the last
10 week, the UK, have closed down all such treatments
11 and banned them by government edict and said that
12 moving forward, the only way that those kinds of
13 treatments in minors can happen is under a carefully
14 scrutinized research protocol, which is governed by
15 an institutional review board, which looks at safety
16 and efficacy.

17 Now, I've done clinical research studies.
18 I'm not an academician at a university, but I have
19 been involved in clinical research my entire
20 professional private practice life. And I have had
21 IRBs review the kinds of studies we're doing, and it
22 is very important for an independent board to look
23 at and to re-look at the consent form in particular
24 and look at the design of the studies and either let
25 that study go forward or not. And if the study goes

1 forward, there is an independent safety committee
2 that looks at any adverse event and looks at that as
3 a stopping criteria for that study no matter how
4 hopeful or beneficial the treatments have been to
5 some of the patients in that study. We are missing
6 that.

7 This is a giant experiment on United States
8 children, 120,000 kids, supposedly in the position
9 of having an incongruent gender, and we are moving
10 forward with a treatment protocol that is not
11 transparent, that is not really a standard of care
12 in the sense that there has been a board of
13 individuals from one concept of treatment to the
14 other and everything in between who've come together
15 and has a consensus of what is a standard of care.
16 There are guidelines that have been promulgated.

17 It was mentioned that the American Academy
18 Pediatrics represents 67,000 pediatricians and is
19 fully behind affirmation, medical and surgical -- or
20 medical affirmation, in particular. Well, the
21 problem with that is that those 67,000 members are
22 not satisfied with what has happened with the
23 leadership and the committee that wrote that
24 particular guideline; 80 percent of the
25 representatives of their leadership forum last year,

1 and again this year, brought up a resolution that
2 said, please remove that statement. Re-look at it.
3 Look at science, and come back with a statement that
4 reflects science and is appropriate and that
5 demonstrates that this is both safe and efficacious.

6 Both of the times where this resolution was
7 approved by the vast majority of attendees, which
8 would essentially reflect the vast majority of the
9 membership that sent them there, the leadership
10 buried that resolution request and ignored it
11 completely and utterly and pretended that it doesn't
12 exist. So the facade of everybody in the
13 professional world sanctioning these things as the
14 standard of care is a mirage. It is not actually
15 true. And I'll stop there.

16 CHAIRMAN DIAMOND: Thank you. So if I may
17 try to succinctly as possible summarize these
18 positions. We have the State that contends that the
19 standard of care as espoused by these professional
20 societies has serious flaws; that the number of
21 minors receiving these treatments is substantively
22 increasing; that they may be causing harm,
23 potentially even irreversible harm, and there are
24 issues related to the capacity they contend for
25 these young children to make these important

1 decisions. And for these reasons, we are being
2 asked, as the body charged with such
3 responsibilities, to enter rulemaking.

4 If I may try to concisely summarize the
5 opposition position. The standard of care is
6 developed by the professional societies as a result
7 of vigorous scientific debate. This is how science
8 works. We yell and we argue in a respectful,
9 scientific way. The numbers of individuals being
10 treated in the state is actually relatively small,
11 and it's not the purview of the State to get
12 involved in these actions. I think that's the
13 bottom line.

14 So at this point, I'd like to ask a couple
15 questions, and these questions are designed to help
16 me understand the positions that both of you hold a
17 little bit better. In no way do they belie my own
18 position.

19 So first thing first, Dr. Van Meter, I want
20 to be very, very clear that this petition does not
21 include individuals with disorders of sex
22 development, does not include congenital adrenal
23 hyperplasia, Leydig cell hypoplasia, Klinefelter,
24 Turner syndrome, Ova testicular disorder. Is that
25 correct?

1 DR. VAN METER: That's correct.

2 CHAIRMAN DIAMOND: Just gender dysphoria,
3 correct?

4 DR. VAN METER: That's correct.

5 CHAIRMAN DIAMOND: And then I have a
6 question for Mr. Wilson. You touched on it before.
7 This board has taken vigorous action in the past
8 with respect to the terrible opioid epidemic in the
9 state and with respect to serious issues such as the
10 large number of deaths that have occurred with the
11 gluteal fat transfers, the so-called Brazilian butt
12 lifts. In both of these cases, we have had a very
13 large number of disciplinary cases brought before
14 us, and we've had deaths.

15 You point out that it is not a necessary
16 condition for those to have occurred to initiate
17 this, but I am just curious for the record: do you
18 have any sense of how many cases related to the
19 standard of care for individuals with sexual
20 dysphoria have been brought before this board?

21 DR. WILSON: Thank you, Mr. Chair. And we
22 could, of course, do a full research project and
23 bring you every shred of data in the possession of
24 the Department of Health on that, should we consider
25 enter rulemaking and workshopping. But having

1 served for the last several years as your chief
2 prosecutor, there have not been any recent public
3 cases that have made it to the Board on this issue
4 in recent history.

5 CHAIRMAN DIAMOND: Thank you so much.

6 Dr. Haller, a couple of questions for you,
7 sir. Obviously -- and firstly, thank you. You've
8 been very kind to share information with the Board
9 publicly. Obviously, you referenced standard of
10 care. Standard of care obviously is a range. The
11 way Dr. Ackerman may treat a person with
12 nasopharyngeal cancer may be a little different than
13 the way I do it. He's probably wrong, of course,
14 but there's a range.

15 CHAIR ACKERMAN: I resemble that.

16 CHAIRMAN DIAMOND: Obviously, there is a
17 range in standard of care. Standard of care changes
18 as medical science advances, and standard of care
19 may also be dependent on location. The standard of
20 care here in the United States on this issue, I am
21 sure is not the same as it is in Mauritania, for
22 example. Is that a fair statement, of course?

23 DR. HALLER: Very much so.

24 CHAIRMAN DIAMOND: Okay. And again, I also
25 like to say, these questions I'm asking do not belie

1 my personal opinions for me to understand you a
2 little bit better.

3 You were kind enough to share with us a
4 little bit of information about what you do at
5 University of Florida. And at present, I believe
6 you have 50 children on pubertal blockers. You have
7 75 individuals on estradiol or spironolactone. You
8 have 250 individuals on testosterone. And I think
9 the point of you saying that is that the numbers are
10 actually relatively smaller than some people would
11 lead to believe. Is that the point of that?

12 DR. HALLER: Yes. That's a correct
13 statement. I think the public has been led to
14 believe that there are more children than there are
15 receiving gender-affirming hormones or therapy in
16 general.

17 CHAIRMAN DIAMOND: Okay. And if I tally up
18 your program, the data you provided to me from All
19 Children's, Johns Hopkins, St. Petersburg, and
20 Nicholas here in Miami, the total of number of
21 children currently receiving pubertal blockers is
22 86. The total number receiving spironolactone or
23 estradiol was 177, and the total number receiving
24 testosterone was 481. So I think that would comport
25 with the comment you just made. Is that right?

1 DR. HALLER: Correct.

2 CHAIRMAN DIAMOND: All right. Now, at
3 University of Florida, your policy is that no
4 individual under the age of 18 is permitted to
5 undergo so-called bottom surgery. So this is
6 orchiectomy, penectomy, vaginectomy; is that
7 correct?

8 DR. HALLER: That's correct. We do not
9 refer any children for those surgeries.

10 CHAIRMAN DIAMOND: So just to help me
11 understand, if there were an institution here in
12 Florida that was recommending it for, let's say, 17
13 years old, 17-year-old individuals, would you state
14 that that is outside of the standard of care?

15 DR. HALLER: Well, I think that would get
16 into your example of your approach versus
17 Dr. Ackerman's approach in a patient. But for us --

18 CHAIRMAN DIAMOND: He's wrong, of course.

19 DR. HALLER: -- that would be outside of --
20 of course, he's accepting that he's wrong, and
21 you're right. I think that's why there's the
22 practice of medicine.

23 CHAIRMAN DIAMOND: No. But I'm trying to
24 understand why did you pick 18 years old as opposed
25 to 17 or 16? How did your institution come to

1 establish that age cutoff?

2 DR. HALLER: Yeah. That's our
3 understanding of the guidelines as available now,
4 and we feel that that's the appropriate age cutoff,
5 the age of a full consent to be able to have a
6 surgery like that.

7 CHAIRMAN DIAMOND: Okay. And in terms of
8 so-called top surgery mastectomy, I understand that
9 you've had 50 referrals for that in the past three
10 years. Three years; is that correct?

11 DR. HALLER: That is correct.

12 CHAIRMAN DIAMOND: Okay. Ten of whom were
13 under the age of 16; is that correct?

14 DR. HALLER: That's my understanding.

15 CHAIRMAN DIAMOND: Okay. Do you know --
16 and you wrote in this note to me, none under the age
17 of 14, so that would imply that there were some 14
18 and 15 year-olds having top surgery or mastectomy at
19 your institution; is that correct?

20 DR. HALLER: Correct.

21 CHAIRMAN DIAMOND: Can you give me any idea
22 what that number would be? I would assume it's a
23 small number.

24 DR. HALLER: I don't know the exact
25 numbers. These were numbers that we pulled from our

1 gestalt for what the numbers are. We don't have a
2 formal registry --

3 CHAIRMAN DIAMOND: Okay.

4 DR. HALLER: -- that we're following as a
5 guide.

6 CHAIRMAN DIAMOND: And so, again, I'd like
7 to ask the question --

8 DR. HALLER: Yeah. If I could, Dr. Dayton
9 is actually director of our clinic, and she could
10 probably provide a more accurate answer.

11 CHAIRMAN DIAMOND: Dr. Dayton, please have
12 a seat. So I'd like to ask the question then --

13 DR. DAYTON: Can I -- is it okay if I just
14 -- I think that last question a little bit
15 misrepresented. I would say we've referred zero
16 patients under 16 for mastectomy. We have had
17 patients within our practice that have received it
18 outside of our university setting and not at our
19 recommendation or us writing letters or encouraging
20 that.

21 CHAIRMAN DIAMOND: Understood. So again,
22 help me understand, why do you set the age of 16?

23 DR. DAYTON: Again, guideline based, based
24 on national, international guidelines.

25 CHAIRMAN DIAMOND: So will you --

1 DR. DAYTON: And it's a starting point,
2 right. It's not that we're absolutely recommending
3 it at that age, but that's an age in which we may
4 consider it for certain select patients.

5 CHAIRMAN DIAMOND: But you would not, at
6 this time, recommend it for, let's say, 12 or 13
7 year olds. Is that a fair statement?

8 DR. DAYTON: No, sir.

9 CHAIRMAN DIAMOND: And that's because of
10 the guidelines, correct?

11 DR. DAYTON: Yes.

12 CHAIRMAN DIAMOND: And what would be the
13 underlying reason within the guidelines for making
14 that recommendation for an age cutoff?

15 DR. DAYTON: My understanding would be this
16 is sort of just based on understanding of maturing
17 process within human individuals, you know, on the
18 level of physicians, mental health professionals,
19 and the level of understanding of the consequences
20 of their actions at those ages.

21 CHAIRMAN DIAMOND: Sure. So if I
22 understand you correctly, the guidelines that you
23 reference, the reason that they have these age
24 cutoffs -- or age ranges would be a better
25 statement, I think.

1 DR. DAYTON: Yeah.

2 CHAIRMAN DIAMOND: It's not predicated on
3 physiology, it's -- anatomic physiology. It's more
4 predicated on capacity to make these decisions. Is
5 that a fair statement or am I off?

6 DR. DAYTON: I mean, you can probably tell
7 based on my lack of too many wrinkles that I wasn't
8 a part of those guideline-making procedures, but
9 that would be my assessment. Yeah.

10 CHAIRMAN DIAMOND: So an ability to
11 understand the full -- and obviously, unemancipated
12 minors don't give consent. They give assent.

13 DR. DAYTON: Assent, yeah.

14 CHAIRMAN DIAMOND: All right. Have you had
15 circumstances where you've had children who espoused
16 a certain position, and perhaps there's one parent
17 that's in agreement and one that is in disagreement?

18 DR. DAYTON: Yes. That is common.

19 CHAIRMAN DIAMOND: It is common?

20 DR. DAYTON: Yeah.

21 CHAIRMAN DIAMOND: And how do you try and
22 resolve that? Obviously, you try and resolve it.
23 But what happens when there's not a resolution?
24 Does that child not proceed with the treatment --
25 with the care?

1 DR. DAYTON: I think it's really complex
2 and hard to answer just in a broad way. It is a
3 ongoing discussion with their families trying to
4 come to the best conclusion on the part of both
5 parents as medical decision makers on what's best
6 for that patient, really. We as doctors can't do
7 anything without parental consent, clearly. So
8 we're going to do it once we have consent from, you
9 know, a parent that can make medical decisions for
10 that child.

11 CHAIRMAN DIAMOND: But as a general
12 statement for an unemancipated minor, if the child
13 says A and the parents say B and B, it's an absolute
14 no-go. If the child says A, one parent says A, one
15 parent says B, you try and resolve it. But if it's
16 not resolved, it's typically a no-go; is that
17 correct?

18 DR. DAYTON: I think it's an area -- when
19 parents disagree, there's not a clear legal reason
20 that -- it sort of depends. Like, you know, is
21 there a divorce agreement? What does it say in
22 that?

23 I think there are times where parents
24 disagree, just to kind of really blanket answer your
25 question. There are times where parents disagree

1 where children are able to pursue treatment, but it
2 would be, you know, in the absence of one parent
3 actively presenting and disagreeing with the
4 treatment. But again, this is on a case by case in
5 a very intricately managed process.

6 CHAIRMAN DIAMOND: If you were to learn
7 that, for example, in the State of Florida, there
8 were, indeed, 13 year olds undergoing top surgery or
9 mastectomy, would you consider that in your
10 professional opinion to be outside the standard of
11 care at this time?

12 DR. DAYTON: It is outside of what our
13 standards state explicitly. Yeah.

14 CHAIRMAN DIAMOND: Okay. You may hear that
15 there's been changes in how this issue is being
16 approached, I think it was referenced already by
17 Dr. Van Meter, how, for example, in the National
18 Health Service in the United Kingdom, Finland and
19 Karolinska in Sweden are approaching these issues.
20 I'm sure we can get a lot more into that depth when
21 we do the workshops if we chose to proceed.

22 But purely from a scientific point of view,
23 do you have any sense why these entities -- do you
24 have any sense what the scientific underpinning may
25 be why they have modified their opinions? Or is it

1 your contention it was not a scientific decision,
2 but rather based upon other factors?

3 DR. HALLER: I'll take that one. I think
4 it's impossible to fully separate the political
5 decision making from the science in this particular
6 area. Even our colleagues in Finland and Sweden
7 would acknowledge that.

8 They have very, very different healthcare
9 delivery systems there with a nationalized
10 healthcare where everybody has access. Everybody
11 has access to mental healthcare. Everybody has
12 access to gender care through specialized centers.

13 So even though they have a different
14 experience than ours, and they have a limited data
15 set as everybody does, because this is the cutting
16 edge of medicine, the data are the data. And the
17 biology is not any different. But it's
18 understandable why countries with different
19 healthcare systems could come to different
20 conclusions on what the standard of care should be
21 based on the way health is delivered.

22 CHAIRMAN DIAMOND: Thank you. And I have
23 one further question before I'll turn it over. And
24 this is a little tangential.

25 You were kind enough to share with me a

1 pre-print from one of your colleagues at University
2 of Miami from Dr. Alejandro Diaz who provided a
3 narrow review on transgender care in pediatrics.
4 And in this paper, the author referenced that those
5 licensees taking care of these individuals should
6 provide gender-neutral bathrooms, should provide
7 identification wrist bands that are gender neutral,
8 and should use preferred names and pronouns in the
9 care of these children.

10 And of course, in what we do here as a
11 Board, we look at the standard of care. We look
12 also at practice issues, how physicians -- how
13 licensees conduct themselves in their practice. And
14 I noticed that in this paper, he used the operative
15 word "should" not "must." Should, not must. Should
16 use preferred names and pronouns and identification
17 response, but not must.

18 I ask either of you, do you think that, for
19 example, if a Florida licensed physician is caring
20 for a transgender person who has a request to use,
21 for example, the pronoun Z or Zed, do you think that
22 if that licensee elects not to use that pronoun, in
23 your professional opinion, is that outside of
24 appropriate professional practice?

25 DR. HALLER: I think that's cruel and

1 heartless but probably not, frankly, illegal. And
2 I'm not an attorney or know what that would say.
3 But it is not appropriately providing care to
4 patients who ask to be referred to by a name. If I
5 ask you to call me Bob, I would think that you would
6 be kind enough to do me the favor of calling me Bob
7 similarly as I'll call you Dr. Diamond.

8 CHAIRMAN DIAMOND: And, Doctor, I'd like
9 your answer on that as well.

10 DR. DAYTON: I mean, I don't -- I
11 definitely don't see it as something that should
12 require someone's license to be under question or
13 anything like that.

14 CHAIRMAN DIAMOND: Well, that's what I'm
15 getting at because --

16 DR. DAYTON: Right.

17 CHAIRMAN DIAMOND: -- when we look at
18 standard of care, we look at standard of practice.
19 You were here for several hours --

20 DR. DAYTON: Yeah.

21 CHAIRMAN DIAMOND: -- where, unfortunately,
22 people have done some very inappropriate things.
23 And I would like to know your opinion if a licensee,
24 for example, does not use this pronoun or does not
25 provide a general-neutral bathroom, should that

1 person be disciplined; should that person lose their
2 license to practice medicine?

3 DR. DAYTON: I wouldn't see that that would
4 be appropriate. No.

5 DR. HALLER: I agree. I concur.

6 CHAIRMAN DIAMOND: Okay. That ends my
7 questions. I thank all of you for your indulgences.
8 It helps me understand your positions better.

9 At this point, I'd like to turn it over for
10 my other board members to ask any questions for our
11 guests sitting up front.

12 Dr. Wasylik, please.

13 DR. WASYLIK: Dr. Haller, you and your
14 associate talked about practice guidelines. You
15 also talked about having very, very few patients to
16 treat. So who developed those practice guidelines?

17 DR. HALLER: Sure. So the guidelines are
18 developed as they are for most associations.
19 They're developed by a team of experts who have the
20 most experience in caring for those patients and
21 folks who have expertise in reviewing the available
22 literature. And they make the best call based on
23 the totality of the evidence and their experience.
24 It's not to say that standards of care and
25 guidelines won't change over time.

1 DR. WASYLIK: Well, the question was did
2 you develop them or --

3 DR. HALLER: No, sir.

4 DR. WASYLIK: Okay.

5 DR. HALLER: Not me personally.

6 DR. WASYLIK: Because I have some
7 experience in developing guidelines on a national
8 level with AMA, and we basically would develop
9 guidelines based on multiple stakeholders coming and
10 giving us information. And mostly, it was high-
11 level randomized controlled studies. And I just
12 seem -- if you've got so few patients, I don't know
13 where the guidelines --

14 DR. HALLER: Yeah, no. I understand that
15 critique. And it's fair one. So --

16 DR. WASYLIK: It's not a critique. It was
17 a question.

18 DR. HALLER: Yeah. Well, a question. This
19 is a diagnosis that's not as common as many other
20 medical diagnoses, so there are limited data. And
21 it forces us to develop guidelines without often
22 having core randomized control trials like we'd all
23 like.

24 The challenge is once something is
25 established as a standard of care within the

1 community, it's almost impossible to always suggest
2 that you're going to get RCTs. So, yes. Most of
3 the data is going to be observational or descriptive
4 in that nature. But it's our duty to do the best we
5 can with the data available, to do the best for our
6 patients. And so I think those guidelines have been
7 developed by people bringing as many experts as they
8 can into the room.

9 I would disagree with Dr. Van Meter that
10 the majority of voices don't agree with what the AAP
11 has suggested, and there is a small but vocal group
12 of folks who would criticize those guidelines. But
13 the overwhelming majority of pediatricians do, in
14 fact, support the standards that we have now.

15 DR. WASYLIK: I have one other question, if
16 I may. Are you doing an investigator study since
17 you are probably having as many patients as anyone?
18 Is -- are your patients under -- yeah, go ahead.

19 DR. DAYTON: We don't have ongoing trials
20 with our patients, but we are working, like, on
21 things like registries of our patients. But no
22 specific, like, investigational trials.

23 DR. WASYLIK: Thank you so much.

24 CHAIRMAN DIAMOND: So may I interject?
25 That raises an interesting point. Do you think

1 doctors, that for individuals receiving this
2 treatment, that it would be prudent, if not very
3 helpful, that they be followed as part of a formal
4 longitudinal study so that these questions that are
5 being asked can be more accurately assessed?

6 DR. DAYTON: Yeah. I do think something
7 like a larger database throughout the country is not
8 only important to have, but actually is something
9 that our pediatric endocrine society has been
10 working toward doing with all the clinics in the
11 country. So it's not yet fully operational, but it
12 is something that a lot of physicians are going to
13 do.

14 CHAIRMAN DIAMOND: I would certainly
15 encourage that at a minimum. You know, like I said,
16 I'm an oncologist and we are very, very --

17 DR. DAYTON: You guys are the best.

18 CHAIRMAN DIAMOND: We're very vigilant
19 about these things. When we -- you know, when we do
20 these newer therapies, we really want to do them on
21 registries and series and follow them because the
22 bottom line is just because you think something
23 works does not mean it works. And the example we
24 always use in oncology is back in the 1990s,
25 thousands and thousands of women with locally

1 advanced breast cancer were undergoing bone marrow
2 transplant and a very, very toxic, very difficult
3 procedure. And everyone thought it ought to work.
4 The data from South Africa purported that it did
5 work. And guess what? It didn't work. And it was
6 a terrible experience.

7 And I think that the point is that all of
8 us in our daily lives, no matter what we do,
9 including science, you know, the unexamined life is
10 not a life worth living. We must continuously
11 assess what we're doing and have the capacity to say
12 maybe what we're doing is wrong. Maybe our beliefs
13 are wrong. Maybe we can listen to the other person
14 or the other side or accept the newer data and
15 potentially make our position a little bit better, a
16 little more refined to better seek the truth.

17 Any other questions?

18 DR. CAIRNS: I had a question, sir. Yes,
19 Dr. Haller. I had a question. Your colleague from
20 Georgia mentioned that the increased incidents of
21 gender dysphoria is one of the contributing factors
22 or main factors was COVID that kids were staying at
23 home on the internet. And it almost seemed like
24 he's insinuating that's like a social contagion.
25 And I just think back, you know, a lot of us sitting

1 here at this table, we grew up at a time where
2 homosexuality was rarely talked about.

3 You know, when I was in high school, I
4 didn't know a single kid who was openly gay or
5 lesbian. And certainly, we know those -- a lot of
6 my classmates were, but mainstream, you know,
7 American society had a stigma. And my question for
8 you is: what would you attribute the increase in,
9 you know, gender dysphoria? Do you think it's --
10 now that it's more openly talked about and accepted,
11 or is it more of a social pressure?

12 DR. HALLER: Yeah. Thank you for the
13 question, Dr. Cairns. I think the analogy is a
14 couple hundred years ago, you didn't find left-
15 handed people. Similarly, to your analogy, a couple
16 decades ago, nobody knew anybody else who was openly
17 homosexual. Trans people have always existed. They
18 will always exist. Whether you choose to
19 acknowledge that or not doesn't change that.

20 So we're here to try and help those folks
21 get the care they need and deserve. And I'm all for
22 making sure that we do it the best way we can and
23 for giving them the best possible outcomes, and that
24 does require study. But to suggest that there are
25 more kids because of some social contagion is a

1 pretty absurd suggestion. And I think it's
2 important that we acknowledge that if we're going to
3 have a scientific discussion, that we keep it in
4 that realm.

5 CHAIRMAN DIAMOND: Further discussions?

6 UNIDENTIFIED FEMALE: I have a question to
7 follow up to that. So what is your explanation of
8 the increase in the -- specifically in the
9 adolescent population versus children or adults?

10 DR. HALLER: I think it's the same answer.
11 I think there have always been adolescents who had
12 gender identity issues, and they're now more
13 comfortable talking about it. So they're able to
14 talk about it and seek care that didn't exist
15 before.

16 DR. CAIRNS: Dr. Haller, you have
17 guidelines at the University of Florida, how you do
18 things, and I think you acknowledge that some other
19 people's guidelines might be a little bit different
20 than yours. So would you support the concept of us
21 initiating guidelines to be promulgated for the
22 State?

23 DR. HALLER: I don't.

24 DR. CAIRNS: Why?

25 DR. HALLER: Because I don't feel like this

1 has been done in a way that's an ingenuous
2 conversation. This has been pushed to you as the
3 Board as a political maneuver, and it's not a
4 necessary thing to do. When you look at the
5 totality of other rules that this Board has made,
6 none of them are on the same order as this small
7 population.

8 DR. CAIRNS: So regardless of how it got
9 here, moving forward, wouldn't it be appropriate for
10 us to put forth guidelines or rules?

11 DR. DAYTON: Can I say something? I would
12 just say I think that most of our centers are
13 already following the same, you know, national and
14 international guidelines that we are. And to me, it
15 seems redundant to have the State adopt an
16 additional guideline that we're already following.

17 DR. HALLER: So it's just the redundancy
18 that you have an issue with?

19 DR. DAYTON: One of the issues.

20 DR. HALLER: So I will go further. No,
21 it's not just the redundancy. If the redundancy was
22 such that it was in line with general practices and
23 data, then I think it would be adequate. But it's
24 clear that that is not the intent of the State.
25 They have provided you with a recommendation for a

1 rule that is contrary to what almost all reasonable
2 providers of gender-affirming care and gender care
3 in general would say is the standard of care.

4 So, you know, I find it odd that none of
5 the experts in the State of Florida were asked to be
6 involved in the GAPMS' document review. None of us
7 were asked to come and present to the Board
8 previously. And so it's hard to have these
9 conversations and assume or give the benefit of
10 doubt to those that are pushing these towards you,
11 that the end rule will actually be in the best
12 interests of our patients. And so for those
13 reasons, I would strenuously object to the idea that
14 we need to further restrict access to care based on
15 a rule that might not actually reflect the benefits
16 and the necessary access to care that our patients
17 have.

18 CHAIRMAN DIAMOND: Dr. Haller, just to be
19 specific, this is the first time this issue has been
20 brought in front of the Board. So I just want to --

21 DR. HALLER: Yeah --

22 CHAIRMAN DIAMOND: -- just want to clarify
23 that. And I hope that you appreciate how
24 assiduously we're trying to conduct this to provide
25 fair input. And if the Board decides to enter

1 rulemaking -- and again, it does not behoove us to
2 make a decision, but the Florida Legislature has
3 placed this burden on us. And it's not one of these
4 things where you can just say, I decline. I walk
5 away, necessarily. That's one of the points of
6 discussion.

7 I can assure you that if we enter the
8 rulemaking process, your team will be invited. We
9 will be inviting the Endocrine Society. We'll be
10 inviting WPATH. We'll be inviting -- if there are
11 some others that you have, they will be invited.
12 And I would strongly encourage you to ask them to
13 attend, because, you know, half the game in life or
14 most of the game in life is showing up. So I am
15 giving you my personal assurance that if we decide
16 to do this, that we're going to really try and do
17 this the right way, okay.

18 Any other comments? Dr. Vila?

19 DR. VILA: I guess I'd like to expand on
20 the dialogue about potentially doing a study. I
21 know in my experience with the training programs,
22 almost all of the training programs, we always had
23 ongoing studies. And so I'm curious, has there been
24 a study on transgender care at the University of
25 Florida in the last 20 years?

1 DR. DAYTON: Yes.

2 DR. HALLER: Yes.

3 DR. VILA: And how many patients were
4 enrolled in that study?

5 DR. DAYTON: So I have a retrospective
6 study I'm doing right now on about 200 patients
7 within our clinic. Nothing published yet, but we're
8 analyzing data right now.

9 DR. VILA: So it's retrospective.

10 DR. DAYTON: Yeah.

11 DR. VILA: Are you looking at long-term
12 outcomes?

13 DR. DAYTON: So that's kind of where we're
14 coming into -- you know, have not yet, but needing
15 to create a registry more formally to look at long-
16 term outcomes. Because we can retrospectively look,
17 but we're not necessarily, you know, systematically
18 collecting like surveys from our patients and things
19 like that to do a more prospective. But I do agree
20 that that would be a really great next step that we
21 need to pursue.

22 DR. VILA: You know, you're a major
23 university. You've got -- looked at your website.
24 You've got the big staff. You've got a degree, a
25 master's degree in doing studies and constructing

1 studies. I mean, I think you're the place to do it.

2 I guess I'm just really kind of surprised that you
3 have all these patients.

4 DR. HALLER: Sir, to do those studies
5 requires a commitment of resources to do them.

6 DR. VILA: I know that.

7 DR. HALLER: And I would think --

8 DR. DAYTON: And I'm not a researcher. I'm
9 a clinician. So I agree it's important, but it's
10 not my primary assignment, in other words. But one
11 of the reasons --

12 DR. VILA: But there's no data. I mean,
13 you're -- I mean, we're struggling for data, and
14 you've got enough resources to do a very nice
15 website. This is the data, so I'm just going to
16 encourage you to consider that as somebody that
17 really wants the data -- I mean, I want to see the
18 long-term outcomes in children.

19 DR. DAYTON: Yeah.

20 DR. VILA: It's there.

21 DR. HALLER: I agree. Long-term registries
22 and --

23 DR. VILA: You're the man, so to speak.
24 Okay.

25 DR. DAYTON: Yeah.

1 DR. HALLER: No. It is not me. We are a
2 multi-specialty team, and we are on the cutting edge
3 of relatively new therapies. And they do require
4 longitudinal studies to definitively prove that
5 there are long-term benefits. The available data
6 today shows that there are more benefits than risks
7 in our healthcare delivery system. And that is why
8 we are here to say that you should not be
9 establishing rules that would restrict that care.
10 That's a separate question from whether or not we
11 should do additional studies, an important one, but
12 a separate question.

13 CHAIRMAN DIAMOND: Any other questions at
14 this time?

15 Thank you so much.

16 DR. HALLER: Thank you.

17 CHAIRMAN DIAMOND: We appreciate all of
18 your time.

19 Thank you so much, Dr. Ladapo. We
20 appreciate you coming in.

21 So what we're going to do now is we're
22 going to transition over to the public comment
23 period. And, Dr. Cairns, the vice chair, will be
24 shuffling up these speaker cards, and we've divided
25 them into A and B. And once again, you're going to

1 have a three-minute time limit. We have timers
2 here.

3 If I ask you -- if you're going over your
4 -- the limit and I ask you to cease, please cease.
5 It's not that I'm being rude. I'm trying to be fair
6 for everybody.

7 UNIDENTIFIED MALE: We'd like to go.

8 UNIDENTIFIED MALE: Here we go.

9 CHAIRMAN DIAMOND: And I'm having trouble
10 reading this. What does this say? Do you see?

11 UNIDENTIFIED MALE: (Indiscernible)

12 CHAIRMAN DIAMOND: Ruth Velinaizo
13 (phonetic). And I'm sorry. It's hard to read your
14 writing. Ruth Velinaizo from Coral Springs.

15 Good afternoon.

16 RUTH VELINAIZO: I am support. Thank you.

17 CHAIRMAN DIAMOND: I believe this says
18 Nakora Katako, K-a-t-a-k-o from Davie, Florida. And
19 I believe the affiliation was save.lgot.

20 NAKORA KATAKO: I'm in opposition.

21 CHAIRMAN DIAMOND: Would you like to make
22 any comment beyond that?

23 NAKORA KATAKO: People have the right to
24 live as they do, and I believe that this -- that
25 passing this would openly inhibit people's right to

1 do so and would see an increase in the decline in
2 mental health of young individuals.

3 CHAIRMAN DIAMOND: Thank you.

4 Elaine Jones of Fort Lauderdale. Elaine
5 Jones? No.

6 William Bennett of Hollywood, Florida.
7 Affiliation is CTF and Wellness Connections. I'm
8 sorry.

9 WILLIAM BENNETT: Thank you. Yes. I've
10 been in education for years and working with young
11 people for 60 years, and I can find it very unusual
12 to hear that this is a social -- that you can't tell
13 a gender by virtue of the birth of the child rather
14 than by some social means. That's kind of beyond my
15 understanding. I think it's more mental, and the
16 problems that come up need to be dealt with from a
17 mental standpoint far more than from a physiological
18 standpoint. I think the mental is the issue rather
19 than the physiological. And I don't see how the two
20 connect without causing a problem. So thank you.

21 CHAIRMAN DIAMOND: Thank you.

22 I believe it says, Noah Maldonado. Is
23 there a Noah Maldonado here? I don't see Noah.

24 UNIDENTIFIED MALE: Okay.

25 CHAIRMAN DIAMOND: Tywin (phonetic) from

1 Davie, Florida. Affiliation is save LGBT, reflect
2 collective.

3 Good afternoon.

4 TYWIN: Good afternoon. I would like to
5 say that I oppose. I genuinely think that
6 healthcare, in general, is between the physician,
7 the patient, the parent. And it goes beyond someone
8 who does not understand what gender is. Whether you
9 understand or do not understand or oppose or don't
10 oppose, that cannot -- should not intervene with
11 someone's healthcare. Thank you.

12 CHAIRMAN DIAMOND: Thank you.

13 I believe this is Sophia Galvin of Miami.
14 No affiliation. Sophia Galvin?

15 Good afternoon.

16 SOPHIA GALVIN: Good afternoon. My name is
17 Sophia Galvin. I'm 22 years old, born female,
18 detransitioning for two years and here independently
19 to speak about my experiences.

20 I was 17 when I began to experience gender
21 dysphoria. At the time, I was a senior in high
22 school, president of the LGBT Club, and actively
23 supported gender-affirming treatment. I began
24 abruptly to socially transition and was immediately
25 affirmed by my peers and school staff. This was

1 after a history of mental affliction due to wounds
2 in my heart, running as deep as an abyss. I was
3 often suicidal with self-harm, and psychiatric drugs
4 and therapy were unable to help me.

5 Nobody around me called into question
6 whether the dysphoria I was feeling could possibly
7 be related to this. Once I was affirmed, I was
8 trapped and was led to believe that each next step
9 of the process would somehow bring me the
10 fulfillment I was looking for.

11 However, after two years of hormone therapy
12 and a double mastectomy, I was left far worse than
13 before. I lost my college scholarship, was
14 unemployed, raped multiple times, addicted to sex
15 and drugs, and unable to have a logical or coherent
16 thought.

17 So at 20 years old, I decided to stop
18 testosterone. It was only then that I gained the
19 maturity to think logically about the possible
20 physical and psychological effects of these
21 treatments.

22 After deciding to detransition, I received
23 no support in this process, neither could I find any
24 substantial online resources. I started
25 experiencing all sorts of medical issues that no

1 doctor was able to explain. If I was in torment
2 before, I was now in literal hell fire. All I
3 wanted was to move on with my life, yet every time I
4 looked in the mirror or opened my mouth to speak, I
5 was reminded of the terrible mistakes I made, and no
6 amount of therapy was still able to do anything for
7 me.

8 Not knowing what else to do, I prayed and
9 asked God to help me. I didn't know who God was,
10 but from a young age, I would pray, hoping he was up
11 there listening. It was then that someone spoke to
12 me about having a personal relationship with Jesus
13 Christ, and I began understanding the abundant love
14 that Jesus had for me. I then received his spirit
15 into my heart. He was the only thing that could
16 fill that infinite abyss I mentioned earlier.

17 If I would have known then what I known
18 now, I never would have made the decision to
19 transition. I believe that gender dysphoria can be
20 attributed to other root causes, notably childhood
21 sexual abuse, and mutilating our external being
22 cannot heal an inward problem. I also believe
23 because of the statistically significant number of
24 detransitioners who find healing through Christ,
25 that Christ-based therapeutic resources should be

1 included in research as we develop the best solution
2 to this growing epidemic.

3 I can tell you personally, I would not be
4 alive and breathing here today if it were not for
5 Jesus Christ nor would I have the strength and
6 boldness as the only detransitioner willing to
7 testify of my experiences in the State of Florida.
8 Also, I will soon be filing a formal complaint with
9 the Florida Board of Medicine about my experiences.
10 Thank you for your time.

11 CHAIRMAN DIAMOND: Thank you.

12 No, no, no. No, no, no. I believe we have
13 a State Representative Anna Eskamani with us today.
14 I think I'm just outside your district, just
15 outside.

16 REPRESENTATIVE ESKAMANI: Yes. You are,
17 Dr. Diamond.

18 It's a humbling experience I get to be
19 before the Board of Medicine today. My name is Anna
20 V. Eskamani. I'm proud to serve District 47, the
21 State Legislature, which includes parts of Orlando,
22 Winter Park, Belle Island, Edgewood. I was elected
23 in 2018.

24 And part of my responsibility is to do no
25 harm and to also accept no harm. And so I come here

1 today speaking in deep concern of this petition for
2 the health and wellbeing of my constituents and of
3 people in the great State of Florida.

4 This proposed rule is dangerous. And I
5 appreciate the point made earlier how it should not
6 be contentious, but to be clear, it never should
7 even be a political issue. And unfortunately, due
8 to actions by other elected officials who would get
9 in between patients and their doctors, we have to
10 come here today to protect this intimate and
11 personal experience for already marginalized people.

12 Now, I want to stress that there are,
13 unfortunately, many people in this room who support
14 this petition, who just don't think trans people are
15 real. They do not -- they don't consider trans
16 people to exist. And I don't know about you all,
17 but if we're talking about climate change, I want to
18 go to climate denials to make policy on climate. So
19 it's very important that we do not allow those who
20 don't think trans people exist to be the decider on
21 policy that impacts trans lives.

22 I also want to stress that many people who
23 support this petition think that this is a phase or
24 a fad. I want to be clear that identifying as trans
25 is not like bell bottom jeans. It is someone's

1 identity, and it must be respected and acknowledged.
2 And these are folks who just want to be treated with
3 dignity and respect like anyone else.

4 And you talked about science earlier. I
5 want to stress that the Department of Health is
6 consistently misusing and misinterpreting data for a
7 political agenda. In fact, recently Vice News spoke
8 to 10 researchers who said that the Florida
9 Department of Health misstated their research. In
10 fact, Vice News found that all 12 citations that
11 Florida presents against the use of gender-affirming
12 care has a clear anti-trans bias and is
13 misinterpreted from what the researcher's
14 conclusions were.

15 Florida's Health Department is reverse
16 engineering rationale for a policy completely
17 counter to research-based medical best practices.
18 But I will stress what information do we know is
19 true. We know that there are some serious mental
20 health concerns for young people, but LGBTQ Plus
21 youth experience suicide ideation four times more
22 than their peers. And without being accepted or
23 receiving care, those statistics can get even more
24 scary and dangerous. Young people who need gender-
25 affirming care go through an informed consent

1 process.

2 Before I ran for office, I worked at
3 Planned Parenthood in Southwest and Central Florida,
4 where we rolled out HRT services just for adults at
5 the time. And it was made very clear that when
6 minors are accessing this type of services, they
7 must have an informed consent and the involvement
8 and the discussion between parents if there is a
9 disagreement of how to move forward.

10 I also want to be clear that what we know
11 to be true is that Florida has a history of anti-
12 LGBTQ Plus policies. And so I understand the
13 objective nature of this Board, which we appreciate,
14 but the reality is that we're not here in a vacuum.
15 There's a national effort to brand people like me
16 who care about these issues as groomers, which is
17 offensive and incorrect, and now has become an LGBTQ
18 plus slur.

19 DOH and AHCA are no longer unbiased. And
20 so to wrap up my remarks, I want to be clear that
21 this petition is designed to circumvent the Florida
22 Legislature. We as lawmakers did not pass a bill
23 for you to do this. This is coming from the
24 Governor, who is clearly politically motivated, and
25 we ask each -- for you to reject this petition.

1 Thank you.

2 CHAIRMAN DIAMOND: Excuse me, may I ask you
3 a question since you are a state representative?

4 REPRESENTATIVE ESKAMANI: Absolutely.

5 CHAIRMAN DIAMOND: We have been told by
6 Counsel that we are specifically charged with having
7 this responsibility. Is it your contention that
8 that is incorrect?

9 REPRESENTATIVE ESKAMANI: Dr. Diamond or
10 Chairman, I would say that statutorily you are
11 required to consider petitions from DOH. My point
12 is that the Legislature should not pass a bill
13 specific to gender-affirming care, that this is an
14 effort coming from the Department that is
15 circumventing the Legislature.

16 CHAIRMAN DIAMOND: No, no, no. I
17 understand that. But I'm saying -- I'm not an
18 attorney. I'm being told that this body is charged
19 with this responsibility, and it's not a
20 responsibility that we can shirk.

21 So I'm a little unclear. Are you saying
22 that the law -- that my understanding of the law is
23 -- not my understanding, what I'm being told is
24 incorrect? Or is it correct? Is it rather that
25 you'd like us to accept our responsibility and then

1 do nothing with it? Is that really what you're
2 getting at as opposed to saying we're going to walk
3 away from it?

4 REPRESENTATIVE ESKAMANI: I'm asking you to
5 oppose the petition. And my point is that there is
6 a statutory requirement that if DOH presents you
7 with the request, that you obviously must hear.
8 That's why we're all here today, and we accept that.
9 My point is that this is not a request via the
10 establishment of new policy from the Legislature.

11 As you know, when the Legislature passes
12 some sort of new scope of practice, for example,
13 oftentimes there's guidelines that come from the
14 Board of Medicine. We did not pass a bill banning
15 or attempting to restrict gender-affirming care.
16 And so this is coming as a proposed rule from the
17 Department of Health, not something Legislature
18 asked you to do. But it is your statutory
19 requirement that when the Department presents with
20 the request, that you must hear this and create
21 public hearing.

22 CHAIRMAN DIAMOND: I'm with you 100 percent
23 on that. But that's what we're doing today.

24 REPRESENTATIVE ESKAMANI: Correct.

25 CHAIRMAN DIAMOND: But again, my

1 understanding -- and I'm asking you if my
2 understanding is incorrect -- is that we are the
3 body that is charged with this responsibility; and I
4 am being told that if we said, no, thank you, it
5 would be a abrogation of our responsibilities?

6 REPRESENTATIVE ESKAMANI: I'm not
7 disagreeing with the fact that when you are
8 presented with this responsibility, that you must
9 pursue, make decision of yes or no. And that's why
10 I'm requesting you that you do not accept this
11 petition.

12 CHAIRMAN DIAMOND: All right. Thank you so
13 much.

14 REPRESENTATIVE ESKAMANI: Thank you.

15 CHAIRMAN DIAMOND: Next. Adeline
16 Alexander, esquire, please? It may be Adeline or
17 Adeline Alexander.

18 Ernie Suave, S-a-u-v-e?

19 ERNIE SUAVE: Good afternoon. Good
20 afternoon, distinguished members of the Board and
21 public in general. Thank you for this opportunity
22 to share.

23 I'd like to tell you that when I was 18
24 years old, I was an idiot. And to honestly believe
25 that an 18-year-old can determine something as

1 important as a mutilation of his or her body is to
2 me beyond my capacity to understand.

3 But if you would please bear with me just
4 for a moment, for a silly rhetorical question, very
5 unscientific, and I like to ask you if I look
6 Hispanic. Obviously, I do not look Hispanic. My
7 accent right now determines that I am not Hispanic.
8 However, I've lived over 20 years in Latin America,
9 and I can convince people very easily that I am
10 Hispanic when I begin to speak Spanish. As a matter
11 of fact, a very intelligent friend of mine told me
12 once, a Hispanic himself, that you, Ernie, are a
13 Hispanic trapped in an American body.

14 Why is that? Well, I've lived so many
15 years outside. I know culture. I've lived in three
16 different countries. I know culture, language,
17 idioms. I've learned it. But I went at an adult
18 age. I learned, and I assimilated that culture way
19 beyond most Americans. And I like to say that also
20 ancestry.com says that I am North European and
21 Eastern European. I am not of Hispanic descent.
22 However, my Hispanic wife can tell you that I have a
23 heart that's Hispanic.

24 What I'd like to say this afternoon that I
25 can identify as a Hispanic, that does not make me as

1 a Hispanic. I can assimilate a culture and
2 circumstances, but mutilating my body will not
3 change my sex.

4 It does cause irreversible psychological
5 and physical damage. It can cause depression,
6 illness. It is not healthcare. It's child abuse.
7 Back in my day, men were men, women were women, and
8 let children be children. They are children. And
9 if by the age 18, if things continue, they insist on
10 transitioning, let them do it. We live in a free
11 country.

12 But let's get back to reason, to common
13 sense, and to truth. And I implore you to think
14 logically with common sense on the issue. Thank you
15 very much and God bless you.

16 CHAIRMAN DIAMOND: Thank you.

17 And once again, guests, please, we don't
18 need any comments from the gallery.

19 Next is Gianna Cook from Palm Beach
20 Gardens.

21 GIANNA COOK: Should I go up here or there?

22 CHAIRMAN DIAMOND: That's fine back there.
23 Good afternoon.

24 GIANNA COOK: Can you hear me?

25 CHAIRMAN DIAMOND: Yes -- not really.

1 GIANNA COOK: Maybe up there. Yes.

2 CHAIRMAN DIAMOND: Good afternoon.

3 GIANNA COOK: Hello.

4 CHAIRMAN DIAMOND: Yes.

5 GIANNA COOK: There we go. I'm happy to be
6 here today. I would just love to affirm the people
7 who are saying to not agree or to not take part in
8 the petition, to oppose the petition. I think an
9 interesting thing you mentioned earlier, a quote,
10 you know, the unexamined life, I think another
11 philosophy thing that we can pick up on, because I
12 am a philosophy major, is existentialism in like
13 making meaning. I think it's really important to
14 let people decide who they are and to help them with
15 that. By the same token, if somebody tells you who
16 they are, you kind of have to -- you accept that,
17 right.

18 Like, if I said -- if you started saying,
19 her name's not Gianna. It's like a completely
20 different name, and she doesn't use -- like, she's
21 not a she. She's like a completely different
22 person. That wouldn't be like respectful. That
23 wouldn't be regular. And me saying, hi, my name is
24 Gianna, I, you, she, her, you saying, no, she
25 doesn't do that, that's completely wrong. The

1 persistence in that is highly illogical.

2 And I would just like to say that -- I
3 mean, vote no honestly. I oppose it. Like don't
4 make these rules based on political decisions. It
5 is not within Floridians best interest for you to
6 get to decide this. It is between the doctor and
7 the patient. Thank you for letting me speak.

8 CHAIRMAN DIAMOND: Thank you.

9 Solen Spu or Spur (phonetic)? I'm sorry.
10 The penmanship is no good.

11 Cruzita Kenotis (phonetic) Cruzita
12 Kenotis, please.

13 DR. ACKERMAN: Mr. Chair, I wonder if you
14 can call even the second name so this next person
15 can be getting ready. You know, so you call
16 somebody, so maybe you could have somebody on deck.

17 CHAIRMAN DIAMOND: Sure.

18 DR. ACKERMAN: Good idea. Just to move
19 things along.

20 CHAIRMAN DIAMOND: Next up is Mary Greg,
21 and following Mary Greg would be Kirk Hopson Garcia.

22 Hello.

23 MARY GREG: Hello. I would just like to
24 repeat what I've read, because I agree with it. The
25 alarmingly high suicide rate among post-operative

1 transgenders demonstrates the deep regret that many
2 feel after irreversible mutilating their bodies with
3 these barbaric procedures.

4 It takes years and years to think through a
5 broken heart, to think through loneliness and why
6 did you get that way, and to think through why did I
7 have my body go through this. So there's a lot to
8 reconcile with as time goes on.

9 I would like to say that transgender
10 surgeries are barbaric and cruel form of genital
11 mutilation, designed to cosmetically mimic the
12 opposite sex. Patients are rarely made aware of the
13 many risk and complications associated with these
14 radical surgeries, which include bleeding,
15 infections, recurring rashes, blood clots in the
16 veins, painful urination, frequent urinary tract
17 infections.

18 The FDA recently warned that puberty
19 blockers may also cause brain swelling and permanent
20 vision loss. Is it worth it to gamble that maybe
21 someday you might be blind as a result? It's
22 against nature and the pattern of -- the natural
23 pattern of life, the way our bodies are made.

24 Transgender surgeries also lead to a
25 lifetime of medical dependence, hormonal support,

1 and often repeated surgeries to deal with urinary
2 complications resulting from transgender surgery.

3 Today's decisions -- may I turn around and
4 talk to the people?

5 CHAIRMAN DIAMOND: No, talk to me.

6 MARY GREG: Today's decisions carry
7 consequences that may be with you longer than you
8 would like to expect.

9 CHAIRMAN DIAMOND: Thank you.

10 Kirk Hobson Garcia is next, and that will
11 be followed by Dennis S. Conklin of Plantation,
12 please.

13 Good afternoon.

14 KIRK HOBSON: Hi, afternoon. My name is
15 Kirk Hobson Garcia, and I am the proud parent of a
16 transgender male. I like to start with a quote
17 before I ease into my own words on the topic.
18 "Include everyone, no matter their gender, sexual
19 orientation, race, or religion. We are all human
20 beings. We are part of the society."

21 What is gender dysphoria? I have a
22 stutter, so please forgive me. It is a feeling of
23 discomfort or distress that occur in people whose
24 gender identity differ from their sexual assignment.
25 My son experienced this psychological distress and

1 its deep pain and struggle.

2 I know about distress and struggle. I
3 experienced deep hurt about my stutter, about my
4 acne during my childhood, my adolescent, my
5 adulthood, and being a foreigner in the United
6 States. Yes. I certainly went home and shed tears
7 on more than one occasion, but also gave power to my
8 inner voice, which compelled me to fight back. With
9 careful soul searching and education today, I'm a
10 successful engineer with a beautiful wife.

11 Little did I know those struggles were
12 nothing compared to what came my way in 2013 when my
13 son informed me that he was born a girl; he needed
14 to live as a boy. That was nine years ago before
15 being transgender was accepted, openly discussed.

16 Like any parent, I was shocked. I thought
17 it must be a phase. I questioned what my wife and I
18 had done wrong, and I wondered what was wrong with
19 my child. I wondered how I could take -- how I
20 could talk him out of this.

21 Thankfully, true once again, one, two punch
22 of careful soul searching and education, I came to
23 realize that my son was no more deserving of my
24 faults to judgment and taken down by other gender
25 identity that I was -- that I was all those years

1 ago for my stutter and me taking work from a US
2 person.

3 Like me, I came to realize my son was
4 indeed very brave to dig deep at his young age of 11
5 and somehow, come to realize that significant
6 depression had grabbed hold of him, robbed him of
7 his grades, his friendship, his purpose of life, his
8 will to live, because he told us the -- that he
9 wanted to commit suicide.

10 CHAIRMAN DIAMOND: Please round it up, sir.
11 It's three minutes.

12 KIRK HOBSON: Yes. Was part of the game
13 Yeah. All right. His greatest fear was not
14 realized that he was not thrown out of his house,
15 because we loved him too much. We wanted to support
16 him. We wanted to give him every chance that he
17 needed to become the person he was meant to be.

18 CHAIRMAN DIAMOND: Thank you very much.

19 KIRK HOBSON: Please do not make this
20 happen. Please do the right thing.

21 CHAIRMAN DIAMOND: Next is Dennis Conklin
22 from Plantation, Florida. Affiliation is Let Kids
23 Be Kids, and that will then be followed by Alan
24 Barsky (phonetic).

25 DENNIS CONKLIN: Thank you. Dennis

1 Conklin, 4581 Northwest Sixth Court Plantation.

2 CHAIRMAN DIAMOND: You don't need to tell
3 us your address.

4 DENNIS CONKLIN: That's all right. That's
5 fine. It's a public access, right.

6 I want to thank you for holding the Florida
7 Board of Medicine board meeting here today for the
8 opportunity to see what most Americans never get to
9 see, and that's medical oversight by actual medical
10 people.

11 I'm in support of this. I happen to have
12 read the letter. It's available. It's online. I
13 recommend it to everybody. It's dealing with
14 children. Basically, informed consent is the way I
15 look at it, Nuremberg Code. And I don't believe
16 that a child can give informed consent. And it was
17 mentioned they give assent, if I got that correctly.

18 Because I was here from the beginning, tab
19 number five, around 9:31 this morning, we had a
20 grievance because a doctor was doing a left knee,
21 and somehow or other, a right knee part got involved
22 with it, and somebody brought a grievance.

23 And I kind of look at this, particularly
24 when we're talking about children only: what if
25 something is performed on the right knee and it was

1 a left knee?

2 So it gets into what a person with no
3 letters at the end of his name knows about the
4 Hippocratic Oath. First, do no harm. So it -- as
5 this letter and as the request for -- or the
6 petition deals with the youth, I believe it should
7 be first, do no harm.

8 And when I was looking up the term
9 dysphoria, because I heard the "phoria," and I think
10 of euphoria. And son of a gun, it is the opposite.
11 And that's kind of basically what I was looking at.

12 I want to just reiterate that I believe
13 that the petition should go forward because of the
14 fact that we're dealing just with the children, not
15 as the person becomes an adult. And that may be
16 exactly what is fitting for them. Thank you.

17 CHAIRMAN DIAMOND: Thank you very much.

18 DENNIS CONKLIN: I'll yield back my time.

19 CHAIRMAN DIAMOND: Thank you very much.

20 Next is Alan Barsky, and that will then be
21 followed by Scott Powell. Scott Powell is
22 affiliated with the Discovery Institute. So go
23 ahead.

24 ALAN BARSKY: Good afternoon. Thank you
25 for hearing us today. My name is Alan Barsky. I am

1 a former chair of the National Ethics Committee of
2 the National Association of Social Workers. I'm
3 speaking on my own behalf though today. But I do
4 want to talk in reference to professional ethics.

5 When we talk about gender-affirming care,
6 we're not just talking about care provided by
7 physicians. I realize that's your primary
8 responsibility. But also, you know, we're talking
9 about interprofessional care. I think some of the
10 examples that people have given today make us think
11 as if, you know, someone can walk into an office, a
12 child, perhaps child with parents, and have a
13 discussion, and the physician is going to decide
14 with them then and there that they're going to get
15 gender-affirming surgery.

16 You know, surgery is not the first step and
17 may not be any step in gender-affirming care. You
18 know, if we just take the word "gender-affirming"
19 and you look at, you know, what would be the
20 opposite? If you oppose gender-affirming care,
21 you're gender rejecting. You're rejecting who the
22 person is.

23 We want to have, I think, a system where
24 healthcare providers, including physicians and
25 mental health professionals, are supportive of, you

1 know, the people that they are serving and have
2 opportunities to do full, you know, examinations,
3 assessments, diagnostics. And not make decisions
4 about surgery right away, but to help the family,
5 help the child make decisions in a strategic manner.
6 You know, there's a lot of, you know, testing out
7 about the person's gender and how they want to
8 present themselves, their social transition before any
9 type of intervention like medication or surgery is
10 even considered.

11 I know that one of the previous speakers up
12 here said, you know, I'm an idiot or was an idiot,
13 you know. Don't trust me to make decisions with
14 doctors. Well, lots of us are idiots, and lots of
15 us talk to doctors about very serious things. I
16 could have cancer. I could have a brain tumor. And
17 we expect doctors to deal with all people with
18 respect and to help people at whatever intellectual
19 capacity that they are at. And if they need the
20 help or legally required to have the help of consent
21 of an adult or a guardian, then so be it. And we
22 can trust our doctors to be able to serve patients
23 of all backgrounds, including cisgender and
24 transgender people.

25 And we know that if we provide people with

1 gender-affirming care, they're more likely to have
2 productive, happy lives. They're less likely to
3 have suicidal ideation, suicide attempts, or suicide
4 completions. And they are more likely to be able to
5 live healthy, which is the primary purpose for, you
6 know, healthcare.

7 Thank you very much, and if anybody has any
8 questions, I'd certainly be willing to answer.

9 CHAIRMAN DIAMOND: Thank you very much.

10 Next is Scott Powell. Following Scott
11 Powell will be Nathan Broomer (phonetic). Nathan
12 Broomer is the LGBTQ consumer advocate for the
13 Office of the Commissioner of the Florida Department
14 of Agriculture.

15 So, Scott Powell, you are next.

16 Okay. Then we'll go on to Nathan Broomer.
17 And then following Nathan Broomer will be Osa
18 Figueroa -- Figueris (phonetic) from the Christian
19 Family Coalition Florida Bar Association.

20 Go ahead, sir.

21 NATHAN BROOMER: Good afternoon. The
22 Florida Department of Agriculture and Consumer
23 Services' mission is to safeguard the public and
24 support Florida's agriculture economy. A chief
25 function in safeguarding Florida is to serve as the

1 State's consumer protection agency. We educate. We
2 advocate, and we protect consumers against fraud and
3 discrimination.

4 As someone born and raised here in Florida,
5 I'm honored to serve our state as the Florida's
6 LGBTQ consumer advocate. And on behalf of our
7 healthcare consumer population, not just LGBTQ
8 Floridians, but all healthcare consumers, I'm giving
9 you these comments in opposition to the Department
10 of Health's petition, to this body to consider any
11 rulemaking to change the existing standard of care
12 related to medically necessary gender-affirming
13 medical care for adolescents or adults.

14 I appreciate the State's role in
15 healthcare. It's important, and it's necessary --
16 licensure, regulation of health insurance, cost
17 control, quality improvement, and improving access.
18 But our state agencies, all must serve and advocate
19 for Floridians, and all Floridians have a right to
20 non-discriminatory healthcare.

21 When a medical care treatment plan or a
22 specific course of treatment is provided to some but
23 denied to others merely because of who they are,
24 that is discriminatory.

25 If we look at the petition details, we

1 focus on a lot of high-level details, but there are
2 some additional requests before this Board,
3 including looking at those who have already started
4 treatments, who are adults, and anyone who even
5 enters the State of Florida. That is a dangerous
6 question before the Board that has not been
7 addressed yet. And I must highlight that.

8 The bottom line is this: the attacks on the
9 transgender community, on our families, on our
10 children are capricious and politically motivated.
11 Hatred and bigotry should never motivate nor
12 determine medical care decisions, and denying those
13 best practice medical care and support can be life
14 threatening. Our transgender children, like any
15 child, has the best chance to thrive when they're
16 supported and they get the healthcare they need.

17 I want to also share a personal note as
18 someone who grew up in Tampa with a mom who was a
19 physician, one of the first female physicians in our
20 state, as someone born and raised here, went to
21 school here, and went to USF, went to Stetson for
22 law school, who sits here as a successful thriving
23 Floridian. I'm also getting old. And I listen to
24 the question about data, and as someone who is
25 nearly 50 and who is a very out and proud

1 transgender man, I assure you, we have a lot of data
2 that we would be happy to share with you.

3 But in my role as a consumer advocate, one
4 of the most important things we have to do in
5 educating and doing outreach is have trust with the
6 communities we serve. And if I remember all the
7 stories, if my mother were here to still tell them,
8 in her practice in the '50s and '60s and '70s and
9 '80s and '90s in this state, that relationship with
10 the patient and that trust is always at the heart of
11 the stories she used to tell me. And I also know
12 she would tell you she always had two sons.

13 Please make the prudent decision for
14 transgender Floridians based on well-documented,
15 scientifically-based medical best practices. Leave
16 medical decisions to patients, their families, and
17 their healthcare providers based on the standards of
18 care you've heard described here today. Thank you.

19 CHAIRMAN DIAMOND: And if you have data
20 that you'd like to share with us, we would love to
21 see it.

22 NATHAN BROOMER: I can certainly provide
23 quite a bit. Yes.

24 CHAIRMAN DIAMOND: Next is going to be Osa
25 Figueris from represent -- or affiliated with the

1 Christian Family Coalition Florida Bar Association.

2 That will then be followed by Jo Staziaki

3 (phonetic).

4 OSA FIGUERIS: Good afternoon.

5 CHAIRMAN DIAMOND: Good afternoon.

6 OSA FIGUERIS: I want to clarify that I am

7 a member of the Florida Bar Association, but I am

8 not here on behalf of the Florida Bar Association.

9 I want to be clear on that.

10 I have been practicing as an attorney for

11 about 25 years, and a portion of the years that I

12 practiced, I did medical malpractice defense work.

13 And frankly, if I had a client come to me with an

14 issue or a complaint was brought in this area, I

15 would be concerned right now, because at the

16 beginning of the statements that you all made, you

17 said that you were vociferously apolitical. And I

18 know that your oath says, as opposed to mine, it

19 says, "Do no harm." And doctor --

20 CHAIRMAN DIAMOND: We're vociferously

21 apolitical as a board. We each have our own

22 (indiscernible), of course.

23 OSA FIGUERIS: Understood. Understood. And

24 then in listening to Dr. Haller, he himself

25 admitted, during one of the statements that he made,

1 that -- he said, a majority of some of these
2 children return to their gender assignment. I went
3 and I did a little research today, and I came across
4 the name Ken Zucker.

5 Ken Zucker is a -- I guess a psychiatrist
6 who chaired the DSM-5 workbook and help define
7 gender dysphoria. He actually recommends, to this
8 day, an approach of a wait and see treatment with
9 respect to children. And the reason he wants folks
10 to take -- other doctors to take a wait and see
11 attitude is that most children with gender dysphoria
12 who display a desire to transform their body, they
13 should be encouraged to wait, because in his
14 experience in all his years -- and, again, Chair of
15 the DSM-5 workbook on this issue -- 70 to 80 percent
16 of the children that manifest these concerns
17 resolve.

18 So because the oath is do no harm, I would
19 -- and based on what our Surgeon General is saying,
20 I would recommend that you really take a deep, long,
21 hard look. It seems that he has given it great
22 thoughtful detail. And that great thought -- great
23 detail of thought, and that you really dig in. And
24 if there is any uncertainty as to whether there
25 could be adverse consequences here, that you would

1 err on the side of not doing this. And what is the
2 harm in waiting until the age of 18? We can't drink
3 until we're 21. Set a standard that prohibits this
4 with respect to children. Thank you.

5 CHAIRMAN DIAMOND: Next is Jo Staziaki.
6 And this will be followed by Carla Spalding.

7 JO STAZIAKI: Can you hear me? Okay.

8 CHAIRMAN DIAMOND: Go ahead, please.

9 JO STAZIAKI: I apologize. By the way, I
10 have social anxiety. This is really difficult for
11 me.

12 CHAIRMAN DIAMOND: And I'm sorry, what's --
13 I probably butchered your name. It was difficult
14 for me to read it. I'm sorry.

15 JO STAZIAKI: It's Portuguese. I'm from
16 Brazil. It's (Indiscernible).

17 CHAIRMAN DIAMOND: (Indiscernible)

18 JO STAZIAKI: Thank you. So I also
19 apologize because I'm not like super informed in the
20 subject. I'm pursuing a degree in science, but it
21 is not like any kind of like health-based science.

22 But as far as I'm aware, like science in
23 general has been able to establish a correlation
24 between the happiness of a patient and the rate of
25 suicide going down with gender-affirming care. We

1 are able to establish a correlation pretty, pretty
2 strongly.

3 And there have been like other studies
4 looking at the results of these various studies,
5 looking together, attempting to establish a
6 causation. And there are some trends showing that
7 -- that the gender-affirming care at the earliest
8 stages is the best course of action for like saving
9 the lives of people who are most at risk.

10 It seems to me that a lot of this issue is
11 just politicized. It has really nothing to do with
12 the science, because it seems to me that the science
13 is erring on the fact that we should continue what
14 we're doing. We should continue affirming the care
15 of young people and withholding, like, surgeries
16 until they're able to consent.

17 My siblings, just for like a routine
18 medical practice, they were given growth hormones.
19 They were not at all like transgender or anything,
20 but they were given some of the same medication that
21 does the same thing and withhold puberty but purely
22 for a regular medical reason. And parents were able
23 to consent to that. Kids were able to -- using the
24 parent's consent and the doctor's consent, they were
25 able to go through with that.

1 And it seems to me that this issue here is
2 only political. It has absolutely nothing to do
3 with the science. We should continue doing what
4 we're doing, and we should attempt to get even more
5 data than we can. And using that, we can come to a
6 conclusion that is based on science, not politics.
7 Thank you.

8 CHAIRMAN DIAMOND: Thank you.

9 Carla Spalding is next, and that'll be
10 followed by Bethel Spargo, MD, from Fort Lauderdale.

11 CARLA SPALDING: Good afternoon, Chairman,
12 Board. I'm Carla Spalding, and I'm here today as a
13 mother, a grandmother, and also as a registered
14 nurse of 20 years working for -- as a psychiatric
15 nurse for children, 6 years old to 18, and also
16 veterans at the VA hospital.

17 I can tell you statistic has shown,
18 depending on what you look at, anywhere from 80 to
19 82 percent of transgender either believe -- of
20 consumed suicidal thoughts, or sometimes wish they
21 were not alive, which is a little bit different,
22 they explain to me. Then the other 40 percent have
23 committed suicide.

24 So I'm not saying that transgender do not
25 have the right to proper healthcare. What I'm

1 saying, however, is children should be children.

2 And I'm saying this because as a single parent, my
3 son growing up, he used to see me in my heels and
4 getting dressed. He used to wear my shoes and put
5 on all those. Now, he's a macho man as much as
6 could be.

7 So you have to let them grow and make that
8 decision for themselves. And if we start
9 intervening as early as one of the young person
10 said, 14 years old, you tell them 14, the next time
11 you talk to them, they'll tell you 13. And they
12 keep going down. So I think we should just let the
13 children be children, and let them enjoy the lives
14 that we did as kids and stop pushing things on these
15 children.

16 And that would be my recommendation is that
17 we allow the children to be children. Do not
18 interfere until after that. I think it's a very
19 detrimental thing to really do those surgeries and
20 very damaging. And thank you.

21 CHAIRMAN DIAMOND: Thank you. Next is
22 Bethels Fargo, MD.

23 BETHEL FARGO: Hi. I come here today in
24 sort of a unique position. I am a pediatric
25 endocrinologist. So I treat patients, children,

1 teens who are transgender, who have gender
2 dysphoria, and I am also, or was also the stepmother
3 to a patient who was transgender. I say "was"
4 because she's not with us anymore.

5 My stepdaughter, Danielle, was born Daniel,
6 perfectly healthy baby boy. And at about the time
7 she hit puberty in middle school, she developed
8 gender dysphoria, anxiety, depression. She had
9 multiple suicide attempts, self-mutilation. And
10 this was back prior about -- probably about 20 years
11 ago. So in all of that time -- I was at that time,
12 was not involved in her life.

13 But in any event, she was seen by multiple
14 psychiatrists, psychologists. She had multiple
15 psychiatric hospitalizations and carried multiple
16 diagnosed -- psychiatric diagnoses. Never once was
17 it thought of to ask about her gender identity.

18 Now, that was back 20 years ago, and I get
19 it. We didn't do that. As a pediatric
20 endocrinologist 20 years ago, if a patient came to
21 me but with gender identity issues, I might not have
22 known what to do.

23 That said, as she -- once she got into high
24 school, and she self-medicated herself. Despite the
25 fact that she was being followed by multiple

1 psychiatrists, she developed multiple drug
2 addiction, alcohol addiction. She began getting
3 spironolactone through the -- from Australia through
4 the internet and went on to continue to suffer each
5 and every day of her life.

6 About 10 years ago is when I first met
7 Danny, after her father and I met each other. And
8 Danny was a beautiful, wonderful young woman who
9 honestly passed really well. If you didn't know
10 that she was transgender, you wouldn't think she
11 was.

12 That said, she ultimately -- my husband
13 bled his savings, sent her to Thailand to get
14 gender-affirming care and gender-affirming surgery,
15 because it was impossible to find here at the time.
16 And she came back, again, still the beautiful young
17 girl that she was.

18 That said, about two years ago, she shot
19 herself in the head. I'm going to wrap it up, but I
20 need to finish this. So about --

21 CHAIRMAN DIAMOND: No. You'll stop when I
22 tell you to stop.

23 BETHEL FARGO: Could I please finish --

24 CHAIRMAN DIAMOND: I'm being very polite.
25 Don't tell me you'll stop when you stop, okay.

1 Thank you.

2 BETHEL FARGO: And two years ago, she shot
3 herself in the head. And in her suicide letter, she
4 expressed that despite the fact that she had been --
5 had her surgery and everything else, that she still
6 felt like she was a fraud.

7 And my point is this: is that she didn't
8 have access to thoughtful medical care, and quite
9 frankly, not even thoughtful psychiatric care. She
10 had been told that she was -- she had anxiety
11 because she was raped in a former life by a
12 psychiatrist.

13 So the bottom line is, is that we as
14 pediatric endocrinologist, we as pediatricians need
15 to affirm the identity of our patients. We need to
16 help them. We need to care for them in a thoughtful
17 way and to not allow them to have pubertal
18 suppression, to take away the dysphoria that they're
19 -- that the hormone that they're producing is
20 causing them and letting them --

21 CHAIRMAN DIAMOND: Thank you very much.

22 Okay. At this time, we're going to take a
23 break.

24 It's now 2:47. We're going to break until
25 just after -- let's resume at 3 o'clock. We're

1 going to take some more public comments.

2 I'd like to thank everyone, how nicely this
3 has been conducted. I've learned a lot, and I
4 appreciate that.

5 (END OF AUDIO RECORDING)

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CERTIFICATE OF TRANSCRIPTIONIST

I certify that the foregoing is a true and accurate transcript of the digital recording provided to me in this matter.

I do further certify that I am neither a relative, nor employee, nor attorney of any of the parties to this action, and that I am not financially interested in the action.

Julie Thompson

Julie Thompson, CET-1036

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Jane Doe

vs.

Joseph Ladapo

Taped Transcription

October 28, 2022



Med Def_001058

1
2 JANE DOE,
3 Plaintiff,
4 vs.
5 JOSEPH LADAP0,
6 Defendant.

7 _____
8 CASE NO. 423CV114RHMAF

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TRANSCRIPTION OF AUDIO RECORDING
FLORIDA BOARDS OF MEDICINE AND OSTEOPATHIC MEDICINE
JOINT RULES/LEGISLATIVE COMMITTEE RULE WORKSHOP
OCTOBER 28, 2022

TRANSCRIBED AUDIO RECORDING BY:

Julie Thompson, CET

Job No.: 322529

October 28, 2022

Page 2

1 Thereupon,
2 The following proceeding was transcribed from an
3 audio recording:

4 * * * *

5 CHAIRMAN ZACHARIAH: The Board of Medicine
6 and -- let's call the meeting to order. The Florida
7 Board of Medicine and Osteopathic Medicine Joint
8 Rules and Legislative Committee Rule Workshop. Let
9 the record reflect that the time now is 8:09. At
10 this time, let's have the roll call.

11 MS. STRICKLAND: Thank you. Dr. Zachariah
12 is present.

13 CHAIRMAN ZACHARIAH: Yes.

14 MS. STRICKLAND: Ms. Garcia has been
15 excused.

16 Dr. Diamond.

17 DR. DIAMOND: Present.

18 MS. STRICKLAND: Dr. Ackerman.

19 DR. ACKERMAN: Present.

20 MS. STRICKLAND: Dr. Barsoum and Dr. Cairns
21 have been excused.

22 Dr. Derick.

23 DR. DERICK: Present.

24 MS. STRICKLAND: Dr. Di Pietro.

25 DR. DI PIETRO: Present.

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1 MS. STRICKLAND: Dr. Gadea has been
2 excused.

3 Dr. Hunter.

4 DR. HUNTER: Present.

5 MS. STRICKLAND: Ms. Justice has not
6 arrived yet.

7 Dr. Pages.

8 MS. STRICKLAND: Mr. Romanello.

9 MR. ROMANELLO: Here.

10 MS. STRICKLAND: Dr. Schwemmer.

11 DR. SCHWIMMER: Present.

12 MS. STRICKLAND: Okay. Also present are
13 staff, Janet Hartman, bureau chief; John Wilson,
14 general counsel; Paul Vazquez, Executive Director
15 Board of Medicine; Danielle Tarrell, Executive
16 Director Board of Osteopathic Medicine; Ed
17 Tellechea, board counsel, Donna McNulty, board
18 counsel; myself, Cherise Strickland, program
19 operations administrator; Carol Taylor, program
20 operations administrator; Ms. Shaila Washington,
21 regulatory supervisor; Cyra Williams, regulatory
22 specialist III; and Mr. Derek Nieves, regulatory
23 specialist III.

24 Chair, you have a quorum.

25 CHAIRMAN ZACHARIAH: Well, thank you so

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1 much. Before we start, I want to thank -- it's an
2 honor to work with Dr. Sandra Schwemmer, who I've
3 worked with many, many, many moons ago on the Board
4 of Osteopathic Medicine. I'm honored that you're
5 here.

6 Now, let's have Mr. Paul Vazquez give the
7 opening advice. Paul.

8 EXECUTIVE DIRECTOR VAZQUEZ: Thank you,
9 Dr. Zachariah.

10 Good morning. It's Friday, October 28,
11 2022, at 8:11 a.m. My name is Paul Vazquez; I'm the
12 executive director of the Florida Board of Medicine.
13 This is a duly noticed meeting of the boards. This
14 is a public meeting and it's being recorded. The
15 audio will be available on the boards' websites next
16 week.

17 I'll now go over some instructions, so this
18 meeting will be successful, and the board members
19 will be able to take care of the matters that are
20 before them today. There is a court reporter in the
21 meeting. If you speak to the committee, it's
22 important that you state your name for the record.
23 When appropriate, the chair will ask for public
24 comments. Therefore, please refrain from speaking
25 during the meeting until the appointed time.

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1 Please remember this is a public meeting
2 and is being recorded. Any side conversations may
3 be recorded and become part of the public record.
4 At this time, please silence all electronic devices.

5 The Board of Medicine invites and
6 encourages all interested parties to provide comment
7 on matters before the board. The following
8 guidelines will apply to public comments: interested
9 parties will be given an opportunity to provide
10 comment on matters before the board after an agenda
11 item is introduced. Interested parties may provide
12 comments on the record during the meeting, or they
13 can waive speaking and indicate their position on
14 the issue, which will also become part of the
15 record. Appearance forms have been provided to
16 facilitate this process.

17 Interested parties will be limited to three
18 minutes to provide comment which may only be
19 extended by the chair if time permits based on the
20 number of proposed speakers. If an interested party
21 is part of a larger group of persons, you're
22 requested to identify one individual who will speak
23 on behalf of the group if possible. Interested
24 parties may use pseudonyms if they do not wish to
25 identify themselves on the record.

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1 The Boards of Medicine and Osteopathic
2 Medicine are apolitical bodies that have the primary
3 mission of protecting the people of the state of
4 Florida. As with any issue before the boards, this
5 committee intends to look at the available science
6 and appropriate standard of care while putting aside
7 any personal feelings on the issues before it today.

8 In terms of how the meeting will be
9 conducted, the committee's expectation is that we
10 will have a civil discourse while discussing the
11 issues on today's agenda. We require that everyone
12 refrain from making any disruptive comments or
13 taking any disruptive actions during the duration of
14 the meeting. The committee reserves the right to
15 remove any individual who chooses to disrupt the
16 progress of the meeting. Please conduct yourselves
17 accordingly.

18 This meeting will end no later than 1:00
19 p.m. Public comment will last no longer than two
20 hours in total, and may last significantly less than
21 that depending on the progress of the meeting. The
22 public comment process will be as equitable as
23 possible. However, it is evident that not everyone
24 who wishes to speak will be able to speak given the
25 time constraints of the meeting.

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1 As stated in the public notice of this
2 meeting, there is an email address set up to receive
3 written statements from the public. That email
4 address is BOMpubliccomment@FLhealth.gov. The email
5 address will be active for 24 hours following the
6 end of this meeting. All comments received are
7 public comments and will become part of the
8 rulemaking record.

9 The agenda for the meeting has been
10 published. We will begin with a discussion with
11 subject matter experts who will make presentations,
12 and then there will be a period of time for
13 questions and answers and discussion with the
14 committee. That will be followed by discussion and
15 development of rule language. A public comment
16 section will follow, and closing remarks and
17 administrative matters will follow the public
18 comment portion of the meeting and followed by
19 adjournment. Just so everyone is aware, there will
20 be administrative matters that will have to happen
21 after public comments, before the 1 o'clock
22 deadline.

23 Subject matter experts present today are
24 Michael Biggs -- Dr. Michael Biggs, Dr. Kristin
25 Dayton, Dr. Aron Janssen, Dr. Riittakertu,

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1 Dr. Michael Laidlaw, and Dr. Meredith McNamara. And
2 we thank them for being willing to participate in
3 this important endeavor of the boards.

4 Dr. Zachariah.

5 CHAIRMAN ZACHARIAH: Well, thank you so
6 much. At this time, can we ask Dr. Michael Biggs to
7 come forward and make his presentation. Dr. Biggs.

8 DR. BIGGS: Thank you. So I'm a
9 sociologist at the University of Oxford where the
10 students urged me to educate myself on transgender
11 children. I read the literature on gender medicine.
12 I was surprised by the poor quality of published
13 research and very disturbed by the absence of
14 literature. There are huge gaps in that literature.

15 One example, the world's largest pediatric
16 gender clinic in London started research on puberty
17 blockers in 2010. I discovered in 2018 that the
18 results had been suppressed and I did a campaign to
19 force the clinic to publish those results. I've now
20 published my original research in journals like
21 Archives of Sexual Behavior, Journal of Sex and
22 Marital Therapy, and the Journal of Pediatric
23 Endocrinology and Metabolism.

24 As time is limited, I'm going to focus on
25 one intervention, the children experiencing gender

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1 dysphoria, and that is puberty suppression. Full
2 documentation is available in my written
3 documentation -- written submission to the board.

4 So puberty blockers are a class of drugs
5 (indiscernible), such as Lupron. These GnRHa drugs
6 stop the production of sex hormones. For males,
7 these drugs achieve chemical castration. The drugs
8 are licensed for a few medical conditions, such as
9 prostate cancer in men, and precocious puberty in
10 children. They have never been licensed to treat
11 gender dysphoria, not in the United States, not in
12 the United Kingdom, nor any other country in the
13 world.

14 Puberty suppression is intended for
15 juvenile transsexuals, and that is the phrase that
16 is in the title of the article that was first
17 published advocating their use published in 1996.
18 So keep that phrase in mind, juvenile transsexuals.

19 GnRHa drugs can be administered from Tanner
20 Stage 2, which is the beginning of puberty. So in
21 Britian, the youngest child to have been given this
22 intervention was nine years old.

23 Advocates for puberty blockers claim that
24 this is analogous to treating precocious puberty.
25 For example, when a girl of five starts developing

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1 breasts. But that treatment for precocious puberty
2 involves delaying a puberty that arrives abnormally
3 early, so the child can undergo puberty at the
4 normal age. By contrast, puberty suppression for
5 gender dysphoria is now stopping normal puberty in
6 order to prepare the child to take cross-sex
7 hormones for the rest of their life.

8 About 96 percent to 98 percent of children
9 who start on puberty blockers continue to cross-sex
10 hormones. Usually around the age of 16, or the ages
11 going down 15 and 14 more recently.

12 The only plausible scientific evidence
13 favoring this intervention comes from a longitudinal
14 study of an early cohort of 70 teenagers. De Vries
15 et al., in 2014 published outcomes shortly after
16 surgery when the patients were in their early 20s.
17 Several psychological measures showed improvement,
18 but these measures were taken for only a small
19 subset of the patients as there was 32 individuals.

20 Gender dysphoria also appeared to decline,
21 but the latter finding on gender dysphoria was
22 likely an artifact of the measures of gender
23 dysphoria being switched halfway through the
24 research study. De Vries et al., acknowledged that
25 one patient was killed by necrotizing fasciitis

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1 during vaginoplasty. Out of 70 patients, that's a
2 death rate exceeding 1 percent. Remarkably high for
3 a group of teenagers. De Vries et al. didn't
4 mention that the death was actually a consequence of
5 puberty suppression, as I'll explain in a moment.

6 The Dutch researchers have recently
7 followed up this patient cohort of 70 people, but
8 they have not published the result, so the long
9 outcomes are still unknown.

10 The only attempt to replicate the Dutch
11 study came from the gender clinic in London, which
12 you might know as the Tavistock. They administer
13 GnRHa drugs to 44 teenagers. Because the results of
14 puberty suppression were not positive, the
15 researchers decided not to publish them. I led a
16 campaign to force them to publish, which took a
17 couple of years and a high court decision in the
18 (indiscernible) Bell case. Eventually, the clinic
19 admitted that puberty suppression did not improve
20 the psychological function of teenagers and did not
21 reduce their gender dysphoria.

22 There is now a handful of American
23 longitudinal studies more recent which are much
24 worse in quality. Instead of replicating the
25 methods pioneered by the Dutch and repeated by the

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1 British, each research team used a different set of
2 psychological measures, they have tiny samples, they
3 have high rates of attrition which is never
4 explained, and they use dubious statistical methods.

5 So what then do we know about puberty
6 blockers? Well, it's certainly true that early
7 puberty suppression produces a closer resemblance to
8 the opposite sex. Patients are more likely to pass
9 superficially. However, this benefit must be
10 weighed against several serious costs.

11 There are some known costs. So for males,
12 early puberty suppression makes subsequent genital
13 surgery more risky and less satisfactory. The penis
14 is so undeveloped that a normal vaginoplasty is
15 usually impossible, and then so instead a portion of
16 the patient's intestine has to be used. Leakage
17 from the intestines after surgery is what killed the
18 early Dutch patient at the age of 18. So that
19 patient died as an indirect consequence of puberty
20 suppression.

21 Second, puberty suppression hinders the
22 normal accumulation of bone mass. Up to one-third
23 of teenagers who take GnRHa for two years end up
24 with abnormally low bone density which puts them at
25 risk of osteoporosis in later life. Frieden

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1 (phonetic) drastically could tell the use of puberty
2 suppression because one of their patients developed
3 severe osteoporosis at the age of 15 years old.

4 More serious are the costs that are
5 unknown. So we have fragmentary evidence, but all
6 the evidence points that in fact early puberty
7 suppression followed by cross-sex hormones prevents
8 the development of normal sexual functioning. There
9 will be no libido and no capacity to orgasm. What's
10 astonishing is that clinicians who prescribe puberty
11 blockers haven't bothered to study their effect on
12 sexuality. So the lead Dutch researcher, de Vries,
13 recently said that orgasm was an interesting but not
14 so far studied question, and that's after her clinic
15 had been using this intervention for 25 years.

16 Finally, the most serious unknown
17 consequence is their affect on emotional and
18 cognitive development, which is particularly
19 important given of course we're concerned about the
20 capacity to consent to further interventions.

21 So a recent randomized control trial on
22 mice showed the GnRHa drugs cause males to manifest
23 high levels of stress, females to display increased
24 anxiety and despair like behavior. Again, it's
25 remarkable that researchers have never studied the

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1 effect of puberty suppression on measures like, for
2 example, acute.

3 Given the accumulating negative evidence
4 and the continuing failure of clinicians to collect
5 pertinent data, the English National Health Service
6 just last week released a draft specification for
7 gender services. In a complete reversal of existing
8 policy, "it will only commission GnRHa in the
9 context of a formal research protocol."

10 I recommend that the Florida Board of
11 Medicine should adopt the same policy. Puberty
12 suppression should be offered only in a proper
13 randomized controlled trial. Obviously, it can't be
14 blind. And most randomized control trials aren't
15 blind. But with a treatment -- so with a treatment
16 group and a control group. Any trial must ensure
17 that follow up continues into adulthood and must
18 guarantee to publish all clinical data. Thank you.

19 CHAIRMAN ZACHARIAH: Does the board members
20 have any questions for the doctor?

21 Go ahead, Dave.

22 DR. DIAMOND: Dr. Biggs, thank you so much
23 for being with us this morning. I have a question
24 for you --

25 DR. BIGGS: I'm finding it very difficult

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1 to hear your one --

2 DR. DIAMOND: Can you hear me now? Is that
3 better? Is that better, Dr. Biggs? Can you hear
4 me?

5 DR. BIGGS: Sort of. Yeah. Go ahead.

6 DR. DIAMOND: Okay. Could you please
7 elaborate a little bit more on the last item that
8 you mentioned, that last week the National Health
9 Service issued a directive regarding a formal
10 research protocol for the use of GHRH agonist, and
11 could you tell us a little bit more about what that
12 protocol involves?

13 DR. BIGGS: I'm afraid I can't because
14 that's still under -- there's no further details
15 that's been released by the NHS.

16 DR. DIAMOND: Okay. Because I was not
17 aware of that; so this is breaking news. I would be
18 very curious to know what the details of that
19 protocol might be.

20 DR. BIGGS: Yes. I can send you the link.
21 That wasn't in my documentation -- in my submission
22 because it came so recently. I'll send you the link
23 right away. But essentially, what they are -- this
24 draft specification -- I should emphasize it's only
25 a draft so far, but it just says that the emphasis

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1 has got to be on psychological care, helping
2 children to reconcile with their own body and their
3 own social circumstances, and that GnRHa will only
4 be offered in the case of a clinical trial. So
5 that's as much as we know.

6 DR. DIAMOND: Thank you.

7 CHAIRMAN ZACHARIAH: Any other board
8 members?

9 Yes, Dr. Hunter.

10 DR. HUNTER: I can clarify what the NHS
11 guidance is because I have it with me. This is
12 quoting from them. "Because of the uncertainties
13 surrounding the use of hormone treatments, NHS
14 England is in the process of forming proposals for
15 prospectively enrolling children and young people
16 into formal research program with adequate follow up
17 into adulthood. NHS England will only commission
18 GNRH analogs in the context of a formal research
19 protocol. This research protocol" --

20 Dr. Diamond, and this addresses your
21 questions.

22 -- "this research protocol will set out
23 eligibility criteria for participation." They're
24 still creating their criteria in their research.

25 DR. DIAMOND: Thank you, Dr. Hunter.

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1 CHAIRMAN ZACHARIAH: Any other board
2 members?

3 If not, Dr. Biggs, thank you so much for
4 addressing -- taking time off from your busy
5 schedule and talking to us. I really appreciate
6 that.

7 Next is Dr. Kristin Dayton.

8 DR. DAYTON: Yes. Good morning, Board of
9 Medicine and Board of Osteopathic Medicine members.
10 Thank you for inviting me to be a part of this
11 discussion on the development of practice standards
12 for the treatment of gender dysphoria in Florida.
13 Please note that my --

14 CHAIRMAN ZACHARIAH: Dr. Dayton, hold on
15 one second.

16 UNIDENTIFIED SPEAKER: Mr. Chair, can we
17 ask staff to maybe tweak the volume, so that we can
18 better hear?

19 DR. DAYTON: Do you need me to speak more
20 loudly?

21 CHAIRMAN ZACHARIAH: Let's ask our
22 audio/visual people if there's something they can do
23 to make the sound system better.

24 DR. DAYTON: I'm sorry, I'm having a very
25 difficult time understanding you. I can try and

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1 speak more loudly if that would help.

2 UNIDENTIFIED SPEAKER: Yes, that would
3 help. Speak louder.

4 DR. DAYTON: Yes, absolutely. Good
5 morning, Board of Medicine and Board of Osteopathic
6 Medicine members. Thank you for inviting me to be a
7 part of the discussion on the development of
8 practice standards for the treatment of gender
9 dysphoria in Florida. Please note my testimony
10 reflects my own personal judgment and is not the
11 official position of my employer.

12 My name is Dr. Kristin Dayton, and I am a
13 board-certified pediatrician, a board-certified
14 pediatric endocrinologist, and a member of the
15 Florida chapter of the American Academy of
16 Pediatrics, which represents more than 2600
17 pediatricians across our state.

18 I received my medical degree from Wake
19 Forest University and completed pediatric residency
20 and a pediatric endocrinology fellowship at the
21 University of Florida Shands Children's Hospital. I
22 am the medical director of the University of
23 Florida's Shands Children's Hospital Youth
24 Transgender Program. I am an assistant professor
25 for the Division of Endocrinology Department of

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1 Pediatrics at (indiscernible).

2 Today, as the practice standards for
3 gender-affirming care are considered, I will speak
4 about my expertise and knowledge on the standards of
5 care for the use of pubertal suppression and
6 (indiscernible) therapy.

7 UFC's gender program launched in 2016 and I
8 have been involved as a clinician in that program
9 since its inception. Our program serves transgender
10 and gender diverse children and adolescents from
11 throughout Florida and provides education to youth
12 and their families about gender identity
13 development, gender nonconformity, psychosocial
14 support, and (indiscernible) medical affirmation.

15 The program's multidisciplinary team, which
16 includes two board certified pediatric
17 endocrinologists, one board certified pediatrician,
18 a psychologist, a psychiatrist, two patient
19 advocates, and a medical-legal partnership, provides
20 developmentally appropriate, evidence-based gender-
21 affirming care to children, adolescents, and young
22 adults diagnosed with gender dysphoria and their
23 families in a safe, inclusive environment.

24 Gender-affirming care interventions fall
25 along a continuum and the risks and benefits of

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1 potential interventions are discussed in an open,
2 respectful manner with each patient and family with
3 no end goal in mind other than providing the best
4 care for each individual patient. The program
5 utilizes national and internationally recognized
6 standards of care developed by the World
7 Professional Association for Transgender Health, and
8 the Endocrine Society.

9 I have years of clinical experience in this
10 area and have cared for over 300 patients during
11 this time. And my recommendations are based on
12 evidence-based standards combined with practices
13 gleaned from my experience in this area. My primary
14 goal as a physician is to provide clinical care, and
15 I have the most clinical experience of anyone in
16 this room in providing evidence-based hormonal care
17 for youth and young adults with gender dysphoria.

18 I was initially drawn to working at this
19 clinic after experiencing the joy it brought to
20 people's lives to be affirmed and respected for who
21 they are. Throughout my time with this clinic, I
22 have seen the struggles that our patients face but I
23 also have witnessed them (indiscernible) when they
24 are able to be affirmed.

25 I always think of one of our patients who

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1 would hide their face every day in online classes
2 during the COVID pandemic, since he did not feel
3 that how he looked on the outside matched how he
4 felt on the inside. Fast forward two years later
5 with the addition of testosterone therapy, as well
6 as affirming mental health support, he is happily
7 back to in person school and is considered the class
8 clown.

9 Our patients report reduced suicidal
10 ideation and improved satisfaction with their life
11 after being able to access gender-affirming hormone
12 therapy. Parents talk about how their children
13 interact more at home and are finally more
14 themselves after years of being closed off to the
15 world.

16 Children and adolescents with gender
17 dysphoria experience challenges such as bullying,
18 discrimination, harassment, and a lack of social
19 acceptance that increase their risk for experiencing
20 depression, anxiety, and other mental health
21 conditions. The high rates of discrimination
22 experienced by transgender youth lead to a greater
23 risk for suicidal ideation and attempts compared to
24 their cis gender peers. A large-scale study of
25 suicidality in adolescents found that up to 51

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1 percent of transgender adolescents reported
2 experiencing suicidal behavior, compared to just 10
3 to 18 percent of their cis gender peers.

4 In providing medical care for children and
5 adolescents diagnosed with gender dysphoria, a
6 specialized approach is recommended. Gender-
7 affirming care is a model that includes assessments
8 and customized care practices to meet the specific
9 needs of each child or young adult experiencing
10 gender dysphoria. There is no one size fits all
11 model of care, nor are the (indiscernible) every
12 child experiences gender dysphoria the same.

13 The guidelines and standards for gender-
14 affirming care are set based on scientific data and
15 evidence and are medical treatments necessary to
16 treat the conditions of gender dysphoria. Gender-
17 affirming care standards are endorsed and
18 recommended by the American Academy of Pediatrics,
19 the Florida chapter of the American Academy of
20 Pediatrics, the American Medical Association, the
21 American College of Obstetricians and Gynecologists,
22 the American College of Physicians, the American
23 Psychiatric Association, the American Psychological
24 Association, the American Academy of Family
25 Physicians, the American Academy of Child and

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1 Adolescent Psychiatry, the Endocrine Society, the
2 Society for Adolescent Health and Medicine, the
3 Pediatric Endocrine Society, the World Professional
4 for Transgender Health or WPATH, and many more
5 organizations committed to providing the best,
6 evidence-based care.

7 As stated previously, evidence-based
8 standards of gender-affirming care recommend that
9 each child and adolescent diagnosed with gender
10 dysphoria is provided an individualized treatment
11 plan that incorporates medical, mental health, and
12 social services to provide care and support to the
13 child or adolescent and their families.

14 In some cases, pubertal suppression and
15 gender-affirming hormonal therapy are indicated
16 treatments. Adolescents may be prescribed pubertal
17 suppression or other hormone therapy to alleviate
18 the stress that may occur with the development of
19 secondary sex characteristics.

20 The decision to initiate puberty
21 suppression is not automatic nor is it applied to
22 every patient. Puberty suppression treatment occurs
23 after the child experiences a prolonged and
24 persistent gender dysphoria, and the decision to
25 initiate treatment is made in concert with the

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1 adolescent, their family, and the medical and mental
2 health (indiscernible), after a careful discussion
3 of risks, benefits, and alternatives to treatment.

4 Strong evidence support pubertal
5 suppression for gender dysphoric adolescents. A
6 study in the well-respected peer reviewed Journal of
7 Adolescent Health examined adolescents who were
8 referred to a gender clinic but had not yet begun
9 undergoing gender-affirming medical care, including
10 pubertal suppression, and adolescents who had
11 already begun receiving gender-affirming care using
12 pubertal suppression with cis gender adolescents.

13 The researchers found that adolescents with
14 gender dysphoria had worse psychological health
15 compared with their cis gender adolescent peers, and
16 that after receiving pubertal suppression as part of
17 gender-affirming care, the adolescents with gender
18 dysphoria had similar or better psychological health
19 when compared to their cis gender peers.

20 A study in the high impact Journal of
21 Pediatrics found that transgender adults who wanted
22 and were able to access pubertal suppression as
23 adolescents were less likely to have lifetime
24 suicidal ideation when compared to transgender
25 adults who were not able to access pubertal

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1 suppression as adolescents.

2 Overall, the studies that have examined the
3 use of pubertal suppression as a component of
4 gender-affirming care demonstrate that the use of
5 these medications is evidence-based. Following the
6 delay of puberty, adolescents may benefit from
7 initiating gender-affirming hormonal therapy. This
8 decision to treat is made with their parents or
9 caregivers and is never made in isolation but is
10 again made in the best interest of the patient at
11 heart and in a team-based approach.

12 Just like the decision to initiate puberty
13 suppression, the decision to initiate gender-
14 affirming hormone therapy is highly individualized.
15 Gender-affirming hormone therapy clearly lowers the
16 chance that adolescents diagnosed with gender
17 dysphoria will experience depression or suicidality.
18 I'm happy to provide these references, as well.

19 In summary, children and adolescents
20 diagnosed with gender dysphoria deserve the best
21 evidence-based medical and mental healthcare
22 available. The medical community has endorsed
23 gender-affirming care as an evidence-based treatment
24 for gender dysphoria. By proposing to develop an
25 alternate standard of care for the treatment of

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1 gender dysphoria Florida would ignore the broad
2 consensus from the medical community and the weight
3 of peer reviewed literature.

4 The role of the Board of Medicine is to
5 ensure that every physician practicing in the state
6 meets requirements for safe practice. To our
7 knowledge, no other (indiscernible) has prohibited
8 their fellow physicians from following evidence-
9 based national and international guidelines.

10 The Florida Board of Medicine should reject
11 the call for the development of new standards of
12 care for the treatment of gender dysphoria and allow
13 pediatricians, child and adolescent psychiatrists,
14 psychologists, and other physicians and mental
15 health providers to continue to provide gender-
16 affirming care under the existing standards.

17 I'm happy to take any questions the board
18 may have about the Youth Gender Program, the current
19 standards of care for gender-affirming care, or the
20 evidence supporting gender-affirming care.

21 Additionally, my colleague, Dr. Brittany Bruggeman,
22 who also provides care in our clinic, is present
23 with me today and would be happy to answer any
24 questions the board may have regarding our
25 expertise. Thank you.

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1 CHAIRMAN ZACHARIAH: Okay. Thank you,
2 Dr. Dayton.

3 Any board members?

4 Okay. Go ahead, Dr. Hunter.

5 DR. HUNTER: Dr. Dayton, can you hear me?

6 DR. DAYTON: Yes, thank you.

7 DR. HUNTER: Do you all keep data on the
8 patients in your clinic?

9 DR. DAYTON: The question was do we keep
10 data on the patients in our clinic?

11 DR. HUNTER: Correct.

12 DR. DAYTON: We don't have an active
13 registry of our patients currently.

14 DR. HUNTER: Okay. You had mentioned that
15 one size does not fit all, correct?

16 DR. DAYTON: Absolutely.

17 DR. HUNTER: Okay. Can you just, off the
18 top of your head, what percentage of kids who
19 present to your clinic are placed on puberty
20 blockers?

21 DR. DAYTON: I would say like probably 30
22 percent.

23 DR. BRUGGEMAN: Yeah. I would have said 20
24 to 30.

25 DR. HUNTER: And what percent --

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1 DR. DAYTON: And there are ways to pull
2 this data, so even though I'm not actively
3 collecting data, we do have some -- you know, we use
4 electronic medical records, and we have some ways
5 that we could pull some more specific answers to
6 your questions, so I'm happy to do so.

7 DR. HUNTER: And of those, what percent
8 would you guess go on to cross-sex hormones?
9 Dr. Biggs had mentioned, and I think most of the
10 literature shows 96 to 98 percent of kids placed on
11 puberty blockers go on to cross-sex hormones. So do
12 you have a feel, since you don't keep data, what
13 your --

14 DR. DAYTON: I would agree that the vast
15 majority that start puberty blocking do progress to
16 wanting to receive gender-affirming hormonal care,
17 which would be a testosterone Estradiol, typically.

18 DR. HUNTER: And then could you just talk
19 about the difference between suicidality and
20 completed suicide?

21 DR. DAYTON: I think that that would
22 probably be a better question for our mental health
23 experts. But my general impression is that
24 suicidality is a thought and feeling that someone
25 has, and a suicide completion is clearly when

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1 someone has died from suicide.

2 DR. HUNTER: And do we have data on those
3 regarding children and youth with transgender
4 identification?

5 DR. DAYTON: I'm sorry, I couldn't
6 understand that.

7 DR. HUNTER: Do we have any data regarding
8 the true suicidality risk and completed suicide
9 risk?

10 DR. DAYTON: From our clinic?

11 DR. HUNTER: From the world, from anywhere.

12 DR. DAYTON: I think that there have been
13 many studies looking at suicidality on a national
14 and international scale in this population.

15 Typically, these are population-based studies and
16 survey-based studies. So as much as we can trust
17 those types of studies, we do have data on that.

18 Chairman, I was wondering if we could bring
19 Dr. Biggs back on because I think he has done
20 research on the difference between suicidality and
21 completed suicide.

22 CHAIRMAN ZACHARIAH: You know, let's finish
23 our presentation and then we can bring him later,
24 because otherwise we'll be out of order too many
25 times.

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1 DR. HUNTER: Okay.

2 CHAIRMAN ZACHARIAH: I think that --

3 Dr. Di Pietro.

4 DR. DI PIETRO: Thank you.

5 Dr. Dayton, can you hear me?

6 DR. DAYTON: Yes, I can.

7 DR. DI PIETRO: So I want to clarify one
8 thing because I think one thing that you said is
9 extraordinarily important and what I really want to
10 get my point made today on this. Is from your
11 perspective the current guidelines, research, the
12 current perspectives we should all be taking on this
13 is that it's a multidisciplinary team approach.
14 Therefore, the pediatrician, the pediatric
15 endocrinologist, psychiatry, and psychology should
16 all be involved in a team approach when discussing
17 hormone and gender therapy, correct?

18 DR. DAYTON: I would say this, in specific
19 from the data that I've seen and from the guidelines
20 we have it is in relation to youth that I would make
21 that recommendation. But yes, for transgender youth
22 it is recommended to use that sort of a team-based
23 approach.

24 DR. DI PIETRO: Yeah. And I think
25 personally, and in looking at most things in

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1 medicine where you're -- and I'll use something as
2 simple as bariatric surgery as an example. Even
3 bariatric surgery transplant recipients all must
4 have a team-based, multidisciplinary approach,
5 because these are very big and important things that
6 we are doing.

7 And so just as a reference, a patient
8 cannot even get a transplant unless they have been
9 deemed that they have a support system at home, that
10 they're able to follow up on their care. And I
11 think that this is very important, and I think when
12 we're discussing this today, we need to keep in mind
13 that this is really no different. This should be
14 very much a multidisciplinary approach. Thank you.

15 DR. DAYTON: I would agree, and I would
16 just also want to say that I don't know that those
17 sort of procedures and surgeries have special rules
18 from their boards, from their -- sorry, from like
19 the Board of Medicine. And I think in the same way
20 if we are to trust our doctors in our state, we are
21 following those guidelines in that same way.

22 CHAIRMAN ZACHARIAH: Yeah, Dr. Hunter.

23 DR. HUNTER: Dr. Dayton, one more question.
24 You mentioned quite a few studies. I was wondering,
25 you're familiar with the systematic reviews out of

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1 Sweden and out of England, and NICE reviews on
2 puberty blockers, cross-sex hormones, and out of
3 Sweden the SBU evidence review team there. And that
4 they found all of these studies to be of low quality
5 -- very low quality, low certainty of the evidence.
6 I was wondering if you could comment on those
7 reviews from those countries?

8 DR. DAYTON: Yeah. Thank you. I have
9 familiarized myself with those reviews and I've
10 looked through the base evidence that they are
11 reviewing, and I think that there are also very good
12 studies and there are also reviews saying that there
13 is evidence to do this care. So I actually welcome
14 you guys to listen a little bit more in
15 Dr. McNamara's piece about the types of evidence and
16 reviews and how we can interpret those.

17 CHAIRMAN ZACHARIAH: Thank you.

18 Are there any board members, any questions?

19 If not, Dr. Dayton, thank you so much for
20 taking time away from your work and addressing this
21 group on a very, very important matter. Thank you
22 so much.

23 Next is Dr. Aron Janssen. Dr. Janssen.

24 UNIDENTIFIED SPEAKER: Oh, excuse me. I
25 wonder if you could close the microphone in the hall

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1 because that would help hearing the speakers when
2 they speak. It's really difficult to hear because
3 there's a lot of noise from the hall.

4 CHAIRMAN ZACHARIAH: I don't understand
5 what they said.

6 UNIDENTIFIED SPEAKER: Can you mute the
7 microphone in the actual room when the speakers are
8 speaking because we're getting a lot of echo and can
9 hear ourselves speaking across the room.

10 UNIDENTIFIED SPEAKER: I think they're
11 asking all of our microphones to be off.

12 DR. JANSSEN: If not, no worries. I will
13 plough through. All right. Thank you for allowing
14 me to address the Joint Board of Medicine and
15 Osteopathic Medicine. My name is Aron Janssen, and
16 I am a board-certified child, adolescent, and adult
17 psychiatrist. I'm an expert in the field of mental
18 health and transgender youth.

19 I received my medical degree from the
20 University of Colorado's School of Medicine, and I
21 completed my residency in psychiatry and fellowship
22 in child and adolescent psychiatry at New York
23 University Langone Medical Center. In 2011 I
24 founded the Gender and Sexuality Service at New York
25 University, a clinical service (indiscernible). My

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1 last (indiscernible) at NYU. That clinic served
2 over 200 families with multiple referrals each week.

3 I'm currently the vice chair of the Bridge
4 Care Department of Psychiatry and Behavioral Health
5 and chief psychiatrist of the Gender Development
6 Program at Ann and Robert H. Lurie Children's
7 Hospital of Chicago. I am also an associate
8 professor of child adolescent psychiatry at
9 Northwestern University Feinberg School of Medicine.
10 And I maintain a clinical practice in Illinois where
11 I treat patients from Illinois and surrounding
12 states.

13 I have treated children and adolescents
14 with gender dysphoria for over 10 years. I have
15 treated over 500 children and adolescents with
16 gender dysphoria during my medical career, and
17 approximately 90 percent of the patients in my
18 clinical practice are transgender children and
19 adolescents.

20 I am the chair of the American Academy of
21 Children and Adolescent Psychiatry Sexual
22 Orientation and Gender Identity Committee and have
23 served on the Transgender Health Committee of the
24 American Psychiatric Association. I'm also a
25 contributing author to the child chapter and adult

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1 mental health chapter of the Eighth Version of the
2 World Professional of Association for Transgender
3 Health Standards of Care, which I'll refer to as the
4 WPATH SOC for the health of trans youth and gender
5 diverse people.

6 The WPATH SOC first published in 1979
7 provides clinical guidelines for health
8 professionals based upon the best available science
9 and expert professional consensus after careful and
10 robust discussion, review, and comment that took
11 many years. The WPATH SOC has been recognized and
12 adopted as the prevailing standard of care by the
13 major professional associations of medical and
14 mental health providers in the United States.

15 In addition, I've read numerous peer
16 reviewed journal articles and chapters in
17 professional textbooks about the treatment of gender
18 dysphoria in children and adolescents. In 2018, I
19 co-edited Affirmative Mental Healthcare for
20 Transgender and Gender Diverse Youth. A clinical
21 casebook which is the first clinical casebook on
22 mental health treatment for children and adolescents
23 with gender dysphoria.

24 I'm an associate veteran for the Journal of
25 Transgender Health, and an ad hoc reviewer for

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1 Journal of LGBT Health, and for the Journal of the
2 American Academy of Children and Adolescent
3 Psychiatry. Each of these is a peer reviewed
4 medical journal.

5 I'm actively involved in training other
6 medical and mental health professionals in treating
7 children and adolescents with gender dysphoria.
8 I've conducted trainings for over a thousand medical
9 and mental health providers and have given dozens of
10 public addresses, seminars, and lectures on the
11 treatment of gender dysphoria in children and
12 adolescents.

13 The widely accepted view of the
14 professional medical community is that gender-
15 affirming care is the appropriate treatment for
16 gender dysphoria, and that, for some adolescents,
17 gender-affirming medical interventions are
18 necessary.

19 Gender dysphoria is a serious medical
20 condition in which the patient experiences
21 significant distress that can lead to impairment in
22 peer and family relationships, school performance,
23 or other aspects of life. Gender dysphoria is a
24 formal diagnosis under the American Psychiatric
25 Association's Diagnostic and Statistical Manual.

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1 Treatments for gender dysphoria have the
2 same or similar level of evidentiary support as many
3 other well-established treatment protocols in
4 psychiatry, and likely in every discipline of
5 medicine. Treatments is individualized based upon
6 the needs of the child and the family, and other
7 psychosocial considerations, and is decided upon
8 only after discussing possible benefits and risks of
9 both the intervention as well as the possible
10 benefits and risks to not proceed with the
11 intervention.

12 Appropriate medical care, including mental
13 health services, hormone therapy, and surgical
14 treatment can help alleviate gender dysphoria. Like
15 non-transgender people, transgender people do not
16 have a choice in their gender identity. Every
17 person has a gender identity which is not a personal
18 decision or preference. A transgender boy cannot
19 simply turn off his gender identity like a switch
20 any more than a non-transgender boy or anyone else
21 could.

22 Increasing research, including perspective
23 cohort studies have pointed to the enduring and
24 innate nature of one's gender identity. Living
25 consistently with one's gender identity is critical

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1 to the health and well-being of any person including
2 transgender people. And efforts to alter one's
3 gender identity to match gender assigned at birth
4 has been proven ineffective and psychologically
5 harmful. There is a reason every major mainstream
6 medical or association in the United States has
7 spoken against conversion efforts, including the
8 American Medical Association, American Psychiatric
9 Association, and others, calling such efforts
10 unhelpful, unethical, and harmful.

11 The steps that make up a transgender's
12 person transition into better alignment with their
13 gender identity will depend upon that individual's
14 medical and mental health needs. There's no
15 specific step or series of steps a transgender
16 person must undertake to complete their transition.

17 Typically, transgender people start their
18 transition with a series of steps commonly referred
19 to as a social transition. These steps include
20 changing their name, using different pronouns,
21 wearing clothing, adopting grooming habits typically
22 associated with their gender identity, and using the
23 corresponding sex specific facilities. Making these
24 changes enable transgender folks to being living
25 their lives consistent with their gender identity

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1 and helps ensure that they are treated as such by
2 family, peers, and others in the community.

3 At the onset of puberty, some transgender
4 young people also start taking puberty delaying
5 medication, known as puberty blockers, to prevent
6 their bodies from developing unwanted and
7 psychologically distressing secondary sex
8 characteristics that conflict with their gender
9 identity.

10 Delaying any of these treatments when they
11 are indicated will not only exacerbate a young
12 transgender person's gender dysphoria but could also
13 lead to the development or worsening of other
14 co-occurring mental health conditions, including
15 depression, anxiety, and disordered eating. And
16 importantly, in longitudinal research studies,
17 accessing these treatments when appropriate improves
18 gender dysphoria, improves (indiscernible), improves
19 quality of life and reduces depression and anxiety.

20 Research and clinical experience repeatedly
21 affirm that transition significantly improves the
22 mental and physical health of transgender young
23 people. This is true of each stage of a young
24 person's transition and transition can and often
25 does alleviate co-occurring mental health issues

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1 that transgender young person experience prior to
2 transition. Following transition, transgender young
3 people are often able to see significant
4 improvements in functioning and quality of life.

5 Mental health professionals use
6 well-established, measurable, and objective criteria
7 to diagnose and treat gender dysphoria. These
8 criteria have been incorporated into the DSM-5
9 diagnostic criteria and are further honed by the
10 ever-growing body of research.

11 The standard of care for mental health
12 treatment of gender dysphoria also commonly referred
13 to as the gender-affirming model of treatment, or
14 gender-affirming treatment, requires a careful and
15 thorough assessment of a patient's mental health
16 including co-occurring conditions, history of
17 trauma, substance use, among many other factors.

18 Therapists practicing consistently within
19 the standard of care will create a space where the
20 patient can explore their gender identity knowing
21 that being transgender and not being transgender are
22 both equally acceptable outcomes.

23 It is imperative that all individuals,
24 including those with gender dysphoria, receive the
25 optimal medical and mental healthcare they need and

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1 deserve. Denying the provision of such care for
2 Florida residents who meet the requisite medical
3 criteria puts them at risk for significant harm.
4 Further, mischaracterizing the professionally
5 accepted medical guidelines for treating gender
6 dysphoria and the guidelines supporting evidence
7 leads to confusion and a possible delay in needed
8 care.

9 If not treated or treated improperly,
10 gender dysphoria can result in debilitating anxiety,
11 depression, and self-harm. Further, eliminating
12 access to evidence-based mental healthcare will make
13 it even more difficult to retain and recruit child
14 and adolescent psychiatrists who provide highly
15 specialized medical care to Florida youth, including
16 vulnerable infants, children, adolescents, and
17 transitional aged youth across the state with a
18 variety of symptoms and diagnoses.

19 Abandoning evidence-based mental healthcare
20 is an overstep into the physician-patient
21 relationship by interfering with the personal
22 medical decisions and individualized treatment plans
23 best left developed between the treating physicians,
24 patients, and families. Again, thank you for the
25 opportunity to address you today and I look forward

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1 to answering any questions you may have.

2 CHAIRMAN ZACHARIAH: Well, Dr. Janssen,
3 thank you so much.

4 Board members, any questions?

5 DR. JANSSEN: The meeting is still muted,
6 so I don't know if you're speaking now.

7 CHAIRMAN ZACHARIAH: Yes. So Dr. David.

8 DR. DIAMOND: Dr. Janssen, thank you so
9 much for being with us this morning. Can you hear
10 me?

11 DR. JANSSEN: It's quiet. So maybe if
12 somebody is in front of the mic can repeat the
13 question, so I can --

14 DR. DIAMOND: Let's try again. There we
15 go. Dr. Janssen, good morning. Can you hear me,
16 sir?

17 DR. JANSSEN: I can hear you. Yes.

18 DR. DIAMOND: Very good. Thank you so much
19 for being with us today. We appreciate it very
20 much. I have a couple questions for you, so that I
21 can better understand your position, and it does not
22 necessarily belie my own. My chief question to you
23 is this. As you well know, our colleagues in Europe
24 were really the leaders in interventions in the
25 treatment of minors with gender dysphoria decades

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1 ago. And as you may know, our colleagues in Europe
2 now have seemed to take a change whereby in England,
3 and Sweden, and Finland, they are now taking a more
4 -- I'm not sure what the correct term is -- a more
5 cautious or conservative approach.

6 And I'm curious as to what this appears to
7 me to be a paradox whilst our colleagues in Europe
8 are now becoming perhaps more conservative, here in
9 the United States we're taking a different approach.
10 I'm curious to your thoughts on that, sir.

11 DR. JANSSEN: It's a great question, and
12 you know, I can't speak to what the environment and
13 the entirety of Europe is. But the part that I
14 would emphasize is that the best data that we have,
15 and the best longitudinal data that we have on
16 transgender youth comes primarily out of the Dutch
17 clinic. Dr. Biggs even referred to a lot of the
18 Dutch studies and the Dutch model of care, and
19 that's the prevailing model that most of the
20 American clinics have based their care upon.

21 There's no effort in the Netherlands to
22 reduce access to care. And similarly, in the adult
23 world, Belgium is really the place where there's the
24 most longitudinal care and the most longitudinal
25 studies around transgender health and transgender

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1 mental health. And similarly, in Belgium, there's
2 been no effort to divert or discern a different
3 standard of care than the one that was put forth by
4 both the Endocrine Society and the World
5 Professional Association for Transgender Health.

6 DR. DIAMOND: Over the last couple nights,
7 Dr. Janssen, I was reading Dr. Hilary --

8 DR. JANSSEN: It's muted again.

9 DR. DIAMOND: Let's try again. Over the
10 last several nights, I had the opportunity to review
11 the interim findings from Dr. Hilary Cass, and I'm
12 sure you know Dr. Cass is a world-recognized
13 authority on this subject and she has been appointed
14 as the chair of the Independent Review of Gender
15 Identity Services for Children and Young People for
16 England's National Health Service. And it's
17 actually very interesting when I read the reports,
18 they're actually very beautifully written. The
19 language is beautiful in terms of the subtly and the
20 nuances of the language.
21 And in the interim reports of the different
22 items that we're discussing today, really the area
23 that her team has focused on as the most problematic
24 is that of pubertal blockers. And it's remarkable
25 how humble they are in their admission of how little

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1 we know. In other words, Doctor, many folks tell us
2 how confident they are of their opinions but there's
3 concern after concern mentioned.

4 So for example, in the most recent letter
5 dated July 19, 2022, to Dr. Stewart, the National
6 Director of NHS England, she mentioned how most of
7 the data with the use of GHRH agonist in children
8 were really focused on biologic males who had
9 dysphoria, but she pointed out that this data does
10 not necessarily reflect what we are seeing primarily
11 today which is the later presenting young people,
12 particular biologic females. So I'm just impressed
13 how much more nuanced or perhaps how much more
14 cautious they may be and I'm curious as to your
15 opinion on that.

16 DR. JANSSEN: Sure. I think it's important
17 to know that there are a lot of ongoing research
18 studies in today's context in the United States.
19 There's an NIH study that's been perspective for the
20 last two years, including four different sites, that
21 includes the proportion of assigned females at birth
22 and assigned males at birth that you are referring
23 to. And there has been data released from those
24 studies that has clearly implicated the value of
25 puberty blockers.

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1 As an example, in one of the cohorts, the
2 kids who had access to puberty blockers and were
3 able to access them appropriately after an
4 evaluation and assessment with that individualized
5 treatment plan in place had diminished depression,
6 anxiety, compared to their transgender peers when
7 accessing gender-affirming hormones. They had a
8 higher quality of life and significant improvements
9 in functioning and body congruence.

10 So we have this data in the U.S. in the
11 context, in the past decade, in the past several
12 years that we've been following. So I think that
13 that data is there. And I think it's important to
14 know that the folks who are participating in this
15 call today, that it's easy for us to talk about the
16 studies, it's easy for us to talk about the
17 policies, but it's also important just to recognize
18 that the clinical work is very valuable. And the
19 data that we have from our families and our patients
20 who are telling us what is helping, what is working,
21 how this has impacted our lives is also really
22 important to recognize.

23 DR. DIAMOND: Thank you.

24 CHAIRMAN ZACHARIAH: Well, thank you,
25 Dr. Janssen.

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1 Next, we have Dr. Kaltiala. I hope I am
2 pronouncing properly. Probably I'm not. Is
3 Dr. Kaltiala here? Hey, Doctor. Thank you so much
4 for coming and we appreciate your time talking to us
5 about this very, very important topic. Thank you.
6 Now you may proceed.

7 DR. KALTIALA: Good afternoon from my point
8 of view. Good morning to you, dear audience. And I
9 thank you for the opportunity to participate in this
10 important discussion. And I feel a little bit
11 underhand because I seem to be the only one here who
12 is not native English speaker but hopefully, I'll
13 manage.

14 I'm Ritta Kaltiala. I work in town for a
15 university in Finland in Northern Europe as a
16 professor of adolescent psychiatry and I'm also the
17 chief psychiatrist in Tampere University Hospital
18 Department of Adolescent Psychiatry, where we have
19 one of the two nationally centralized gender
20 identity teams for minors.

21 They have been seeing gender identity
22 patients since 2011 and I have been participating in
23 the clinical work meeting practically all
24 adolescents who have in Finland ever proceeded to
25 hormonal interventions with gender identity

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1 indication. Because I'm not only seeing all the
2 patients in our unit, but I also see all those
3 patients who have been referred to hormonal
4 treatments in the so-called second opinion visits
5 they need to make to our unit. My research work
6 also nowadays primarily centers around gender
7 identity. I have published extensively since we
8 started to do the gender identity assessment with
9 minors.

10 In Finland -- and I also have to notice --
11 observe here that my opinion about the quality of
12 evidence and as well the best interest of minors in
13 this issue is rather different than some of the
14 other opinions we have already heard today.

15 So in Finland, the regulation is as
16 follows: diagnostic assessment that may result in
17 medical gender reassignment is in Finland
18 centralized by a code of law two of the five
19 university hospitals in the country, and they are
20 considered third level services. The whole
21 population is, by the way, only 5.3 million, so you
22 may wonder why so small numbers, but we are not such
23 a huge nation.

24 Both of these centers have a unit for
25 adults and another unit for minors. And in these

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1 gender identity teams, mental health teams perform
2 the diagnostic assessment and behavior.
3 Endocrinology team, or hormone (indiscernible)
4 clinic based on the gynecology as appropriate, bear
5 the responsibility for initiating and balancing
6 hormonal interventions. When hormonal interventions
7 have been balanced, this mainly concerns those
8 patients who are cross-sex hormones, the hormonal
9 long-term care, hormonal care is transferred to
10 local services.

11 Surgeries with gender dysphoria indication
12 are available only for legal adults. This is from
13 age 18 and by referral from the adolescent
14 assessment teams. Genital surgery is centralized to
15 one center in the country.

16 Legislation level can never give actual
17 practical clinical guidelines, and so national
18 guidelines for treatment were issued 2020 by the
19 COHERE of Finland. It is body under Ministry of
20 Health and Welfare that has the responsibility of
21 outlining what kind of services are available in
22 publicly funded services or reimbursed by national
23 health insurance in Finland.

24 We also have another system of service
25 guidelines which is by the Scientific Society

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1 (indiscernible), and they give guidelines inline,
2 for example, (indiscernible) parameters. But here
3 we have a bit more official level given guidelines
4 by COHERE of Finland.

5 And the national guidelines for the
6 treatment of gender dysphoria in children and
7 adolescents define that with children, they only
8 provide possible interventions to associate with
9 difficulties. So it is well known that 80 percent,
10 even up to 85 percent of children who experience
11 gender dysphoria and cross-sex identification feel
12 differently when they reach puberty, after the
13 various phases of puberty. And therefore, any
14 medical interventions are not recommended to
15 prepubertal children.

16 Also, you cannot make the identity and
17 assessment and kind of prepare for possible medical
18 interventions before the puberty has started because
19 the onset of puberty is such an important phase in
20 the gender identity experience and in consolidation
21 of the gender identity for those who have gender
22 identity issues from childhood.

23 With adolescents, the first line of
24 treatment of gender dysphoria is exploratory
25 psychotherapy with intervention in local services,

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1 and this has to be provided in the level of care
2 that is otherwise appropriate given that
3 adolescent's possible associated difficulties. If
4 the adolescent is thriving and doing well and does
5 not have any psychiatric treatment needs, then it
6 has to be the primary care level services, such as
7 student health who provides the exploratory
8 intervention. And if the adolescent is experience
9 psychiatric symptoms or mental disorders, then this
10 intervention can be intertwined with the appropriate
11 psychiatric treatment according to their needs.

12 Appropriate treatment of possible
13 psychiatric comorbidities and management of
14 associated needs, such as for example,
15 (indiscernible) needs or child welfare needs have to
16 be before considering actual gender identity
17 assessment is also included in the guidelines.

18 If considering medical gender reassignment
19 after the first line interventions appear
20 appropriate and timely, the referral to the
21 nationally centralized gender identity services can
22 be issued. Then the actual gender identity
23 assessment and diagnostics that may result in
24 medical gender reassignment interventions is taking
25 place in the nationally centralized services.

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1 These assessments take place in a
2 multidisciplinary assessment with the young person
3 and their guardians. The professionals who
4 participate this multidisciplinary assessment
5 include children and adolescent psychiatrist,
6 psychologists, social worker, and a psychiatric
7 nurse. And these assessments comprise multiple
8 meetings over a period of 6 to 12 months in practice
9 (indiscernible) and very rarely they can do it in 6
10 months. And they cover the next -- the following
11 phases, excluding contraindication such as, for
12 example, they nevertheless find that there are
13 (indiscernible) psychiatric comorbidities that
14 warrant treatment more urgently, then the adolescent
15 is first referred to appropriate psychiatric
16 treatments.

17 The next step is the assessment of gender
18 identity in the context of identity development at
19 large and evaluation of how well the developmental
20 tasks of adolescents are progressing.

21 And next there will be the assessment of
22 readiness, so they explore the expectations and --
23 what the expectations of the young person and the
24 family and how realistically they see the possible
25 interventions and outcome of the interventions. And

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1 whether they have the appropriate resources and
2 psychological strength for the possible medical
3 interventions that are not an easy step for an
4 adolescent. And also require appropriate level of
5 mental support and psychological resilience.

6 And then based on all those previous steps,
7 then follow appropriate (indiscernible) and follow
8 up of the young person. If the young people proceed
9 to hormonal interventions, they remain in our follow
10 up until they have completed the treatments they
11 currently desire.

12 We first prepare to follow up then until
13 the end of all treatment, but it has turned out that
14 this impractical because many adolescents after
15 initiating hormonal treatments, they do not proceed
16 to surgical interventions, particularly not to
17 genital surgery so quickly that it would be
18 appropriate to keep the follow up in the adolescent
19 mental health team. Therefore, they nowadays
20 discharge the young people from our follow up
21 individually in a (indiscernible) phase of the
22 course of the treatment, and absolutely before it's
23 (indiscernible) and they are transferred to adult
24 services if they further continue going further in
25 treatment.

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1 During the assessment period, a transfer to
2 more appropriate or more timely interventions can
3 take place at any stage of the assessment if they
4 appear -- those needs appear. If medical
5 interventions are initiated based on gender identity
6 indication, then assessed further.

7 For childhood onset of gender dysphoria
8 that intensifies in puberty, if there are no severe
9 psychiatric comorbidities and there is appropriate
10 development of (indiscernible). And this would be
11 the patient group originally described as the model
12 patients for the support (indiscernible) model of
13 care.

14 CHAIRMAN ZACHARIAH: Doctor, we are passed
15 the 10-minute mark, so I really appreciate it if you
16 can wrap it up quickly. You have already spent 10
17 minutes, so I appreciate if you can wrap it up
18 quickly.

19 DR. KALTIALA: Sorry, I really don't hear
20 but you ask me to be quicker.

21 CHAIRMAN ZACHARIAH: Yeah.

22 DR. KALTIALA: So for this, we can offer
23 our analogs to help pubertal development from early
24 stages of puberty and cross-sex hormones from about
25 16 --

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1 CHAIRMAN ZACHARIAH: Okay. Doctor, you
2 know, thank you so much. Let me have the board
3 members ask any questions of the good doctor.

4 Yeah, Dr. Hunter?

5 DR. HUNTER: Dr. Kaltiala, can you hear me?

6 DR. KALTIALA: Very poorly. I hope that a
7 discussion could be --

8 DR. HUNTER: Right when you were finishing,
9 you were mentioning that children or youth could not
10 have -- I think, if I understood you correctly,
11 could not have mental health issues at the time of
12 transition. Then we're hearing from Dr. Janssen
13 that transition helps with mental health issues,
14 comorbid mental health issues. Could you clarify
15 what you understand there about the comorbid mental
16 health issues and if transition helps or does not?

17 DR. KALTIALA: Yes. Mental health
18 comorbidities are often discussed in the light that
19 they would be secondary to gender dysphoria, but
20 actually, they have observed, and I have also
21 published this finding, that many of the adolescents
22 who are referred to our service suffer from
23 long-term mental health issue which are similarly
24 impairing their adolescent development and
25 functional capacities and that have had the onset

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1 well before the onset of gender dysphoria. So that
2 the gender dysphoria has first emerged in the
3 context of severe and functionally impairing mental
4 health problems.

5 In this case, I think it is not possible to
6 conclude a persistent identity because so severe
7 mental disorders impair the identity development and
8 there are great risks in concluding that gender
9 identity would be so fundamental and stabilized that
10 it would be safe to proceed to hormonal
11 interventions, not to mention surgical interventions
12 based on gender identity. So I consider it of
13 utmost importance and severe psychiatric disorders
14 first be treated into remission.

15 Very seldom we see patients where you could
16 think that the mental health comorbidities would
17 only be secondary and mild. It is often stated in
18 the literature. There is no basis for such
19 statements. I have also myself reviewed the
20 literature and the evidence for -- because it is
21 often stated that the gender reassignment will also
22 help in the mental health difficulties and the
23 functional impairments. This is not the case.
24 There is no evidence base for such claims.

25 Literature and the research on the impact

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1 of gender reassignment of mental health is lousy at
2 best and I cannot conclude based on my own reviews
3 and the reviews by COHERE Finland, and also the Cass
4 review and some other experts, that there is
5 evidence to say that mental health difficulties,
6 psychiatric disorders (indiscernible) if an
7 adolescent experiencing gender dysphoria is given
8 gender reassignment, for instance. These are
9 separate problems and if the psychiatric problems
10 seem to be more fundamental, they have to be treated
11 first.

12 DR. HUNTER: Speaking to what you said at
13 the beginning about you had some other opinions
14 about the evidence in general, could you share about
15 that? Not just the mental health but the overall
16 evidence in general.

17 DR. KALTIALA: (Indiscernible), you may be
18 wondering why I seem to have a different evidence
19 from the American speakers. Yes, this is an
20 interesting question, but I have myself reviewed the
21 evidence for the impact of medical gender
22 reassignment on the mental health in children and
23 adolescents for a webinar of WPATH and Society of
24 Sexual Medicine. And also, this was presented in
25 the Congress of European Professional Association

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1 for Transgender Health, and also invited to be
2 repeated in the European Society of Pediatric
3 Endocrinology. And this is really my sincere
4 understanding that the evidence is lousy.

5 Research on the impact of child and
6 adolescent gender reassignment -- medical
7 reassignment in children and adolescents is mainly
8 comprising the one Dutch study which can be
9 criticized because they didn't have a comparable
10 comparison group and it only included some 70
11 patients and we are now treating tens of thousands
12 of patients all around the world. So 70 patients as
13 the model for treatment for tens of thousands of
14 patients, I find it really lousy. And it is not in
15 the same level as is usually expected for
16 evidence-based medicine in any field of medicine
17 nowadays.

18 And the other treatment studies after the
19 Dutch study have been even worse. They only have a
20 handful of patients; the follow up times is up to
21 one or two years only; they have been using a
22 variety of instruments; and they mainly have not
23 been able to demonstrate any improvement of mental
24 health or functional capacity -- functional
25 abilities; and they have also not reported who were

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1 the patients who were not included in the study. So
2 there is no basis for critical (indiscernible) what
3 kind of group is the treatment group representative
4 of.

5 So evidence is lousy in general regarding
6 mental health and adolescent progress and adolescent
7 development in particular. I am convinced in the
8 light of current evidence that there is evidence
9 that modifies secondary sex characteristics, clearly
10 modified secondary sex characteristic. There as
11 almost all of the other claims of their
12 effectiveness is questionable, based on questionable
13 quality studies.

14 DR. HUNTER: One last question. I
15 understand there's been significant changes in the
16 way Finland does things, Sweden, and the NHS in that
17 -- this is a difficult maybe but why are they making
18 those changes? What's driving that?

19 DR. KALTIALA: Why?

20 DR. HUNTER: Why are these changes
21 happening in Europe? That may be too big of a
22 question.

23 DR. KALTIALA: Oh, why have in Europe going
24 to go more conservative? Because of the
25 observations that the treatment -- the impact of

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1 treatment on the adolescents' mental health
2 functioning and thriving in every way in the society
3 are not that great. So they have been increasing
4 concerns about the assessment -- quality of the
5 assessments and also the impact of the treatments
6 and the miserable results on mental health and
7 functioning.

8 And therefore -- and also, it's the matter
9 of that the patient mix has changed totally. And
10 the literature based -- also, the Dutch literature
11 was based mainly on patient groups where they had
12 childhood onset gender dysphoria cases in children
13 with male sex. Now we are seeing increasing numbers
14 of adolescent onset cases in young people with
15 female sex. And about this condition, the natural
16 course of this condition and the optimal treatments
17 for these conditions, we know nothing about. There
18 is no literature about what is the natural cause of
19 adolescent onset gender dysphoria.

20 And therefore, even the literature in favor
21 of the Dutch model of care was modest at its best
22 when we consider optimal patients for the Dutch
23 model of care which I defined earlier. But now we
24 are treating totally different patient mix and there
25 is no evidence what should be the treatment options

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1 for this patient group. Therefore, I personally
2 think that actually hormonal treatments on gender
3 dysphoria indication for children and adolescents
4 should preferably be limited into the context of
5 formal research studies at the moment.

6 CHAIRMAN ZACHARIAH: Well, thank you
7 Dr. Kaltiala. Let's move on to our next expert.
8 Again, thank you so much, Doctor, for coming all the
9 way from Finland. We really appreciate it.

10 Now let's have Dr. Michael Laidlaw. Thank
11 you.

12 DR. LAIDLAW: Can you hear me now?

13 UNIDENTIFIED SPEAKER: A little bit better.

14 DR. LAIDLAW: Okay. Thank you,
15 Dr. Zachariah. Thank you, Board, for having me. I
16 have slides.

17 DR. ACKERMAN: Can you just make him a
18 little bit louder?

19 DR. LAIDLAW: Is that better?

20 DR. ACKERMAN: Oh, much. Yeah.

21 DR. LAIDLAW: Okay. Sorry about that.

22 Okay. Thank you for having me. I'm
23 Dr. Michael Laidlaw; I'm a board-certified
24 endocrinologist practicing in private practice for
25 the last 16 years in Rockland, California. Trained

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1 at University of Southern California primarily. Did
2 internal medicine residency and a fellowship at that
3 location. I've been studying and publishing in this
4 area for the last five years, including a peer
5 reviewed journal such as Journal of Clinical
6 Endocrinology and Metabolism, and others. I also
7 serve as an expert witness on subject matter in this
8 area on a number of cases. I also have a patient
9 who is a de-transitioner.

10 So start with some definitions. Some of
11 this has been gone over but the gender identity is
12 an internal feeling of being a boy, or a girl, or
13 some variation. Gender dysphoria is a distress that
14 arises from an incongruence between that identity
15 and the physical body, leading to impairment. I
16 think it's important to note that desistance, or
17 growing out of this condition of children by
18 adulthood is very high, some 50 to 98 percent. And
19 these are studies done primarily on 12 years old and
20 younger.

21 Now, as an endocrinologist, I treat, for
22 example, diabetes. I want to be sure before I give
23 someone a very powerful hormone like insulin that
24 they in fact have diabetes. I want to test to show
25 that the glucose levels are high, or I could

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1 possibly injure or even kill the person. What about
2 cancer? Before we give any powerful agent such as
3 chemotherapeutics or surgeries, we certainly want to
4 have physical evidence of this problem, such as
5 biopsies or imaging.

6 Now, the gender affirmative therapy
7 treatment proposed by WPATH and in place with WPATH
8 gives very powerful hormones and surgeries on what
9 basis? Where can we find the gender identity to be
10 certain that these children will not desist by
11 adulthood? Can we use imaging of the brain, or
12 blood tests, genetic testing? Are there other
13 biomarkers to ensure that we are correct? There is
14 no such thing.

15 Starting with basic -- just go back a bit
16 to basic biology. There are two human sexes, male
17 and female. Males produce sperm, females produce
18 eggs. An embryo is conceived in such a process.
19 When we move on to sexual development and
20 differentiation of the embryo, there are two
21 pathways based on two ductal systems, the wolffian
22 ducts become male associated organs, such a
23 epididymis, seminal vesicles. The malarian ducts
24 develop into fallopian tubes, uterus portion of the
25 vagina.

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1 It's important to note that this
2 bifurcation or splitting down pathways occurs and
3 one cannot switch from one pathway to the other. In
4 other words, the actual ductal systems that produce
5 these are destroyed in the process. And so this
6 process is complete by around 12 weeks of
7 embryologic development.

8 Moving on to puberty, the next development
9 in sexual maturity occurs during this time. The
10 purpose of puberty is to achieve full adult sexual
11 function and reproductive capacity. It's not
12 optional. One cannot switch from one pathway to
13 another. A testicle cannot be induced to produce
14 eggs and ovaries cannot be induced to produce sperm.

15 I think it's important to note that around
16 what you see there, Tanner Stage 4 or 3, is when
17 fertility is established. And so blocking puberty
18 at Tanner Stage 2, which is what's advised by
19 Endocrine Society WPATH, will necessarily lead to
20 infertility. Cross-sex hormones given over a
21 prolonged period of time may lead to sterility. And
22 certainly surgeries to remove sex organs will ensure
23 sterility.

24 The basic problem with this treatment as I
25 see it is what happens when you force a square peg

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1 into a round hole? You end up injuring or
2 destroying the peg in the process.

3 So what is gender affirmative therapy?
4 There's really four stages. Social transition,
5 puberty blockers, cross-sex hormones, and then
6 surgical modifications.

7 What do we know about this? The biggest
8 study showing data over 30 years and looking at the
9 entire medical databases of the entire population of
10 Sweden found 324 individuals who had such hormones
11 and surgeries and tracked them out. Here you can
12 see at around -- this is showing survival, and at
13 around 10 years, the bottom two dotted lines show a
14 rapid increase in mortality starting around year 10.
15 And you can see by the end the survival rate is much
16 lower. They also found increased risks of all
17 causes of mortality of three times and in patient
18 psychiatric care. And there was 19 times completed
19 suicide rate compared to the general population.

20 Dr. Biggs covered puberty blockers very
21 well and I just want to add a couple of things.
22 Here is showing normal pituitary function where you
23 have signals sent out by the pituitary. In this
24 case to tell the testicles to make testosterone, or
25 in the case of females, the ovaries to make

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1 estrogen. What happens when you give puberty
2 blockers? You actually cause a medical condition
3 that endocrinologists would try to treat. It's
4 called hypogonadotropic hypogonadism. This is an
5 iatrogenic injury from this type of treatment. And
6 to emphasize the idea from the guidelines is to stop
7 at Tanner Stage 2 there will be no further pubertal
8 development even when giving cross-sex or opposite
9 sex hormones.

10 Just quickly, here's a look at bone
11 density, the male and female over time. You can see
12 where there's a rapid increase. Should be a rapid
13 increase in bone density somewhere in the teen
14 years. You can see the red and blue lines rising
15 very quickly, an increase in bone density. Then you
16 can see the flatlining that I've shown which occurs
17 with puberty blockers, which will lead to adulthood
18 lower bone density potential for osteoporosis and
19 fractures.

20 Moving onto cross-sex hormones or opposite
21 sex hormones. I want to give you an idea of what
22 sort of doses we're talking about. Now, I have here
23 in blue is a normal adult female testosterone range
24 is somewhere from 10 to 50. Conditions that we
25 treat which are called hyperandrogenism, or high

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1 testosterone conditions such as PCOS may have levels
2 from 50 to 150. With endocrine tumors, such as with
3 adrenal carcinoma, for example, you might have much
4 higher, 150 to 1000, which is the red box you see
5 there. And what are they advising in their
6 guidelines for females for transition? Somewhere
7 from 300 to 1000, which is exceedingly high. If you
8 calculate, it's about 6 to 100 times higher than
9 androgynous female testosterone levels.

10 What are the sorts of problems when giving
11 high dose hormones to males or females? Well, in
12 both you have an increased risk of myocardial
13 fraction and death due to cardiovascular disease.
14 You also have sexual dysfunction and infertility.

15 Sticking with a female born person who is
16 taking high doses of testosterone, erythrocytosis,
17 or high red blood cell counts. Severe liver
18 disfunction is a possibility. Hypertension.
19 Increased risks of breast/ovarian cancer. Hirsutism
20 or permanent hair growth of the face, chest,
21 abdomen. Permanent deepening of the voice.

22 How about male bodied persons taking
23 estrogen? There's a five times increased risk of
24 thromboembolism, or deadly blood clots. Gallstones,
25 high triglycerides. Breast cancer risk has been

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1 shown to be increased 46 times above normal.
2 Gynecomastia or abnormal breast tissue growth, which
3 if the person desists is a big problem as far as
4 removal.

5 I'd like to move on to surgeries. This is
6 a person born as a female who identifies as a trans
7 male. You can see here evidence of the
8 hyperandrogen state with hair growth on abdomen and
9 face. Now, the types of problems you can have with
10 this surgery are significant scarring, 7 to 10
11 inches. Problems with normal nipple sensation. I
12 think I read a study where one nipple fell off, it
13 did not adhere afterwards. Difficulties with wound
14 healing.

15 What sort of ages are we talking about here
16 in the United States? You may hear that, well,
17 surgeries aren't done on kids. But here's a study
18 published 2018, JAMA Pediatrics, I believe. You can
19 see age groups. There is a couple of 13-year-olds
20 who had mastectomy. What five 14-year-olds,
21 15-year-olds, 16-year-olds. Very young ages. It's
22 important to --

23 CHAIRMAN ZACHARIAH: Dr. Laidlaw, you have
24 already surpassed your 10 minutes.

25 DR. LAIDLAW: Darn, okay.

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1 CHAIRMAN ZACHARIAH: I appreciate your
2 presence, so if you can wrap it in the next 30
3 seconds, or 40, I really appreciate it.

4 DR. LAIDLAW: Sure. Let me just jump to --
5 I want to emphasize the Endocrine Society guidelines
6 are written in 2017. 9 out of the 10 of these folks
7 were all part of WPATH. WPATH is an activist
8 advocacy organization. In the disclaimer it says
9 very clearly, page 3895 that "They do not establish
10 a standard of care." This is not standard of care.
11 There's already a community standard of care. All
12 of the evidence is of low or very low quality or
13 absent evidence. It's right there in their
14 document.

15 The WPATH has actually created standards of
16 care eight and has removed all of the age minimums
17 they had. They had 15-year-old for mastectomy,
18 hysterectomy, orchiectomy, 17 years old. They've
19 removed all these ages restrictions against the
20 advice of their own experts. They've also done a
21 very poor job with grading the evidence. They've
22 invalidated it. They have a chapter on how to make
23 men into Unix.

24 This is an extreme document and presents a
25 grave danger to minors. I would advise

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1 investigating children with autism, depression,
2 anxiety. Help them with their psychological
3 comorbidities, psychotherapy, cognitive behavioral
4 therapy, individual counseling, and family support.
5 Thank you.

6 CHAIRMAN ZACHARIAH: Thank you,
7 Dr. Laidlaw.

8 Board members have any questions?

9 You know, I have one question, Doctor. Not
10 a question, a comment.

11 DR. LAIDLAW: Yes.

12 CHAIRMAN ZACHARIAH: You made a very good
13 presentation. From what I understand, the
14 complications, the short-term, the long-term
15 complications I believe are irreversible and
16 significant. Is that what your message was?

17 DR. LAIDLAW: Yes. I'm making the case
18 that they are -- well, certainly surgery is
19 irreversible. Removing testicles and ovaries is
20 permanent sterilization. Some of these other
21 problems will be permanent. Like being on puberty
22 blockers for a couple of years will cause permanent
23 loss of bone density. There's brain development
24 which occurs under the influence of sex hormones
25 which will be altered permanently. And other such

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1 effects, like I said, hirsutism, changes in voice
2 will be permanent. Yeah. And fertility and such.
3 Sexual dysfunction, also.

4 CHAIRMAN ZACHARIAH: Thank you.
5 Board members?

6 DR. HUNTER: I hear from you that there's a
7 50 to 90 percent natural desistance rate, and I've
8 seen that in the literature, but then we hear from
9 Dr. Janssen that this identity cannot change.
10 There's a clear conflict there. What are we to
11 believe?

12 DR. LAIDLAW: Well, you can believe the
13 studies. It's there in black and white. I have it
14 -- I have references to look at. I mean, the reason
15 why they're saying it's a permanent identity is
16 because they're -- a lot of the studies doing now,
17 they kids have already socially transitioned,
18 they're on puberty blockers, which you've heard
19 there's very high rates of kids continuing on to
20 cross-sex hormones. So they're doing the
21 interventions and then they're saying, "Look, they
22 don't desist." But they've already undergone the
23 treatments, so it's not a fair comparison in anyway.

24 DR. HUNTER: And then we hear that the --
25 you're saying that the evidence is low quality,

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1 Endocrine Society and their guidelines, say that
2 it's low quality. But then we're hearing that the
3 quality is -- the evidence quality is there. Again,
4 we're hearing conflicting -- what are we to believe?

5 DR. LAIDLAW: Well, if you look at quality
6 of evidence, we're talking about are there any
7 randomized controlled studies that look at -- let's
8 take a group -- two groups of kids with gender
9 dysphoria. One we give psychological support, the
10 other we give hormones and other therapies, and
11 compare those. Those studies don't exist. Those
12 would be called high quality studies. They don't
13 exist. Even the NIH study that he referenced
14 doesn't do such a thing. So we don't have high
15 quality evidence based on that.

16 CHAIRMAN ZACHARIAH: Any other board
17 members?

18 DR. DERICK: I have a question.

19 CHAIRMAN ZACHARIAH: Dr. Amy.

20 DR. DERICK: Your slide number 10 on the
21 long-term mortality with using cross-sex hormones,
22 what is the age of the transition of the
23 participants that are being studied? Is it people
24 who have been transitioned as youth or at all times?

25 DR. LAIDLAW: These -- yeah, here is it.

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1 These are, to my knowledge, all -- well, they're
2 adults, for the most part. Yeah. There is no such
3 long-term study for children. But one would
4 predict, based on what's happening to adults, it
5 would be similar for children or worse.

6 CHAIRMAN ZACHARIAH: Hearing no other
7 questions from the board, Dr. Laidlaw, thank you so
8 much for coming from California and spending the
9 time with us on such a very important matter.

10 DR. LAIDLAW: Appreciate it. Thank you.

11 CHAIRMAN ZACHARIAH: I really appreciate
12 it.

13 Next is Dr. McNamara.

14 DR. MCNAMARA: Mr. Chairman and members of
15 the Florida Boards of Medicine and Osteopathic
16 Medicine, thank you all for your invitation to
17 testify today. My testimony addresses the board's
18 proposal to develop draft rule language related to
19 practice standards for the treatment of gender
20 dysphoria. I appreciate the opportunity to furnish
21 the public record with a truthful account of the
22 evidence regarding gender-affirming care. And I'm
23 honored to testify alongside Doctors Dayton and
24 Janssen whose expertise in gender-affirming care,
25 gender dysphoria, and gender expansive identity I

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1 hold in high regard.

2 Please note that my testimony just reflects
3 my professional judgement. It is not the official
4 position of my employer which is Yale University.

5 A bit about my qualifications. I'm a
6 board-certified adolescent medicine physician and
7 pediatrician with an MD and a master of science in
8 clinical research from Emory University, and I am an
9 assistant professor at the Yale School of Medicine.
10 I provide clinical care for youth aged 12 to 25,
11 which includes transgender and gender expansive
12 youth.

13 I join you from Connecticut to address
14 health policy matters in Florida because
15 misinformation about gender-affirming care poses a
16 threat to the wellbeing of youth everywhere, and the
17 use of misinformation to set legal standards will
18 degrade medical authority.

19 On June 2, 2022, the Florida Agency for
20 Healthcare Administration, the AHCA, issued a
21 purported scientific report, which I'll refer to as
22 the June 2nd report, concluding that standard
23 medical care for gender dysphoria does not meet
24 generally accepted medical standards and is
25 experimental. I'm concerned that the board may rely

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1 on this flawed report in crafting its own standard
2 of care for gender dysphoria.

3 I'm part of an interdisciplinary cohort of
4 subject matter experts who have performed the most
5 in-depth analysis of Florida's AHCA report to my
6 knowledge. My testimony today summarizes portions
7 of our analysis, but I urge the board to read our
8 report in its entirety and reject the conclusions
9 that the June 2nd report reaches.

10 To state the matter firmly and positively,
11 standard medical care for gender dysphoria does meet
12 generally accepted medical standards. It is not
13 experimental or investigational. Gender-affirming
14 care for youth is supported by every relevant major
15 medical organization, and this consensus is based on
16 a solid body of evidence with more than 16 studies
17 confirming that standard medical treatments for
18 gender dysphoria are safe and effective.

19 The deeply flawed June 2nd report was
20 commissioned by the state of Florida to provide
21 cover for the deprivation of healthcare of 9000
22 transgender Floridians who are insured by Medicaid.
23 The misinformation and flawed methodologies of this
24 report are grave. The report reaches an incorrect
25 conclusion based on the misuse of the scientific

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1 method and poor insight into the nuances of clinical
2 research. Its veneer hides the flawed analysis that
3 ignores the truth and relies instead on
4 pseudoscience particularly purported expert reports
5 that are biased, actually inexpert, and filled with
6 errors.

7 After a line-by-line examination of the
8 June 2nd report, including all 142 pages of its
9 contents and appendices, I testify today that its
10 conclusions are incorrect and scientifically
11 unfounded.

12 The lynchpin of the report is a so-called
13 systematic review that is deeply flawed and violates
14 basic standards of research integrity. Its design
15 and execution raise several red flags for bias.
16 Neither of the authors of the state's review was a
17 subject matter expert. One individual is a dentist,
18 the other is a post-doctoral fellow in
19 biostatistics. At a bare minimum, a systematic
20 review should be conducted by those who are
21 qualified to critically assess the literature. I
22 would trust a dermatologist's review of the
23 literature on a neurosurgical procedure, for
24 instance.

25 The authors also make no effort to engage

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1 with peers or subject matter experts, which violates
2 foundational aspects of the scientific method and
3 standards established by the National Academy of
4 Medicine for Systematic Reviews. And also, finally,
5 the authors uncritically assign equal weight to peer
6 reviewed studies and gray literature. I personally
7 vetted the gray literature sources included and
8 found them to be politically biased and from an
9 anti-transgender website.

10 Also, the state only examines an
11 arbitrarily truncated sample of the literature on
12 gender-affirming care sourcing only from 2020 to
13 early 2022. The authors don't justify this. This
14 also spans the worse public health emergency in a
15 century which likely stalled the production and
16 publication of non-COVID research.

17 Moving on, the state claims that the
18 absence of randomized control trials negates all
19 evidence for the benefits of gender-affirming care.
20 First, an RCT, or randomized control trial for
21 gender-affirming care would never pass an
22 institutional review board's safety or ethical
23 standards.

24 Second, if the board feels strongly that
25 RCTs offer the only acceptable evidence and that

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1 medical care not backed by RCTs should be
2 restricted, the board would have to consider banning
3 statins, mammography, insulin for diabetes,
4 penicillin, and some minimally invasive surgeries,
5 just to name a few. All of these types of medical
6 care derive their evidence base from robust
7 observational studies, not RCTs, and yet, there are
8 no calls to limit this care. This raises concerns
9 about the exceptionalist standards that gender-
10 affirming care are being held to.

11 The June 2nd report repeatedly and
12 erroneously dismisses solid studies and clinical
13 practice guidelines as "low quality." We've just
14 heard this. The misuse of technical language is
15 confusing to nonexperts. Low quality evidence is a
16 technical designation rather than terminology that
17 should be viewed in lay terms. Low quality evidence
18 does indeed inform strong recommendations for
19 clinical practice.

20 For instance, the Endocrine Society's
21 guidelines in obesity recommend that children
22 consume fruits and vegetables rather than sweetened
23 beverages such as juice. This is based on "low
24 quality evidence," but it's been adopted widely in
25 the counseling and treatment of pediatric obesity.

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1 Reye's Syndrome is a mysterious
2 neurodegenerative disorder that may be associated
3 with Aspirin in febrile children. Evidence strongly
4 recommends against Aspirin for the treatment of
5 pediatric fever, but this is low quality and yet,
6 resoundingly supported by the medical community. An
7 RCT in this case would be absolutely inappropriate.

8 The technical rating system that identifies
9 studies as high or low quality specifically states
10 that low quality studies can and do provide a sound
11 basis for clinical recommendations.

12 The June 2nd report also reiterates that
13 puberty blockers are used off-label for the
14 treatment of dysphoria -- or gender dysphoria, and
15 falsely supposes that this should prompt safety
16 concerns and tight regulation. Actually, off-label
17 use is so common in pediatrics that off-label drugs
18 are prescribed in 30 percent of patient visits. In
19 palliative care, neonatology, addition medicine,
20 psychiatry, gynecology, and general pediatrics,
21 off-label medication use is the cornerstone of
22 essential treatments.

23 In our report we review key examples
24 spanning from the use of steroids for croup,
25 ondansetron for nausea, vomiting, dehydration; birth

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1 control pills for heavy menstrual bleeding; and
2 sertraline for depression. The key message here is
3 that off-label does not equal off evidence. Again,
4 the exceptionally high burden of proof that gender-
5 affirming care faces is unfair in the context of
6 other accepted treatments that do not face such
7 scrutiny. Off-label use does not denote
8 experimental treatment but use of that term by the
9 state risks stoking public fear.

10 Throughout the June 2nd report, individual
11 studies are misused, misquoted, and distorted, and
12 the entire body of research that establishes the
13 benefits of gender-affirming care is seriously
14 mishandled. Leading researchers have come forward
15 to describe how the state of Florida
16 mischaracterized their work. They were not
17 contacted to verify that the state was correctly
18 summarizing the results of their research.

19 One study on the impact of gender-affirming
20 care is criticized because it did not have a control
21 group of youth without gender dysphoria. This is
22 ignorant to the norms of clinical research. Control
23 groups are not necessary to study the effect of an
24 intervention. Thousands of published studies have
25 advanced medical care with observational research

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1 protocols. I myself have performed statistical
2 analysis on and reviewed several observational
3 studies where the independent effect of an
4 intervention on an outcome was detected with a
5 single cohort of participants. Either the June 2nd
6 report's authors are not qualified to conduct such
7 an influential literature review, or their baseless
8 claims are purposeful.

9 Perhaps the most glaring, and repeated, and
10 troubling error in this report is the singling out
11 and thoughtless dissection of single studies rather
12 than engaging with the entire body of evidence. As
13 I said, at least 16 studies show that puberty
14 blockers and hormones benefit patients with gender
15 dysphoria, but none appear in the June 2nd report
16 and are treated fairly. This is likely an effective
17 way to dismiss consensus and throw fog up around the
18 issues at hand, but it should not and cannot guide
19 healthcare.

20 Before legal interference a year ago, the
21 United States was not out of step with practice in
22 other countries. No other country in the world has
23 prohibited the provision of gender-affirming care
24 for youth. Despite the picture painted by some, in
25 Sweden, Finland, the United Kingdom, Canada, and

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1 others, gender-affirming healthcare is available to
2 any adolescent whose clinician recommends it as long
3 as the required consents are obtained. I submit to
4 the board an amicus free from Stonewall U.K. et al.,
5 which details an accurate account of gender-
6 affirming care in other countries from those who
7 provide it.

8 In conclusion, I emphasize that standard
9 medical care for gender dysphoria does need
10 generally accepted medical standards and it is not
11 experimental or investigational. Nothing in the
12 state of Florida's June 2nd report calls into
13 question the solid medical evidence that underlies
14 consensus recommendations of WPATH, the Endocrine
15 Society, the AAP, and many others.

16 I urge the board to read out report, not
17 rely on the June 2nd, which is full of
18 misinformation and errors. And as physicians and
19 scientists, the members of the board can give the
20 June 2nd report the critical scrutiny it deserves
21 and make the right decision for Floridians. Thank
22 you so much for your time.

23 CHAIRMAN ZACHARIAH: Well, Dr. McNamara,
24 thank you for the very eloquent presentation.

25 Now, the board members, any question for

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1 Dr. McNamara?

2 I think Dr. Derick first and then

3 Dr. Hunter.

4 DR. DERICK: Certainly a percentage of
5 non-gender conforming children with gender dysphoria
6 will not have persistence and will be post pubertal
7 homosexuals. What is the way that these children
8 are identified in clinic in your clinical
9 experience?

10 DR. MCNAMARA: I heard you here and there,
11 in and out, so I'm going to repeat your question and
12 you'll tell me if I have it right. You're asking
13 about younger children who present with gender
14 dysphoria and you're asking about their chances of
15 persistence into their adolescent years?

16 DR. DERICK: What I'm asking is, there are
17 a certain percentage, which is debatable, of kids
18 who have nongender conforming behavior and have
19 gender dysphoria that does not persist.

20 DR. MCNAMARA: Yeah.

21 DR. DERICK: And so my question is what are
22 the discussions and what are the mechanisms to
23 determine these children? Because those children
24 might have a different course of action than
25 children who will ultimately have persistent gender

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1 dysphoria.

2 DR. MCNAMARA: Yeah. I mean, I think one
3 of the prevailing themes of all of our testimony
4 today is that it's highly individualized. These
5 children and their families meet with therapists,
6 with experts on gender dysphoria, a range of options
7 to help this child live authentically and
8 comfortably are offered. For prepubertal children
9 though this does not include medications of any
10 kind, and I really want to state that clearly. That
11 is stated emphatically in clinical practice
12 guidelines from WPATH and the Endocrine Society.

13 CHAIRMAN ZACHARIAH: I think Dr. Hunter, I
14 think you were next.

15 DR. HUNTER: This is going to be more of a
16 statement but then I would like Dr. McNamara to
17 comment. The concern seems to be with the June 2nd
18 report, and I just wanted to clarify that this -- my
19 reading of the June 2nd report, my understanding of
20 the June 2nd report, this is not a Florida report,
21 this is a report from McMaster University in Ottawa,
22 Canada, okay.

23 And I agree those people who wrote the
24 report are not physicians, they are not involved in
25 gender medicine, but they are experts in evidence

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1 reviewed. McMaster University being the home of the
2 term "evidence-based medicine." Gordan Guiette
3 coined that term, and these are all trainees of
4 Dr. Guiette. And I think there was some concern in
5 the literature that if evidence is not reviewed in a
6 systematic fashion and it is reviewed by people
7 heavily involved in the field that the conclusions
8 may in fact be biased.

9 So I don't think there's a bigger name in
10 evidence-based medicine than McMaster University and
11 the experts who reviewed the literature in this
12 area. I just wanted that clear and for the record,
13 and if Dr. McNamara would like to comment on that.

14 DR. MCNAMARA: I'm not sure if you'd like
15 me to comment but I really couldn't hear much of
16 what you said. I apologize if I've missed --

17 DR. HUNTER: Should I try to say it again?

18 DR. ACKERMAN: Yeah. Speak louder.

19 DR. HUNTER: I think to describe the
20 evidence reviewers as inexperienced and not qualified
21 when it's coming from McMaster University where the
22 term evidence-based medicine and they have an entire
23 program in reviewing the quality of evidence, I
24 think that's --

25 DR. MCNAMARA: I see. Yeah, I actually can

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1 respond to that if you would like, quickly. The
2 National Academy of Medicine stipulates that
3 systematic reviews must be conducted by people who
4 have specific clinical and research expertise in the
5 area at hand. The National Academy of Medicine,
6 about 10 to 15 years ago, I believe developed
7 standards (indiscernible), and those are viable by a
8 system used from outside of the United States in
9 this report.

10 CHAIRMAN ZACHARIAH: Next, Dr. Pages, and
11 Dr. David.

12 DR. PAGES: Can you hear me? So the first
13 gender clinic was established in 2007 in this
14 country, and now we see there are over, I believe
15 around 50 gender clinics. So my question to
16 Dr. McNamara, as an adolescent medicine expert, why
17 in your opinion are we seeing this significant
18 increase in gender dysphoria in children, especially
19 in the adolescent population?

20 DR. MCNAMARA: I have so much to say about
21 that and I really value this question. First of
22 all, we're not seeing much larger numbers. I think
23 that that has been blown out of proportion and
24 discourse, but if you look at the absolute numbers,
25 it's not exponential by any means. The fact of the

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1 matter is that we live in a more forgiving and
2 nurturing environment than we did 20 years ago for
3 gender expansive identities. I believe that there
4 are -- there are trans and nonbinary role models.
5 There are people that are trailblazing and showing
6 young people that it's safe to be who they are.
7 That's my simplest answer.

8 The data do not back up the social
9 contagion claim at all. If social contagion was
10 indeed driving these "spread" of gender dysphoria --
11 I really dislike even saying that -- the numbers of
12 young people identifying as trans or gender
13 expansive would be much higher. Another way to
14 think about it is this is a predominantly,
15 overwhelmingly cis gender society and young people
16 are far more exposed to cis gender social norms,
17 social contagion would work in the reverse if that
18 were the case.

19 So I appreciate this question, I appreciate
20 the opportunity to speak to it. I want to just
21 pushback substantively that we're seeing much larger
22 numbers and that represents a change. I think
23 merely young people feel safe to be who they are.

24 CHAIRMAN ZACHARIAH: Well, thank you.
25 Dr. Pages, one of the reports that I read said that

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1 in 2007 there was 1 and now in 2020 there's over 300
2 in the United States. That's what I read.

3 Dr. David.

4 DR. DIAMOND: Dr. McNamara, good morning.
5 Thank you for joining us from scenic New Haven,
6 Connecticut. I'd like to ask you the same question
7 as I asked Dr. Janssen, which is that our colleagues
8 in Europe, who I'm sure you would agree are of
9 goodwill, are trying to do the best for their
10 patients, clearly are not bigots. How do you
11 explain this obvious paradox that these individuals
12 who had been the leaders in a more permissive
13 approach to the treatment of minors with gender
14 dysphoria, how do you explain the paradox of their
15 institutions taking a more conservative approach
16 whilst we in the United States have moved to a more
17 permissive approach? How do you address that,
18 ma'am?

19 DR. MCNAMARA: I suppose that I disagree
20 with the assessment that international guidelines
21 are more conservative. In my experience, in my
22 professional collaborations across the country, I
23 have observed gender-affirming care being practiced
24 according to clinical practice guidelines. I don't
25 really see any substantive differences in other

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1 countries. And I do believe --

2 DR. DIAMOND: But Dr. McNamara, I must
3 interrupt you.

4 DR. MCNAMARA: -- put a thorough primer on
5 some of these issues.

6 DR. DIAMOND: Doctor, I must interrupt you
7 though. You just mentioned that you don't see any
8 substantive difference. However, we just heard
9 experts telling us that for example in NHS, going
10 forward, the use of some of the medical
11 interventions will be on a clinical trial, so I'm
12 not sure why you say there's no substantive
13 difference.

14 DR. MCNAMARA: That's a wonderful question.
15 Thank you for highlighting that. The word trial
16 does not appear at all in that document. They're
17 not proposing clinical trials, they're simply
18 proposing to gather data. So I think the
19 distinction between a trial and an observational
20 study is really important. There will be no
21 randomization to different types of treatment. And
22 also, those are bulleted guidelines. There's really
23 nothing specific in there yet. What they want to do
24 is gather evidence moving forward, just roll out
25 more perspective studies.

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1 DR. DIAMOND: Understood. And just as an
2 aside, in our August meeting, the one item that I
3 think everyone agreed upon is that there is a
4 pressing need for better data, so I could concur on
5 that. I would also like to ask you --

6 DR. MCNAMARA: Yeah. There's always a need
7 for better data. Sorry, I didn't mean to interrupt.

8 DR. DIAMOND: I'd also like to ask you at
9 Yale New Haven what are your policies of treatment
10 with respect to age cutoffs for referrals of
11 individuals for so-called bottom surgery and
12 so-called top surgery? Do you have any hard and
13 fast age cutoffs or is it an individualized
14 assessment?

15 DR. MCNAMARA: Individualized based on
16 pubertal stage which follows the WPATH and Endocrine
17 Society guidelines.

18 DR. DIAMOND: So for example, are patients
19 being referred at Yale New Haven at age 17 or 16 for
20 bottom surgery? I'm just curious.

21 DR. MCNAMARA: No.

22 DR. DIAMOND: What age would that be?

23 DR. MCNAMARA: I -- what do I think of
24 what?

25 DR. DIAMOND: What age would it be that --

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1 you seem to have a cutoff that you just put
2 discrimination for referrals, and I'm asking for
3 bottom surgery is it age 18? Is it age 17?

4 DR. MCNAMARA: So to be honest, it's so
5 rare. I've never referred a patient for bottom
6 surgery. I don't know of a recent case in which
7 it's been done here. I think what we're dealing
8 with is extremely rare cases in which that's done.
9 And to my knowledge, it has not been done under the
10 age of legal majority in my institution.

11 DR. DIAMOND: And I believe that's the
12 policy at University of Florida and other
13 institutions here in the state. What about for
14 so-called top surgery or mastectomy?

15 DR. MCNAMARA: The exact same thing. To be
16 honest, I've never referred a patient for a surgery.
17 I've never had a patient express that they desire
18 top surgery. And I've never had to explore that
19 because, again, it's quite rare.

20 DR. DIAMOND: I'm a little surprised
21 because --

22 DR. MCNAMARA: I think they're
23 (indiscernible) cases in the past year that have
24 been reported.

25 DR. DIAMOND: I'm a little surprised

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1 because I believe at some of our institutions, we
2 are seeing biologic females being referred at age 16
3 for a mastectomy. But that's not your experience,
4 ma'am; is that correct?

5 DR. MCNAMARA: No. It's not my experience.

6 DR. DIAMOND: Thank you.

7 DR. ACKERMAN: I have a question. Zach,
8 over here to your left.

9 CHAIRMAN ZACHARIAH: Yeah. Go ahead,
10 please.

11 DR. ACKERMAN: So I'm confused,
12 Dr. McNamara. You really are an advocate for
13 gender-affirming care and what I'm hearing from you
14 and other speakers is this is healthy for people,
15 it's healthy for mental health, it's healthy for
16 them in general. So why would you not refer a minor
17 for surgical sex affirming surgery?

18 DR. MCNAMARA: You know, I -- I also
19 appreciate this question because it lends insight
20 into the shared decision-making process. I've never
21 referred a patient for surgery because a patient has
22 never desired surgery who I've cared for. It's all
23 about what the patients want, how that fits into the
24 informed consent model, and how that is -- and how
25 that goes along with clinical practice guidelines.

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1 DR. ACKERMAN: I'm sorry, so what age group
2 are you seeing? I think up to 25 or something?

3 DR. MCNAMARA: 10 to 25.

4 DR. ACKERMAN: Yeah. So at no age has any
5 of your patients desired to have surgery for their
6 mastectomy, a phalloplasty, a phallectomy, none of
7 that?

8 DR. MCNAMARA: Right. None of my patients
9 have desired that surgery at that moment in time.
10 We discuss openly --

11 DR. ACKERMAN: So again, if gender-
12 affirming care is what's proper, why have you not
13 recommended that surgery?

14 DR. MCNAMARA: I don't -- I think what --
15 what I'm trying to say is that I haven't recommended
16 that surgery, I haven't helped facilitate it because
17 none of my patients have expressed a desire for it.
18 That's my --

19 DR. ACKERMAN: Right. So I'm an
20 oncologist. Patients don't come to me requesting
21 desire for chemotherapy, but I recommend
22 chemotherapy because that's what's best for them.
23 So as a physician, if you think that gender-
24 affirming care is best for your patients why have
25 you not recommended surgery on any of your patients?

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1 DR. MCNAMARA: Gender-affirming care does
2 not equal surgery.

3 DR. ACKERMAN: I understand. There's a
4 continuum --

5 DR. MCNAMARA: You know, I think they're a
6 little bit different.

7 UNIDENTIFIED SPEAKER: That behavior is
8 inappropriate, please.

9 CHAIRMAN ZACHARIAH: We need to have some
10 quorum here, so we would appreciate it if you do not
11 do those actions at this point in time. Let's have
12 an intelligent and cohesive conversation, please.

13 DR. ACKERMAN: Dr. McNamara, I understand
14 there's a continuum of puberty blockers, sex
15 hormones to change the sex, and surgery. And what
16 we've heard from all the other experts is that
17 there's this whole continuum is part of gender-
18 affirming healthcare. So do you think that the
19 surgery is part of gender-affirming healthcare or
20 not?

21 DR. MCNAMARA: I do think it's part of
22 gender-affirming healthcare for some individuals.

23 DR. ACKERMAN: Okay. So but you don't
24 recommend it to anybody is what you just said?

25 DR. MCNAMARA: That is not an appropriate

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1 characterization of what I said. I have not had a
2 patient who has expressed a desire for it in my
3 experience.

4 DR. ACKERMAN: Again, they may not express
5 the desire but you as a physician make
6 recommendations to patients based on what you think
7 is best for their overall care. So you have never
8 made the recommendation? Just want to get that on
9 the record. Did you hear me?

10 DR. MCNAMARA: Yeah, I have. I can hear
11 you.

12 DR. ACKERMAN: So are you going to answer
13 my question or just not?

14 DR. MCNAMARA: Oh, I'm sorry. Did you ask
15 another question? I promise I can only hear about
16 50 percent of what you're saying.

17 DR. ACKERMAN: So my question was, have you
18 ever -- you know, as a physician, we recommend
19 treatment to patients based on our judgement of
20 what's best for their care. And so in the continuum
21 of gender-affirming healthcare, surgery is part of
22 that.

23 DR. MCNAMARA: Yeah.

24 DR. ACKERMAN: And so I'm asking you have
25 you ever recommended surgery to your patients?

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1 DR. MCNAMARA: I don't tell anybody, "You
2 need surgery. You should get surgery." That's not
3 how gender-affirming care works. Physicians don't
4 tell patients what they should do with their bodies
5 or their gender expression.

6 DR. ACKERMAN: I understand. Again, as an
7 oncologist, I give my recommendation as to what they
8 need. So again, just answer the question yes or no.
9 Have you ever recommended surgery for your patients?

10 DR. MCNAMARA: I have -- I wonder if maybe
11 we're disagreeing on the definition of
12 recommendation.

13 DR. ACKERMAN: Okay. I'm done. Thank you.

14 DR. MCNAMARA: Is there a --

15 CHAIRMAN ZACHARIAH: Dr. McNamara, I have
16 one question. Just one question that as a board
17 member. My only question is that if tomorrow a
18 patient comes to your office and that person says he
19 or she believes that they need a top or bottom
20 surgery, would you recommend the surgery? The
21 patient really wants the surgery done. He or she
22 believes that they must have the surgery done.
23 Would you recommend the surgery, yes or no?

24 DR. MCNAMARA: At what stage of the
25 patient's care are we in?

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1 CHAIRMAN ZACHARIAH: What's that?

2 DR. MCNAMARA: At what stage are we at in
3 this patient's care?

4 CHAIRMAN ZACHARIAH: No. The patients that
5 you see for gender dysphoria. If the patient comes
6 to you and the patient believes that he or she needs
7 the surgery, would you recommend surgery? Please
8 answer yes or no.

9 DR. MCNAMARA: I can't do that. How old is
10 this patient?

11 CHAIRMAN ZACHARIAH: Let's say 17.

12 DR. MCNAMARA: 17, okay. And how long has
13 this patient been in my care for?

14 CHAIRMAN ZACHARIAH: Well, I didn't talk to
15 the patient. Let's assume the patient had it for
16 several years and now the patient believes that he
17 or she must have the surgery.

18 DR. MCNAMARA: Must have the surgery.

19 CHAIRMAN ZACHARIAH: Yes.

20 DR. MCNAMARA: And what kind of surgery are
21 we talking about specifically?

22 CHAIRMAN ZACHARIAH: Either the top or the
23 bottom surgery.

24 DR. MCNAMARA: Either surgery, okay. So if
25 a patient came to me after they had been in my care

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1 for several years and they expressed a strong desire
2 for a gender-affirming surgery and they were 17, the
3 WPATH guidelines state that this patient should be
4 referred for an informed consent discussion with a
5 qualified surgeon who can discuss the risks and the
6 benefits of that surgery with them. I would
7 facilitate that referral and refer that person to an
8 expert in the surgery that they desire.

9 CHAIRMAN ZACHARIAH: You would recommend
10 the surgery?

11 DR. MCNAMARA: I would allow the surgeon to
12 discuss the options, the risks, and the benefits,
13 because that is not my specific area of expertise as
14 somebody who does not practice any surgery.

15 CHAIRMAN ZACHARIAH: Thank you,
16 Dr. McNamara. Next is Dr. Pages and Dr. David.

17 DR. PAGES: I have another question for
18 you, Dr. McNamara. Can you please walk us through
19 the assessment that gets done in your clinic when a
20 patient presents with issues on possible gender
21 dysphoria before they get referred to an
22 endocrinologist for further treatment?

23 DR. MCNAMARA: I'm actually wondering if I
24 could refer that question to Dr. Dayton who is an
25 endocrinologist who practices in your state? I feel

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1 like she would be the more appropriate person to
2 answer.

3 DR. PAGES: No, but I'm sorry. I want your
4 opinion as an adolescent medicine expert, because
5 when they get to the endocrinologist they are
6 already affirmed. Am I correct?

7 DR. MCNAMARA: Say that again.

8 DR. PAGES: I want your opinion as an
9 adolescent medicine expert because they go to see
10 you or a psychologist before. Once they get to the
11 endocrinologist, they usually go there for
12 treatment, so they're pretty much affirmed when they
13 get there.

14 DR. MCNAMARA: I don't think that that's
15 true. I apologize this is so hard, I can hear about
16 50 percent of what you're saying again and very
17 limited. It's not quite a yes or no because --

18 DR. PAGES: I'm sorry?

19 DR. MCNAMARA: -- we all follow the same
20 guidelines.

21 DR. PAGES: I was just curious about what's
22 the assessment done in your clinic before they get
23 referred to an endocrinologist? You as an
24 adolescent medicine patient. You see a teenage girl
25 that is going through issues with sexual identity,

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1 gender dysphoria. How do you approach these
2 patients? Who do you send them to when you come to
3 see you, referred by their pediatrician?

4 DR. MCNAMARA: I believe what you're asking
5 is how do we approach these patients in their
6 adolescent years. We approach them initially with
7 an interdisciplinary team. So for all intents and
8 purposes, in the provision of gender-affirming care,
9 Dr. Dayton, for instance, and I, practice the exact
10 same type of clinical care. She is an
11 endocrinologist, I am an adolescent medicine
12 specialist. We're both physicians. We're both
13 totally capable of providing this care in the same
14 way. And Dr. Dayton is able to provide youth
15 friendly, developmentally appropriate care for
16 adolescents. The initial approach is just with a
17 team of supportive clinicians. They work with
18 psychiatry, psychology, social work, and others as
19 we've discussed.

20 DR. PAGES: So how long does a patient get
21 seen by a psychologist, psychiatrist before they
22 move forward is my question? How in depth is this
23 evaluation of an adolescent? Especially females,
24 we're seeing more in the female population that are
25 having this issue before they move to

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1 endocrinologist. Because a lot of the times they go
2 to the endocrinologist and these kids are already
3 affirmed by somebody. So who is doing the
4 affirmation of these children is my question?

5 DR. MCNAMARA: It's all individualized. It
6 truly depends on the individual. It does take quite
7 some time for people to move from the initial
8 assessment, the first visit, to any sort of
9 medication, things along those lines. But people
10 are ready for different things at different stages
11 in their life and their journey. It's a really
12 tough question to answer with an absolute. It's
13 impossible, actually.

14 CHAIRMAN ZACHARIAH: And Dr. David, you
15 will ask the last question because we've been going
16 on for 40 minutes.

17 DR. DIAMOND: Thanks. Dr. McNamara, we are
18 regulators. That's why we're trying to ask some of
19 these questions. Cases come in front of us. We see
20 terrible things happening every day. So when we're
21 asking some of these questions it's because this is
22 what's going to come in front of us. I think what
23 Dr. Ackerman was trying to get a sense of was how do
24 we respond when we see cases of 14- or 15-year-old
25 biologic females having mastectomies? Is that in

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1 the public interest of the great state of Florida,
2 or is it not? That's what we're really trying to
3 get at. We're asking for your help.

4 So for example, as a -- I'm asking your
5 personal opinion now. At age, let's say 15, is it
6 an appropriate consideration in your professional
7 experience that mastectomy be a consideration for an
8 individual whom, in your opinion, has gone through
9 all of the requisite antecedent steps?

10 DR. MCNAMARA: I'm wondering if I could
11 give this question to Dr. Janssen, one of our
12 additional experts who is really, truly an expert on
13 that process?

14 CHAIRMAN ZACHARIAH: David, if she cannot
15 answer the question, I need to stop the meeting and
16 take a 10-minute adjournment.

17 DR. DIAMOND: Yes, sir.

18 CHAIRMAN ZACHARIAH: Let the meeting
19 adjourn for the next 10 minutes. Thank you so much,
20 Doctor.

21 (Recess taken)

22 CHAIRMAN ZACHARIAH: Can we get started?
23 Okay. Let's get started. At this time we will have
24 some discussion about what will happen to the rule
25 language. Can we all have some attention? Can you

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1 please stop talking in the back if you don't mind.

2 Hello? Okay. Let's start the discussion about the
3 rules, board members.

4 Dr. Diamond, do you want to start? Just
5 kidding.

6 DR. DIAMOND: I believe Romanello had some
7 comments.

8 MR. ROMANELLO: So Mr. Chair, let me start
9 the discussion on the development of a potential
10 rule.

11 Am I on?

12 Mr. Chair, let me start the discussion with
13 the development of a potential rule by reminding the
14 board that we historically have prescribed and
15 regulated standards of care. In fact, one of the
16 rules in the Florida Administrative Code that this
17 board submits rules to is chapter 64B8-9, which is
18 entitled, "The Standards of Practice of Medicine."
19 And in that chapter, this board -- and there's a
20 parallel rule for our osteopathic physicians.

21 That rule historically has created
22 registries and standards for such practice areas as
23 prescription drugs to treat obesity, office surgery
24 standards, opioid dispensing and prescription,
25 electrolysis, use of laser and light-based devices,

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1 medical marijuana, including a consent form. And by
2 extension, this board regulates the standard of care
3 of a physician when they are supervising a PA or an
4 anesthesia assistant. And most recently, we took up
5 the issue of the Brazilian butt lifts. So we have a
6 -- and Mr. Tellechea, who has been board counsel for
7 a long time, could probably think of other areas
8 where the board has weighed in on standard of care
9 issues.

10 So this morning, it was certainly helpful
11 to hear from the subject matter experts, as well as
12 to review the materials in the portal that we were
13 provided, and to hear the questions of my much more
14 learned colleagues.

15 Mr. Chair, I believe that based upon the
16 testimony that we heard this morning and the
17 materials in the portal that the risks of puberty
18 suppressing therapies, cross hormonal therapy, and
19 surgery, those risks outweigh the possible benefits
20 and that there is a lack of consistent, reliable,
21 scientific peer-reviewed evidence concerning the
22 efficacy and safety of such treatment.

23 And with that in mind, for discussion
24 purposes, I would propose a rule that would prohibit
25 such therapies. And again, I'm talking about

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1 puberty blocking therapies, such as GRH, and I'll
2 look to my colleagues to better define what that
3 looks like, as well as kind of cross hormonal
4 therapies and surgery to treat gender-affirming care
5 or gender dysphoria for patients under the
6 chronological age of 18.

7 CHAIRMAN ZACHARIAH: Do you make this in
8 the form of a motion?

9 MR. ROMANELLO: I do.

10 CHAIRMAN ZACHARIAH: Well, we have a motion
11 on the floor. Do I hear a second?

12 DR. ACKERMAN: I'll second that.

13 CHAIRMAN ZACHARIAH: There is a motion and
14 a second. Is there any further discussion regarding
15 that?

16 DR. ACKERMAN: Yes. I think we --

17 CHAIRMAN ZACHARIAH: Yeah, go ahead.

18 DR. ACKERMAN: I think we should have some
19 further discussion regarding that. I think there's
20 more to it. It was a simple motion. I assume
21 Mr. Romanello put that motion in a fairly simple way
22 right now, so we can discuss this, but I think that
23 there's more to it than that that we need to get
24 through and regarding young Floridians that are
25 already in the process, regarding children that

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1 might have other disorders in where those
2 medications would be appropriate in children that
3 have genetic chromosomal aberrations that need to be
4 addressed.

5 So I just want to -- I don't know how to --
6 I don't want to necessarily incorporate that into
7 the motion but I'm just putting that out there as a
8 point of information and I'm looking for some
9 guidance of how we encompass that in there, as well.

10 DR. DIAMOND: Dr. Ackerman, I think what
11 you're saying is that this is specifically limited
12 to individuals with gender dysphoria. It has no
13 application to individuals with disorders of sexual
14 development. Is that correct?

15 DR. ACKERMAN: That's part of, Dr. Diamond.
16 I think there's some other medical disorders where
17 these children would benefit from some of these
18 drugs. I just would want to make sure that we flush
19 through that and make those drugs still available
20 for the --

21 DR. DIAMOND: Precocious puberty, for
22 example.

23 DR. ACKERMAN: Exactly. Exactly.

24 MR. ROMANELLO: So to that point,
25 Dr. Ackerman and Dr. Diamond, right, the motion I

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1 had talked specifically about the treatment of
2 gender affirmation care or gender dysphoria.
3 Certainly open to expanding that or contracting it
4 and creating -- you know, and I would look to add.
5 I mean, if it's pretty --

6 DR. ACKERMAN: I guess my input is just I
7 want to make it clear that that's what it's for and
8 that these drugs remain available for those that
9 need it that have other disorders. And just saying
10 that in there as part of the motion is a healthy
11 thing to do.

12 MR. ROMANELLO: Yeah.

13 CHAIRMAN ZACHARIAH: See, we have a motion
14 on the floor but we're not going to vote on it until
15 we have full discussion by the board --

16 DR. ACKERMAN: By the board or by the
17 committee?

18 CHAIRMAN ZACHARIAH: By this committee --
19 with this committee. And we can have some public
20 hearing before we actually vote on the issue. But
21 right now, I just wanted to make sure we had a
22 motion, and we can hear from the rest of the board
23 members. Then I will have to allow the public to
24 speak on either side of the issue and then we can
25 vote on the issue.

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1 Other board members?

2 Dr. Hunter.

3 DR. HUNTER: I think we should -- and I'm
4 not sure how this would be done but to include that
5 the standard of care would involve availability of
6 psychotherapy to address the gender dysphoria,
7 distress associated with gender dysphoria, and as
8 we've learned, any other comorbid mental health
9 issues, anxiety, depression.

10 Also, there's -- that I don't believe was
11 brought up, the concern about the high rate of
12 children with neurodevelopmental disorders, such as
13 autism, and ADHD, and others, that are involved in
14 this, that those also have to be addressed. That
15 this isn't just a moratorium but that this is -- the
16 standard involves psychotherapy.

17 DR. DERICK: I'll --

18 CHAIRMAN ZACHARIAH: Yeah, please.

19 MS. JUSTICE: I'll try to say I have some
20 hesitation. I just -- I haven't heard enough about,
21 from my perspective, perhaps the unintended
22 consequences of pulling the guidance around this
23 treatment out from the medical community and into
24 this realm. Not to say that we are not part of that
25 community, right. But I just want to make sure that

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1 we're thinking about potential unintended
2 consequences for the population that would be served
3 by this treatment. In particular, mental health as
4 we've heard from many of the experts today.

5 I recognize from the work that I do that
6 that is a service that is in dire shortage. And so
7 I do think we have an obligation to consider
8 potentially the unintended consequences of any work
9 that we might do here, and consider buffers for
10 that, however that might go. I don't know.

11 UNIDENTIFIED SPEAKER: You folks are the
12 physicians. I think that's something that you're
13 going to have to consider and address through your
14 motions.

15 CHAIRMAN ZACHARIAH: Dr. Diamond.

16 DR. DIAMOND: So Mr. Romanello, to help
17 develop this it's your intent that this motion is
18 limited to individuals with gender dysphoria, and
19 specifically excludes individuals with disorders of
20 sexual development and other types of medical issues
21 as Dr. Ackerman referenced.

22 The second point would be, with your
23 motion, is your intent that once this rule may be in
24 effect, would it take -- would it have jurisdiction
25 over all persons? Would it have jurisdiction only

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1 over those individuals who have not yet begun
2 treatment? Obviously, if a person is currently
3 under hormonal therapy, that is an important item to
4 consider.

5 MR. ROMANELLO: A potential unintended
6 consequence that Ms. Justice had raised and aware
7 of. Yes. So, you know, the answer to your first
8 question is yes. It would exclude, my proposal or
9 my thoughts would be to exclude those conditions
10 that Dr. Ackerman had first spoke about. And
11 certainly welcome the remainder of the board to add
12 other conditions that would be excluded from the
13 rule.

14 The second point, Dr. Diamond, is, you
15 know, my rule would be a prospective rule to take
16 effect, and I would look to board counsel to help on
17 a prospective start date. And then recognize,
18 though, that a potential consequence of a
19 prospective rule would be that it would have an
20 impact on minors who are currently somewhere in the
21 continuum of care that we talked about earlier
22 today.

23 And so for those patients I would propose
24 that we continue that care but that we -- to ensure
25 kind of the safety and ensure an educated and

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1 well-informed patient that we enhance the consent
2 process for those sorts of therapies. Very similar
3 to the way that this board in the past has created
4 specific consent forms for the use of and dispensary
5 of medical marijuana. And so with respect to a
6 potential consent, I would, again, for the board's
7 consideration -- three, I think significant portions
8 of the consent. Again, very similar to what we did
9 with marijuana.

10 So the first, I think is that we need to
11 create some sort of a multispecialty type of
12 consent. We heard the witnesses today, specifically
13 Doctors Dayton and McNamara, agree to a
14 multidisciplinary approach when treating patients
15 seeking gender-affirming or dysphoria type of
16 treatment. So a multidisciplinary consent to
17 include, you know, concurrence from pediatrics,
18 endocrinology, psychiatry. And even I heard, you
19 know, about social workers, licensed clinical social
20 workers, for the importance of ensuring that
21 patients who go through this treatment to have
22 adequate support during the treatment and following
23 the treatment. So I think that's the first thing
24 that I would propose that we consider in creating a
25 consent.

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1 The second, similar to marijuana, would be
2 highlighting and specifically documenting the
3 patient's or the family's attempt with alternative
4 treatments for gender dysphoria, or gender
5 affirmation. You know, counseling -- and again, I
6 don't know what's at the very beginning of the
7 continuum, but before we get to puberty blockers and
8 such, were there other alternative treatment options
9 considered?

10 And then finally, a section where we would
11 specifically require the identification of risks
12 associated with such treatment. You know, the
13 irreversibility or the permanency of, you know,
14 surgery, the effects of puberty blockers. And
15 again, I would look to my colleagues to weigh in on
16 what the appropriate list of risks are. But it
17 would seem that for the protection of patients, and
18 for patients, minor patients and their parents or
19 guardians to be fully and knowingly informed, that
20 they would have that list of risks presented to them
21 at the time of treatment.

22 CHAIRMAN ZACHARIAH: Other board members?

23 DR. SCHWEMMER: Dr. Zachariah?

24 CHAIRMAN ZACHARIAH: Go ahead, Sandra.

25 DR. SCHWEMMER: Mr. Romanello, you talk

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1 about a consent but yet, we're talking -- who would
2 be signing this consent?

3 MR. ROMANELLO: Yeah. So the parents or
4 guardian of the minor patient.

5 CHAIRMAN ZACHARIAH: Any other comments
6 from the board?

7 DR. DIAMOND: So again, Mr. Romanello, if I
8 understand you correctly you are proposing a
9 prospective rule and as an interim measure, are you
10 stating that individuals currently receiving this
11 therapy should receive this enhanced education and
12 asked to go through an enhanced consent process? Am
13 I understanding that correctly?

14 MR. ROMANELLO: Yes.

15 DR. DIAMOND: So if I understand correctly,
16 if this rule were promulgated, there would be some
17 time window that individuals who are currently
18 receiving care would be asked and required to go
19 through this enhanced consent process in order to be
20 able to continue on this treatment; is that correct?

21 MR. ROMANELLO: Yes.

22 DR. DIAMOND: Thank you.

23 DR. ACKERMAN: So this is the end of
24 October. If we put this rule forth at this
25 committee, it then goes to the Board of Medicine and

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1 the Board of Osteopathic Medicine for their next
2 meetings, which is not next week's meeting -- is it
3 next week's meeting that we're talking about? The
4 joint meeting. So it would go to that meeting next
5 week and then that joint committee can then decide
6 when it would go into effect. Whether it would go
7 in effect immediately, or 1st of the year, or 1st of
8 December, or what. We would discuss that I guess
9 next week.

10 MR. ROMANELLO: So can I just -- so
11 Mr. Tellechea, if there's a rule that's acted upon
12 today, procedurally, it would go to the Joint
13 Committee next week and then to each respective
14 board at their next regular meeting? Or does it
15 just stop at the joint meeting?

16 EXECUTIVE DIRECTOR TELLECHEA: Well, is it
17 going to be the full board that's going to be
18 meeting jointly?

19 UNIDENTIFIED SPEAKER: Yes, Ed.

20 DR. ACKERMAN: Yes. Next Friday.

21 EXECUTIVE DIRECTOR TELLECHEA: Then if it's
22 the full board that are meeting jointly, both of the
23 full boards, then that could be the final stop if
24 necessary.

25 CHAIRMAN ZACHARIAH: Does any of the other

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1 board members want to make any comments before I
2 allow the public hearing?

3 DR. DI PIETRO: So just to touch on what I
4 mentioned earlier, I'm in full support of a
5 multidisciplinary team. I think that's of the
6 utmost importance in this to have a mental health
7 counselor, a board-certified pediatric
8 endocrinologist, a board-certified pediatrician --
9 not a nurse practitioner -- a board-certified
10 physician, and part of a multidisciplinary team to
11 ensure that we're doing this correctly.

12 Because it's very easy a lot of times, and
13 I'll use an emotional support animal as a perfect
14 example, to get a letter from someone stating that
15 you need something. And I think the -- for the
16 safety and welfare of these children who very well
17 might need this, it is extremely important to have
18 that multidisciplinary team to make sure that the
19 pediatric endocrinologist is the one who is
20 assisting with hormones, and that the social worker
21 or the psychologist is making sure that there's a
22 support system in place for these children.

23 But I do have a question. So if we're
24 talking about this and the informed consent, sorry,
25 this is for over the age of 18?

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1 MR. ROMANELLO: No. Under the age of 18.

2 DR. DI PIETRO: Okay. That's where I was a
3 little confused. So we're talking this informed
4 consent process with this multidisciplinary team
5 approach for under the age of 18, correct?

6 MR. ROMANELLO: Yes.

7 DR. DI PIETRO: Okay.

8 CHAIRMAN ZACHARIAH: Dr. Hunter.

9 DR. HUNTER: If this -- where this
10 discussion is going, and I'm hearing what
11 Ms. Justice had to say about there is not -- there's
12 a concern about access to mental healthcare and I
13 think mental healthcare should be part of the
14 standard of care. I'm not sure what the role the
15 board has in this area, but we've heard that the
16 research is very conflicted in this area, very low
17 quality. Would a board rule need to include the
18 option of research in this area where these could be
19 used in IRB protocols, IRB approved protocols,
20 research protocols, what England, and Finland, and
21 Sweden have in plan with the appropriate safety and
22 ethical oversight?

23 DR. DIAMOND: Dr. Hunter, are you referring
24 to psychologic care, or are you talking about
25 hormonal care? Please be more specific.

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1 DR. HUNTER: I would be talking about all
2 of that. Yes.

3 DR. DIAMOND: So if I understand you
4 correctly, you would prefer to have a rule in place
5 that outside of participation in a clinical study,
6 these actions that Mr. Romanello enunciated would be
7 prohibited, but you would be willing to entertain
8 them on a clinical study that meets certain
9 specifications? Ala, the National Health Service
10 approach?

11 DR. HUNTER: Yes. Yes. With certainty of
12 safety and ethical oversight.

13 CHAIRMAN ZACHARIAH: Dr. Amy.

14 DR. DERICK: Yeah. I feel I would be
15 supportive of that, too, in order to continue
16 investigating the science.

17 DR. DIAMOND: Dr. Hunter, could you give us
18 a little bit more of your sense as to the mechanics
19 of these studies? Would this have to be an IRB
20 approved study? Would it be limited to a university
21 setting? Could it be in the office setting? What
22 is your -- do you have any sense on this?

23 DR. HUNTER: No doubt it would have to be
24 IRB approved, no doubt. And that hopefully would
25 provide the safety and ethical oversight. I think

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1 I'd prefer it being a center, like a university, a
2 Florida based medical school. I would be even more
3 grateful if it involved international experts,
4 Dr. Cass and the NHS, and Dr. Kaltiala in Finland.
5 And the partner in a way like that, so we do get
6 good quality data, so we know what's the best thing
7 for these kids.

8 DR. DIAMOND: And so Dr. Hunter, again, I'm
9 trying to understand, you're proposing that there
10 would be an allowance that minors who have given
11 appropriate -- whose parents have given appropriate
12 consent, and the child of course given assent, that
13 there would be a mechanism for clinical trials to be
14 conducted, ideally in the university setting, both
15 with GRH agonist and with cross-sex hormones?

16 DR. HUNTER: No.

17 DR. DIAMOND: So please revise.

18 DR. HUNTER: That I think is to be
19 determined, and I think that's what the NHS guidance
20 is saying, that they are writing those now. So to
21 be -- I think we cannot be that specific at this
22 point.

23 DR. DIAMOND: So therefore, you would be
24 supportive of a rule but include in that rule an
25 exception that there could be a carve out for

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1 appropriate research studies and not be more
2 specific than that. Is that correct?

3 DR. HUNTER: Correct.

4 UNIDENTIFIED SPEAKER: So IRB approved --

5 EXECUTIVE DIRECTOR TELLECHEA: So this is
6 something that's going -- this is a whole new area
7 that you folks are entering into within the context
8 of a standard of care rule, and it's going to have
9 to be specific. You cannot be -- just provide these
10 generalized terms for an IRB approved study in a
11 university setting.

12 DR. DIAMOND: I agree with that. Because,
13 Dr. Hunter, I understand what your intent is is to
14 have flexibility to help further scientific research
15 but it's going to make Ed's job impossible. It
16 won't be -- there's going to be no way to enforce
17 these provisions and it will lead to a lot of
18 confusion.

19 EXECUTIVE DIRECTOR TELLECHEA: Yeah. I
20 mean, it's something that's going to have to be
21 clear, understandable, defensible, and it has to be
22 written by next Friday.

23 ATTORNEY MCNULTY: Can I interject? Just
24 one other option that I was thinking of as you were
25 making this presentation and listening to this

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1 discussion is the opportunity for maybe a registry,
2 a Florida registry, which the state has done in
3 other situations. And it would allow then for, you
4 know, the families to optionally enter into a
5 registry. You know, that could be a potential. But
6 then the information about that individual and the
7 therapies could be captured. And it could be -- you
8 know, you could start a registry that could monitor
9 and give data back to the boards to be able to have
10 our specific Florida data to be able to review.

11 EXECUTIVE DIRECTOR TELLECHEA: I think the
12 problem with that, that that goes beyond the
13 standard of care rule.

14 ATTORNEY MCNULTY: Okay.

15 EXECUTIVE DIRECTOR TELLECHEA: So I don't
16 really think you would have the authority to create
17 that registry and to be able to enforce it and all
18 that through the standard of care practice. I think
19 that would be something that you would need to go to
20 the legislature and ask the legislature to create.

21 ATTORNEY MCNULTY: Yeah. My thoughts
22 around that were that, you know, certainly as we've
23 heard with, you know, the testimonies this morning,
24 the patient specific therapies would -- you know, it
25 gives more of a general umbrella, I suppose, to

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1 reporting on those case specific treatments, so --
2 and variation of age. You know, I still think that
3 registries are very helpful. You know, so are -- of
4 course, so are the studies, but when you have small
5 participation in those studies. We know we're going
6 to have a small participation in the registries, and
7 so, you know, the conclusions may not be as direct
8 in a registry as one would conclude in a study with
9 an IRB, but I still think it opens an opportunity to
10 be able to monitor this ongoing situation,
11 therapies. Anyway --

12 CHAIRMAN ZACHARIAH: Any other comments
13 from the board?

14 DR. ACKERMAN: I just want to make sure
15 we're all on the same page here, or I understand
16 what we're talking about here. Mr. Romanello
17 proposed a rule which was seconded by me. Now I'm
18 hearing discussion about a registry and is this
19 registry a loophole to avoid the rule, or is this
20 registry for those individuals that are already in
21 care?

22 ATTORNEY MCNULTY: Collecting data.

23 DR. ACKERMAN: Collecting data on who? I
24 mean --

25 ATTORNEY MCNULTY: Those individuals who

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1 are already in care.

2 DR. ACKERMAN: I'm sorry, if we're having a
3 rule, the rule is the rule, and you can't go around
4 the rule by having a registry.

5 ATTORNEY MCNULTY: And Dr. Ackerman, my
6 comments were only within the discussion of what we
7 were talking about with IRB. My thoughts were about
8 a registry, but I agree.

9 CHAIRMAN ZACHARIAH: See my concern with a
10 registry is you can form all the registries you
11 want, nobody is going to enroll. Why would you do
12 it? What is in it for you? So you can get your
13 records public. Nobody is going to register in the
14 registry, it's not going to happen.

15 DR. ACKERMAN: Well, they're anatomized.

16 CHAIRMAN ZACHARIAH: Yeah.

17 DR. ACKERMAN: No, you would. A lot of my
18 patients are in registry trials. It's all
19 anatomized. They don't -- the records aren't
20 public.

21 CHAIRMAN ZACHARIAH: I agree but, you know,
22 treatment for a cancer, treatment for a heart
23 disease is slightly different than what we're
24 dealing with.

25 MR. ROMANELLO: So, Mr. Tellechea, so we

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1 can make your job a little harder, right. So I
2 think what you're hearing from the board though is
3 kind of a coalescing around the idea of excluding
4 from the rule clinical trials. Like IRB approved,
5 academically sponsored. I don't know, I would look
6 to Doctors Diamond, and Hunter, and Ackerman, and
7 others to weigh in on how to define that. But we
8 certainly don't want to impair progress. We want to
9 promote the continued research in this area for the
10 betterment of all patients. So how could be
11 accomplish that? I mean, I wouldn't want a rule
12 then to inhibit or chill clinical research.

13 EXECUTIVE DIRECTOR TELLECHEA: Well, you
14 would write it in such a way that, as you stated
15 earlier from the outset is that the current
16 procedures are prohibited unless it is done under a
17 -- you know, these particular circumstances. And
18 I'm going to need from you, you know, clinical
19 trials, you know, what type of language you would
20 put in there to make it clear that these are the
21 type of clinical -- that under these circumstances,
22 that it would be approved. So it's a prohibition
23 except for under these circumstances, and then you
24 would have to outline what the particular
25 circumstances are, in a clear, you know, enforceable

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1 manner.

2 DR. ACKERMAN: And I think it's difficult
3 to craft the language to allow for clinical trials,
4 and I think it could easily be gamed.

5 DR. DIAMOND: Dr. Hunter, how would you
6 respond to Dr. Ackerman's comment on that?

7 DR. HUNTER: I probably would agree with
8 that but I -- we need to learn more in this area.
9 We need to learn more.

10 DR. DIAMOND: So I think where we stand
11 right now is there's a sense that if promulgate a
12 rule, it should be a prospective rule. Number two,
13 that those individuals who are currently receiving
14 therapy, that those individuals be required to go
15 through a process of more robust consent as was
16 discussed. And then number three, that the rule, if
17 we were to go and set a chronologic age of 18 for
18 these different points of bifurcation, GHRH agonist,
19 cross sex hormones, and surgical procedures, that
20 there be an opportunity for exceptions to be made in
21 the limited context of robust clinical studies
22 conducted at the appropriate centers. Those are the
23 different elements I'm trying to help synthesize
24 here. Is that the sense of where we stand right
25 now?

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1 DR. ACKERMAN: I think it is but the last
2 thing you said is the difficult thing to define what
3 a robust clinical study is and define what those
4 appropriate centers are. That's my reservation
5 about that. And there's -- not to --

6 ATTORNEY MCNULTY: Where are they normally
7 done?

8 DR. ACKERMAN: Well, I guess other rules
9 that we have, we keep -- those rules are for
10 Florida, and people may do things contrary to those
11 rules in other states.

12 EXECUTIVE DIRECTOR TELLECHEA: Well, you
13 only have jurisdiction in Florida, okay, so --

14 DR. ACKERMAN: I understand. I know but my
15 point -- that's what I'm saying. We have
16 jurisdiction in Florida but if we have a rule here
17 and people do research in another state, similar to
18 the fat transplant to the butt, if they do some
19 research in the state that shows that our rule is
20 not appropriate, then we change our rule. And so
21 people can do research, just not in Florida.

22 ATTORNEY MCNULTY: So we would want them
23 done in university centers?

24 DR. ACKERMAN: No. I don't think we need
25 to make any comment about research. Just leave it

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1 at that. I think it's too -- I think it's difficult
2 for us to craft appropriate language for that. And
3 so I think if there's a rule, there's a rule. And
4 if there's research done, the research can be done
5 in Yale.

6 UNIDENTIFIED SPEAKER: Right.

7 CHAIRMAN ZACHARIAH: Any other discussion?

8 DR. DERICK: Can someone re-read for me
9 because -- can someone re-read the motion that's
10 currently on, that's seconded?

11 DR. DIAMOND: I think where we are, we're
12 trying to develop a sense of different elements --

13 DR. DERICK: I know. I'm still a little --
14 because whenever the motion was initially given,
15 there was a specific age given, and so that's what
16 I'm trying to clarify. So after the age of 18, the
17 consent process we're speaking of is no longer
18 applicable, correct?

19 DR. DIAMOND: Correct. So --

20 DR. DERICK: That's what I needed
21 clarification on.

22 DR. DIAMOND: So for example, my sense
23 would be that once we moved past this, I was also
24 going to make a motion that for individuals who have
25 passed the age of majority that there should be no

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1 restrictions on hormonal therapy or restrictions
2 regarding surgery. I think a person, for example,
3 who is 25 years old, who is mentally competent, to
4 go and tell that person no, I think that is
5 inappropriate. I would like to see this limited
6 just to minors. I think that the state perhaps
7 overreached a little bit on its initial petition
8 when it spoke to individuals who had passed the age
9 of majority.

10 DR. DERICK: I agree with that.

11 DR. DI PIETRO: Will we have opportunity to
12 discuss again after public comment?

13 CHAIRMAN ZACHARIAH: Yeah, sure.

14 DR. DIAMOND: Yes. Perhaps we have some
15 comment now.

16 CHAIRMAN ZACHARIAH: Okay. So let's get
17 the public comments. The comments are for a
18 timeframe of three minutes. And again, if someone
19 who came before you, if they have already stated
20 their case, there's no reason to repeat it, for the
21 interest of time.

22 The first speaker is Zoe Hawes -- am I
23 saying it right? H-a-w-e-s. Zoe Hawes. Yeah.
24 Please come forward.

25 ZOE HAWES: My name is Zoe Hawes. I'm a

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1 23-year-old wife and expectant mother, who at the
2 age of 16 believed I was a boy and that
3 transitioning would bring me peace. Growing up, I
4 experienced a lot of trauma. I was molested when I
5 was 6. My parents divorced when I was 8. My mom
6 attempted suicide when I was 13. I was diagnosed
7 with depression and anxiety in middle school, and I
8 couldn't accept my body and puberty. I just wanted
9 to escape.

10 By the age of 16, I was very unstable and
11 suicidal. I came to believe I was male in a female
12 body after reading a memoir about someone who had
13 transitioned. I came out to my mom who was scared I
14 was going to kill myself if she didn't affirm me. I
15 was immediately taken to a gender therapist who
16 diagnosed me with gender dysphoria and wrote a
17 letter recommending I start testosterone after only
18 three months of therapy.

19 I started T 7 months after coming out at
20 the age of 16, and I really thought transitioning
21 was going to fix everything. My period stopped,
22 facial hair grew. Pretty soon, I was passing as
23 male. At first, I was elated, but my mental health
24 did not improve. I became more suicidal, more
25 unstable, and the anxiety became debilitated. The

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1 testosterone was never questioned as a contributing
2 factor to my increasing instability. I was in and
3 out of mental hospitals six times while being
4 affirmed as a male and supported in my decision to
5 transition by my doctor, psychiatrist, immediate
6 family, and even church. I was also diagnosed with
7 complex PTSD and OCD during this time.

8 I desperately wanted top surgery and a
9 hysterectomy but couldn't afford them. After a
10 serious suicide attempt in February of 2018, I
11 realized that just changing my appearance was not
12 going to take away the pain, so I started working
13 really hard in therapy, but I still believed I was a
14 male.

15 A year later, in 2019, I had a life
16 changing encounter with Jesus and begin to find deep
17 healing and peace within myself. After nearly four
18 years of being on testosterone, I decided to
19 detransition and accept my womanhood. My mental
20 health improved exponentially. I'm no longer in
21 therapy, nor even on mental health medication. I
22 have not been suicidal or hospitalized since
23 stopping testosterone.

24 Three years later, my menstrual cycle has
25 still been irregular, I still have to shave my face

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1 daily, and I struggle with hormonal acne. I'm truly
2 grateful I never got surgery because now I'm happily
3 married and 28 weeks pregnant. But if I had gotten
4 the surgeries that I so desperately wanted as a
5 teenager, that would have stolen this future from
6 me. So I'm asking the board to create a rule that
7 makes it unethical for doctors to prescribe these
8 hormone treatments for people under the age of 18
9 and surgeries under the age of 21. Thank you.

10 CHAIRMAN ZACHARIAH: Thank you, Zoe, for
11 the courage, and appreciate you coming before the
12 board.

13 Next is Rachael Foster (phonetic).

14 RACHAEL FOSTER: Hello, my name is Rachael
15 Foster, and I am a 32-year-old de-transitioned
16 woman. At 21, I was diagnosed with gender identity
17 disorder, as it was at the time, and spent the next
18 five and a half years taking synthetic testosterone.
19 I was told by my psychologist and by my general
20 practitioner she referred me to that if I did not
21 take this drug, I would kill myself.

22 Within a few weeks, I went from talking
23 with my psychologist to being prescribed synthetic
24 testosterone. I was discouraged from seeing an
25 endocrinologist and was told all effects except hair

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1 growth and hair loss were reversible. This was a
2 lie. My provider failed to assess risks based on my
3 medical history or in fact critically analyze
4 whether I was fit to consent, or if there were more
5 psychological reasons for my distress around my sex.

6 In addition, my therapist lied on
7 documentation to say I had been her patient for far
8 longer than I had been and that I had no preexisting
9 conditions that might affect my gender identity
10 disorder diagnosis.

11 There are many compounding factors for why
12 I felt wrong in my body. At 17, I was diagnosed
13 with schizophrenia with major depression, now
14 diagnosed with schizoaffective disorder. I also
15 have a history of sexual abuse and trauma. I
16 disclosed these things to my psychologist and
17 prescribing physician but was still told that I need
18 to transition.

19 At the age of 26, I began to experience
20 renal failure. I was jaundiced, vomiting, and
21 urinating blood. The only drug I was on at this
22 time was synthetic testosterone. I saw a new
23 practitioner who suggested I stop the injectable
24 synthetic testosterone in exchange for a topical
25 version at a much lower dose. My symptoms improved.

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1 At 27, I stopped all together.

2 Shortly after, I experienced the first of
3 three transsystemic attacks, also called
4 ministrokes. Then at 28, I was diagnosed with
5 endometriosis and adenomyosis. At 29, I lost my
6 uterus and my cervix to the disease and had a
7 hysterectomy. After the operation I discovered that
8 my vaginal tissue was excessively thinned and
9 weekend by testosterone use. I had multiple tears
10 which lead to infections. I also learned that my
11 ovaries no longer function, and I am on supplemental
12 estrogen.

13 Today, I implore you to consider the risks
14 these medical experiments have and stop this method
15 of treatment. We cannot consent to treatment as
16 experimental as this. No one, child or adult,
17 should have to go through the constant health
18 battles I've been through. Instead of my mental
19 health being taken care of, I was sold a medication
20 that has left me with physical pain, emotional
21 trauma, and the same mental illness I had before.
22 Medical intervention should not be taken to effect
23 emotional distress over one's body. Thank you.

24 CHAIRMAN ZACHARIAH: Thank you, Ms. Foster.
25 Next is Chloe Cole (phonetic).

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1 CHLOE COLE: My name is Chloe Cole, and I
2 am an 18-year-old de-transitioned female from the
3 Central Valley of California. I was what some may
4 refer to as a trans kid as I transitioned between
5 the ages of 12 to 16. I began my social transition
6 by cutting my hair, wearing boys' clothes, and
7 asking my family and friends to refer to me using a
8 new name.

9 At 13, I started taking puberty blockers
10 and testosterone. And at 15, I underwent a double
11 mastectomy in which my breasts were removed, and my
12 nipples were grafted. And yet, at 16, after years
13 of medically transitioning, I came to realize that I
14 severely regretted my transition. It has been over
15 a year since my last testosterone injection.

16 During my diagnosis for dysphoria and the
17 consultations for my treatments, the overall picture
18 of my life just went completely unaddressed. From a
19 young age, I was actually quite a very feminine
20 girl, although I did somewhat model myself after my
21 older brothers. Up until my transition I had
22 relatively normal levels of teen distress, but my
23 early exposure to social media and the internet led
24 to my body image worsening. I was introduced to
25 inappropriate content and an echo chamber of

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1 far-left ideology, such as that sex and gender are
2 separate, women are inherently victims, men are
3 inherently superius in every way, and that dysphoric
4 children need hormones and surgeries in order to
5 live. These reductive ideologies have crept their
6 way into science, and by extension, medicine.

7 I knowingly gave my mind and eventually my
8 body to an anti-science movement that reduces
9 womanhood to long hair, Barbie dolls, dresses, and
10 false self-perception. I actually developed more
11 psychiatric issues the further I went into
12 transition. I was on the verge of suicide for
13 nearly all of high school. Some things went
14 undiagnosed for years until after I stopped
15 transitioning, like autism and body dysmorphia.

16 All that talk about mental health, self-
17 perception, pronouns, and ideology leads me to the
18 question why is the mental health epidemic not being
19 addressed with mental health treatment to get at the
20 root causes for why female adolescents like me want
21 to reject their bodies? I was not suicidal before
22 going on hormones, and yet, doctors asked my parents
23 the question, "Would you rather have a dead daughter
24 or a living son?" This is not how medical
25 professionals are supposed to talk. This is how

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1 activists talk.

2 What was the cost of treating mental health
3 with barbaric surgeries? I have bandages on my
4 chest today, over two years post op, because my
5 nipples leak fluid and they stain my clothes. I
6 have no breasts. I want to be a mother someday, and
7 yet, I can never naturally feed my children, my
8 future children. My breasts were beautiful and now
9 they have been incinerated for nothing. Thank you,
10 modern medicine.

11 CHAIRMAN ZACHARIAH: Well, thank you so
12 much, Chloe, for coming here today.

13 Next is Camille Keifel (phonetic).

14 CAMILLE KEIFEL: My name is Camielle
15 Keifel. I stand here before you today, Florida
16 Board of Medicine, in hopes that you'll make the
17 right decision regarding transitioning children and
18 take greater consideration for adults.

19 Prior to my transition, I had spent 20
20 years of mental health therapy with conventional
21 modalities. I didn't respond well to medication,
22 saw a gender therapist, and had two rounds of
23 transcranial magnetic stimulation therapy. I was
24 diligent and wanting to heal, but nothing my doctors
25 offered had healed me because they always saw my

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1 issue strictly as a mental one.

2 I was 30 and at the end of my rope when I
3 transitioned. At the time, I believed I was
4 nonbinary. I struggled with severe mental illness
5 and suicidal ideation. I had a trauma history.
6 When I was in sixth grade, my best friend had been
7 raped by her brother. Being a girl meant I was
8 vulnerable. I started to present more masculine.
9 This should have been a red flag, yet, within months
10 of requesting top surgery, it was performed on me.

11 I developed complications after my surgery.
12 There were many times I didn't know if I would make
13 it through the night. If I made this mistake as an
14 adult, a young girl could too. Not only did my
15 surgery exacerbate my mental health issues, I now
16 struggle with physical complications as well.
17 Presenting and taking on another gender was a way
18 for me to escape womanhood. Escape is not a valid
19 way of dealing with trauma. You will have to deal
20 with it eventually.

21 I was able to work through these difficult
22 emotions and improve my mental health through a
23 holistic approach. I had physical health issues
24 that had been previously overlooked. Had that been
25 managed, I would have never gotten the surgery. The

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1 surgery was an abhorrent misdiagnosis. The goal of
2 healthcare should always be to get to the root cause
3 of the problem. Today I am more grounded than I
4 have been in my entire life, but I am mutilated.
5 Between my carved-up body and the physical
6 complications, I often question if there's anything
7 on the other side. Where my breasts were are
8 hollow, I can never get them back. I can never fit
9 a dress the same way again. I can never breastfeed.
10 Who will love me? You know what keeps me going?
11 Stopping this from happening to someone else. Thank
12 you for your time. You will have a lot to consider,
13 and I know you will make the right decision.

14 CHAIRMAN ZACHARIAH: Thank you, Ms. Keifel,
15 for coming. I appreciate you spending time with us.

16 Next is Shay Scheffler (phonetic).

17 SHAY SCHEFFLER: Hi. My name is Shay. I
18 started identifying as transgender at 22 while still
19 in college. Before that, I was just a feminine gay
20 man. Being asked about my pronouns led me to
21 research transgender ideology, and pretty quickly I
22 got convinced that I was transgender woman. I was
23 able to get hormones really easy through Fenway
24 Health (phonetic) and was only on them for a year
25 before receiving facial feminization and breast

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1 augmentation surgeries at 23.

2 Taking hormones actually worsened my mental
3 health but therapists thought it was because I was
4 stuck in the wrong body. They're clearing me for
5 sex reassignment surgery by diagnosing me with
6 gender identity disorder. Immediately after SRS I
7 was super excited to start a new life. I was happy
8 for a few months while recovering.

9 However, soon I realized that my new part
10 wasn't what doctors promised me. My new vagina
11 started constricting, despite reverse dilation which
12 resulted in me developing vaginal stenosis. This
13 left me unable to have penetrative sex, which
14 adversely impacted my mental health. I also lost my
15 sex drive, my motivation to achieve anything, and
16 became brain fogged and lethargic. I had multiple
17 unsuccessful revisions attempting to get a few
18 inches of new vaginal tunnel. I even had colon
19 vaginoplasty. The last revision was at the
20 University of Miami by Dr. Christopher Salgado in
21 2018 and has left me with a colorectal fistula.
22 I've been all over the country trying to seek help,
23 but I have received none.

24 Earlier this year after hitting rock bottom
25 with my depression, I reached out to a new

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1 therapist. This therapist helped me realize that I
2 have complex PTSD from a traumatic childhood and
3 also pointed out that I have body dysmorphia, OCD,
4 borderline personality, and bipolar disorders. I
5 also realized I had internalized homophobia. I
6 realize now that medical transition was sold to me
7 as a hardware fix for software issues.

8 A few months ago, I started
9 de-transitioning by taking testosterone. However,
10 it is traumatic to be on testosterone without having
11 functional genitals. Moreover, my back hurts every
12 day due to a psoriasis and scoliosis that I
13 developed post SRS. I'm now dependent on synthetic
14 hormones for life.

15 I traded my perfectly healthy genitals for
16 an artificial one-inch tunnel that is sexually
17 nonfunctional. I realize that I'm never getting
18 back a functional penis and full detransition is not
19 really possible in my case. I feel stuck in
20 surgically created body. I believe nobody under 18
21 should be allowed to medically transition. Sex
22 reassignment surgery should only be allowed in very
23 rare cases after full psych evaluations. Patients
24 should be made aware that what they're really
25 getting is a cosmetic surgery and it's a genital

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1 approximation surgery that does not change
2 biological sex. Thank you.

3 CHAIRMAN ZACHARIAH: Well, thank you so
4 much.

5 Next is Billy Burley (phonetic).

6 BILLY BURLEY: Good morning, members of the
7 board of medicine. My name is Billy Burley and I
8 used to be transgender. When I was about five years
9 old, I started having the reoccurring thought that
10 God made a mistake, I'm a girl. I prayed before
11 going to bed and always asked, "God, please make me
12 a girl before I wake." If I could have, I would
13 have chosen any path that would have transformed me
14 into a girl.

15 In my early 20s, I sought help for the
16 disconnect between my mind telling me I was a woman
17 and my body telling me I was a man. In seeking help
18 and doing my own research, the message I received
19 was that I had to change my body to match my mind.
20 I decided to follow the therapists' and medical
21 researchers' encouragement to change my body. I
22 started on testosterone blocker and estrogen. My
23 emotions were up and down, and my body was changing,
24 but I was supposedly on this new road to happiness,
25 which made me happy.

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1 In my first surgery, I had a penile
2 inversion, an Adam's apple shave, and a brown shave.
3 After the surgery, the doctors and nurses had
4 difficulty stopping the bleeding from my new vagina.
5 My artificial vagina was packed with gauze and a
6 sandbag was placed on my lower abdomen, but the
7 bleeding did not stop. I received a blood
8 transfusion and plasma and eventually, the bleeding
9 did stop. My two-week stay in the hospital turned
10 into a three-week stay. But changing my penis to an
11 artificial vagina required two surgeries, so about
12 four months later, I was back for part two,
13 labiaplasty.

14 I was desperate for the happiness I believe
15 was ensured me. After this, I had additional
16 feminization surgeries but no matter how many I had,
17 every time I looked in the mirror, I saw a man
18 looking back at me. I tried hard to resolve the
19 conflict between my mind and my body but after seven
20 years of trying, I had more problems at that point
21 than when I started on the road of transition.

22 The bottom line is that the therapists and
23 medical researchers were wrong. I have fully
24 transitioned back to male. I am happily married. I
25 have two beautiful stepdaughters. And I have peace

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1 of mind and body. I was an adult when I made the
2 horrible decision to transition. The therapists and
3 doctors failed to help with my underlying problems.
4 They identified me as transgender, and they were
5 wrong. How often are they wrong? I urge you to
6 create a rule that makes it unethical for doctors to
7 prescribe gender converting treatments or puberty
8 blockers for people under the age of 18. Thank you
9 for hearing my testimony.

10 CHAIRMAN ZACHARIAH: Thank you, Mr. Burley,
11 for coming and talking to us.

12 Next is Cat Cadison (phonetic).

13 CAT CADISON: I'm Cat, a de-transitioned
14 woman, singer, and molecular biologist. As a child,
15 I was artistic, nerdy, and socially awkward
16 struggling to find my place in the world. I was
17 subjected to both abuse and bullying beginning in
18 toddlerhood. As a result, I felt alien in my body
19 very early on. If I was a body, I thought I could
20 protect myself.

21 At 5, I asked my mother if it was possible
22 to change genders and she said no. For the next
23 eight years, I disliked my sex but believed I was
24 resigned to my fate until age 13 when I came across
25 an online forum for transgender people. That day I

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1 began believing that the reason I suffered from
2 anxiety, depression, and anorexia nervosa was
3 because I should have been born male. I read that
4 if one had gender dysphoria it meant she was trans
5 and that she was extremely likely to take her own
6 life if she didn't transition. But back then in the
7 mid-2000s, gender-affirming culture did not yet
8 exist. My parents, peers, and pediatrician did not
9 affirm me, for which I am now grateful.

10 My cross-sex identification persisted until
11 age 17 when my parents took me to a gender
12 therapist. They hoped he would take a holistic
13 approach considering my many comorbid mental health
14 issues, but he affirmed as a boy immediately. The
15 therapist began using he/him pronouns for me, and my
16 appointment three, he suggested I started
17 testosterone. My parents were astounded and did not
18 comply with his recommendations.

19 I was unable to pass as male without any
20 medical interventions, and I temporarily desisted.
21 But my unhealthy beliefs about gender such as you
22 cannot be happy unless you transition, continued to
23 fester in my mind. After years of rumination, this
24 culminated in me deciding to medically transition.
25 I obtained testosterone by calling Planned

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1 Parenthood and was prescribed after just a 30-minute
2 phone conversation.

3 Within months of starting testosterone, I
4 experienced side effects such as liver and gall
5 bladder damage, heart palpitations, and the
6 permanent loss of my natural singing voice. This
7 was what ultimately influenced me to detransition as
8 I realized appearing as a man was not worth
9 sacrificing my music. But if this hadn't been my
10 tipping point, I might have pursued surgery and come
11 to regret it as countless others have.

12 If I had been prescribed puberty blockers
13 at age 13, I'd likely be suffering from infertility,
14 osteoporosis, and/or stunted brain development. All
15 gender-affirming care is experimental, lacking
16 controlled studies, and sufficient data on its
17 long-term outcomes, so I caution against treating
18 patients of any age in this manner. However,
19 patients younger than 25 when the brain is fully
20 developed are particularly vulnerable.

21 Because puberty blockers stunt brain and
22 bone maturation leading to lifelong disabilities, I
23 advocate for the complete cessation of prescribing
24 them to gender dysphoric youth and for no other
25 medical interventions to occur prior to age 25.

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1 Thank you.

2 CHAIRMAN ZACHARIAH: Well, thank you so
3 much, Ms. Cadison.

4 Next Helena Kershner (phonetic).

5 HELANA KERSHNER: Hello, my name is Helena
6 Kershner and I'm 24 years old. I'm here today as a
7 de-transitioner with grave concerns about the
8 so-called gender-affirming model of responding to
9 minors and young adults who believe they are
10 transgender.

11 As a young girl, I had no discomfort with
12 being female. What I did have was a history of
13 family issues, difficulty fitting in with other
14 girls, eating disorders, self-harm, and depression.
15 When I was 14, I began spending a lot of time online
16 in communities where countless other troubled
17 adolescent girls were encouraging each other to
18 interpret social, emotional, and body image
19 difficulties as signs of gender dysphoria with the
20 belief that body modification would be a
21 transformative solution.

22 When I took steps in the direction of being
23 trans, I received more positivity and encouragement
24 than I had ever experienced. By age 17, I
25 identified as a trans boy and was fully convinced

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1 that my only chance at living a happy life would be
2 to take hormones and undergo surgeries to change my
3 body.

4 My school counselors and school therapist
5 both affirmed my beliefs, and the psychologist even
6 told my mother that she was risking my suicide if
7 she would not agree to testosterone treatments. But
8 thankfully, she was not intimidated.

9 I went to a Planned Parenthood a few weeks
10 after my 18th birthday. None of the clinicians were
11 interested in what was behind my desperation to
12 change my body. They told me that because I seemed
13 so sure they would prescribe the hormones that day,
14 forgoing blood tests. I told the clinicians that I
15 wanted a high dose, so I would see more changes in
16 my body. They agreed and prescribed me 100
17 milligrams of testosterone per week.

18 The mental health effects of testosterone
19 were profound. I began experiencing uncontrollable
20 episodes of rage and paranoia where I was a danger
21 to myself and others. I also became more suicidal
22 and self-harming. Due to this, I was hospitalized
23 twice. None of the clinicians in the hospital or
24 outpatient center ever mentioned testosterone as a
25 possible source for my mysterious new symptoms.

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1 Instead, I was prescribed a litany of psychiatric
2 drugs.

3 This time was so dark that it caused me to
4 question the original promises of a joyful trans
5 life, and after five years of identifying as trans
6 gender, I stopped taking testosterone and began the
7 journey of de-transitioning. My mysterious new
8 mental illness went away soon after and has never
9 returned.

10 I am forever grateful that clinicians were
11 not able to affirm me any further. I am very
12 fortunate to not have experienced any obvious
13 physical detriments, but the negative impact of the
14 so-called gender affirmative care on my life cannot
15 be understated. Not only was I in serious danger
16 under the influence of testosterone, but the mental
17 process of returning to reality, accepting my body,
18 coping with everything that happened, and facing the
19 mental health issues that were compounded by these
20 experiences has been very difficult.

21 I ask the board to see these dangers of
22 gender affirmation and create a rule prioritizing
23 exploratory psychotherapy and long-term health over
24 dangerous cosmetic interventions for these
25 vulnerable young people. Thank you.

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1 Thank you, Ms. Helena.

2 Next is Ted Haley (phonetic). Yeah, please
3 proceed.

4 TED HALEY: Yeah. I've got 31 minutes. I
5 could do it but you all might not want to listen, I
6 don't know. I want to be fair to everybody.

7 Okay. First of all, it is an honor and a
8 privilege, and I am humbled to be here to testify to
9 the Medical Board of Florida. I also want to say to
10 all my trans friends, been there, done that, got the
11 badge. Not many people are going to say this but
12 being transgender is not easy. It takes a lot of
13 courage, you have to be brave and determined. So no
14 matter what you say, being transgender is difficult.

15 Well, with that, I want to say thank you to
16 Dr. Laidlaw, I can confirm that what he says
17 personally is true. All the things that he laid
18 out, I got the badges. What makes me qualified?
19 Well, at age eight, I too had gender dysphoria. But
20 I was an old school because back then you couldn't
21 do anything. So I had to wait until I was 50. But
22 in that time, I had to wait until then, I had five
23 adopted children and I was, you know, divorced and I
24 had free range because my kids were adults,
25 basically. But what did I do? I did it all.

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1 Everything you could do. Two facial feminization
2 surgeries, trach shave, in and out bottom surgery,
3 hundreds of hours of electrolysis. If you've ever
4 done that, it is painful.

5 So why am I telling you all this? I'm
6 telling you because yeah, I was happy for a few
7 years. It's kind of like buying a car, you know, an
8 expensive one with the real expensive payments.
9 Then a few months later, you get buyer's remorse.
10 Well, that was me. I was very happy for about 8 to
11 10 years, then I started experiencing waves of
12 depression so severe that, yes, I might not be here
13 today had it been for my faith in God and the fact
14 that I'm raising my granddaughter.

15 This is a serious issue. We don't take it
16 lightly. I don't take it lightly. I have two
17 friends that have died in these procedures, medical
18 procedures. They're dangerous. This is something
19 very, very serious. I have two trans friends that
20 committed suicide. Yes, I know what it's about.

21 So what am I asking? Is that the medical
22 board seriously consider delaying this until the age
23 of consent. I was 50 years old when I transitioned,
24 and it took me to 62 to figure it out. So if me at
25 62 can't figure out, how in God's green Earth is a

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1 minor going to? They want to be a fireman one day,
2 a policeman, a boy, or girl, whatever. But I know
3 you all will make the right decision. They you for
4 the privilege to being here and thank you trans
5 friends for being here too.

6 CHAIRMAN ZACHARIAH: Thank you, Mr. Haley.
7 Next is Yako Shenfield (phonetic).

8 YAKO SHENFIELD: Ladies and gentlemen, good
9 afternoon. What you're about to hear is tragic. My
10 name is Yako Shenfield and last year on August 22nd,
11 I buried my beloved daughter because of what gender
12 transition treatment did to her. My daughter had
13 been in counseling for depression since the age of
14 15 but had never said anything about gender
15 dysphoria to her counselor.

16 At age 17, her mother told me that she was
17 transgender. She did suffer from rejection in
18 school and was seeking affirmation. Five of her
19 friends announced they were transgender. When she
20 said that she was trans, she finally had her peers'
21 acceptance, so she thought. And she had not
22 previously experienced in high school, I mean the
23 acceptance.

24 When my daughter went to college, she began
25 taking testosterone. When I saw her at the college,

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1 she was very depressed. Actually, she was almost
2 rejected for non-performance of her academic
3 studies. A social worker presented a meeting with
4 my daughter. Her name is Shannon Sonnet, MSW
5 (phonetic). She told me that my daughter was going
6 to get a double mastectomy. When I objected to her
7 taking such a drastic step at such a young age at
8 that point, 19 or 18 and a half, the social worker
9 told me I was a typical chauvinist male. I am a
10 typical chauvinist male who doesn't love his child
11 enough. She said, "This is what we are going to do,
12 and you need to just get on board." The social
13 worker assured me that everything would be fine if I
14 just loved my daughter.

15 My daughter had a double mastectomy at age
16 19. Exactly when, I don't know, because she didn't
17 speak to me for about two years. It wasn't my
18 decision, it was her decision. At some point,
19 finally, it was very painful to me that separation
20 from my child. Things were amended. I accepted her
21 and to the best that I could because inside, I was
22 in such dichotomy of feelings because I rejected
23 this whole journey. I think it's against God. It's
24 against biology as we heard from Dr. Laidlaw.

25 UNIDENTIFIED SPEAKER: Time.

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1 I'm talking, okay.

2 UNIDENTIFIED SPEAKER: Time.

3 UNIDENTIFIED SPEAKER: These people also
4 cheated. I was the second person here that handed
5 in my speaker card and none of these people --

6 CHAIRMAN ZACHARIAH: Excuse me. You've got
7 to stay quiet.

8 You know, Mr. Shenfield, thank you so much.
9 Your three minutes has expired. I really appreciate
10 you coming.

11 Now let's go on to -- you're next.

12 UNIDENTIFIED SPEAKER: Okay. I'd like to
13 called --

14 CHAIRMAN ZACHARIAH: No, no. You had three
15 minutes and that's it.

16 UNIDENTIFIED SPEAKER: Next, please, Bob
17 Flynn (phonetic). Bob Flynn if you're here, we're
18 calling you.

19 CHAIRMAN ZACHARIAH: Sir, we are not going
20 to allow it. You have to sit down. You have to do
21 an orderly manner and you're going to run this
22 meeting. You sit down. I am just telling you, you
23 sit down, or somebody will sit you down.

24 UNIDENTIFIED SPEAKER: We're calling Bob
25 Flynn at this time.

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1 Mr. Bob Flynn, please.

2 MARY FLYNN: Mary Flynn. We both have
3 cards. Would you prefer just Bob and then I go
4 later, or --

5 UNIDENTIFIED SPEAKER: No. I'm okay with
6 both of you, please.

7 MARY FLYNN: Okay. I'll start in the
8 essence of time. So my name is Dr. Mary Flynn; I'm
9 a consulting psychologist and a proud mother of a
10 transgender child who is now 12 years old. It's a
11 joy to raise this beautiful child and everything
12 we've heard before is nothing that I've ever heard
13 before in any support group, by any physician, by
14 anything.

15 So to be clear, our child at age 4 was --
16 came out as transgender. She told us who she is.
17 We worked with a panel of experts, just to your
18 point. We have a full team of people. She meets
19 with a psychologist every single week. She's met
20 with three over the years.

21 For the past 8 years, we've been on this
22 beautiful journey helping our child who had suicidal
23 ideation at age 5 and now is a healthy, happy 12-
24 year-old thriving in Florida. But we are scared
25 we're going to have to move because she has started

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1 gender-affirming care at age 12. She has a puberty
2 blocker. And you all have the power to save her
3 life and all of the lives of these people that need
4 this medicine. You actually have the power here.

5 If we did not have this medicine, she would
6 not be alive. We are so proud of her, and we are so
7 proud to be in Florida where they have allowed her
8 to get her care. What you're talking about is
9 waiting until age 18. Well, they won't be here.
10 This group commits suicide. They will not be here.
11 So we need the medication, please.

12 BOB FLYNN: We want to put the hands -- we
13 want to put the control in the hands of the parents,
14 right. We want to be able to make these decisions
15 for our kids. One lady said, "Wait until they're
16 25." We all have the ability to be able to make
17 these decisions as adults. For every study, there
18 is always a counter study, right. We've heard that
19 today through in and throughout.

20 And I feel that, you know, we can answer
21 these questions and we should let these children
22 proceed and put the capability in the hands of the
23 parents, so that the kids can do their thing, okay.
24 When you take that medication away, we can't do that
25 decision. And now the burden is on our daughter.

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1 We'll probably have to move, and that is even deeper
2 despair for her.

3 And what happens in the Netherlands is the
4 same thing that happening here. It's all political.
5 100 and 30 something bills have already been
6 positioned, and that, as a result, against
7 transgender care. And that to me is just atrocious.
8 We're here to support our kid. I need you to help
9 us support our kid. At least keep us to have the
10 tools to support our kid.

11 UNIDENTIFIED SPEAKER: Thank you very much.

12 CHAIRMAN ZACHARIAH: Thank you. Next is
13 Blaze Treatis (phonetic).

14 BLAZE TREATIS: Good morning. I'd like to
15 thank State Surgeon General Joseph Ladapo for
16 seeking Florida medical guidelines which prohibit
17 medical doctors from prescribing puberty blockers
18 and cross-sex hormones for children, and from
19 performing sex change surgeries on children.
20 Dr. Ladapo correctly asserts that puberty blocker
21 drugs and cross sex hormones cause irreversible
22 lifelong injury to children such as loss of bone
23 mass, blood clots, and lifelong sterility.

24 Until the Florida legislature criminalizes
25 medical doctors performing genital mutilation

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1 surgery on children, the Board of Medicine and Board
2 of Osteopathic Medicine should adopt the
3 recommendations of State Surgeon General Ladapo. It
4 is an oxymoron to call sex change surgery for
5 children "gender-affirming care." As there is no
6 care being provided but instead only child abuse
7 which has been outlawed and criminalized in some
8 states in America.

9 What is happening is that social media,
10 such as TikTok, promotes gender dysphoria which
11 leads to peer pressure among teenagers and preteens
12 to succumb to the pressure to believe that they
13 should try to become the opposite sex. In the
14 extremely rare cases of gender dysphoria, the child
15 invariably is experiencing depression will pass with
16 time and perhaps, treatment. The solution to the
17 temporary depression in children is not irreversible
18 side effects of puberty blocking drugs and cross-sex
19 hormones and life altering, irreversible sex change
20 surgery.

21 It is way past time for women and feminists
22 to reject men's false assertion that men can become
23 women by putting on a dress and makeup and take some
24 hormones. When feminist succumb to the false
25 demands of these transgender men who claim now to be

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1 women, the feminist are victims of what they say
2 they are fighting against, which is patriarchal men
3 dominating and controlling them, women. Transgender
4 men dominating girls and women in high school
5 sports, in college sports, public discourse, public
6 policy, and every other aspect of society. Women
7 should stand up against this attempt by transgender
8 men to dominate women.

9 University of Kentucky swimming champion
10 Riley Gaines has been outspoken on television
11 arguing against transgender men such as Leah Thomas
12 being allowed to dominate women swimmers in the
13 college swimming championships. Ms. Gaines spoke
14 the truth when she said that "Womanhood is not a
15 mental disorder suffered by men." That concludes my
16 remarks.

17 I would just like to say that I agree with
18 the board member in the front who says to leave the
19 clinical studies out of this proposed rule. It
20 seems to be complicating it greatly. And as the
21 gentleman said, there's 49 other states where these
22 studies can be done, and I think it would be better
23 to leave that out. I appreciate you. It looks like
24 you're going in the right direction. Please
25 continue. Thank you.

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1 ATTORNEY MCNULTY: Thank you. Calling Hope
2 McClay, please.

3 HOPE MCLAY: Hi, I'm Hope McClay. This is
4 my mother. I am not a medical professional. I am
5 not a scientist. I am just here as a mother. In
6 2023, I was a mother to three little boys. Today, I
7 am the mother of two little boys and one beautiful
8 little girl.

9 Our journey started since my daughter could
10 walk or talk. Ever since she could walk or talk,
11 she presented as female. I thought I had a very
12 creative little boy, possibly would grow up to be
13 gay and never leave his mother. She would wear
14 dresses, fashion long hair out of t-shirts.

15 And it wasn't until -- and we allowed this
16 to continue inside the home, but outside the home,
17 we forced her to conform and to be a boy. We
18 physically, at times, had to force her to put her
19 boy clothes on. We physically had to force her to
20 cut her hair and keep a short haircut. And these
21 escalated to such an extent that it was becoming
22 distressing, really for all of us, to physically
23 force a child.

24 My daughter is a very determined person.
25 She's always known who she is. At one point, she

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1 came up to me at about three and a half years old
2 and begged me, crying, and said, "Please, don't make
3 me be this way anymore. This is not who I am. I
4 want to die." And while I know it sounds profound
5 that a three-and-a-half-year-old would be able to
6 say these words, we still did not support her. What
7 we did was we educated ourselves and we went to
8 professionals.

9 We went to some of the best professionals
10 in the state of Florida who helped us understand
11 what transgender is. I didn't really know what that
12 was. And so we supported her social transition and
13 her journey. Today she is almost 10 years old. She
14 is a competitive synchronized swimmer. And no, she
15 does not dominate the sport. She just had her level
16 one test and failed magnificently, but she loves the
17 sport.

18 She -- we're not looking to have surgery,
19 we're not looking to do anything harmful to our
20 daughter other than support her mental health. It
21 would be psychologically damaging if she had to go
22 through puberty as a male. It would be
23 psychologically damaging for her siblings, for our
24 family.

25 All we're asking is that the medical

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1 professionals treat each patient individually. Our
2 doctor is here in this room. We have sought out
3 psychiatry, psychological, medical, pediatric,
4 endocrinologist's help. So we do not make these
5 decisions lightly, but these are the decisions that
6 should be made by the families not by the state and
7 not by a board. Thank you.

8 ATTORNEY MCNULTY: Thank you.

9 CHAIRMAN ZACHARIAH: Okay. Next is
10 Dr. Edward Drass.

11 EDWARD DRASS: Good morning, Board. I'm
12 Dr. Edward Drass. I practiced here in Florida for
13 the last 40 years. I've done general internal
14 medicine and family practice. I also chaired our
15 hospital ethics committee for 12 years. Today I
16 loudly speak out against all forms of chemical and
17 surgical cross-sex therapy.

18 I've seen the full range of mental illness
19 in children, adolescents, and young adults. We all
20 agree mental illness is destructive for the
21 individual, the family, and for society. Many of
22 the individuals that I've seen that are LGBTQ or
23 transgender have significant levels of mental
24 illness, and often, this mental illness has not been
25 satisfactorily addressed by counseling or

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1 psychotherapy. Is it not the best practice to
2 address psychopathology with approved psychotherapy
3 before instituting lifechanging, unhealthy
4 transition treatments?

5 Gender identity disorder only came to my
6 attention five or six years ago, but it's now
7 diagnosed in the code book for mental illness, the
8 DSM-5 as Gender Dysphoria. It appears that we're
9 dealing with an unprecedented epidemic of mental
10 illness in adolescent females. This demographic
11 comprises the bulk of the 4400 percent rise in new
12 cases of gender dysphoria seen in the past few
13 years.

14 So I ask you physicians, for what other
15 disease do we allow an adolescent patient to make
16 his own diagnosis and then demand a preferred
17 treatment? As the Board of Medicine, what ethical
18 standards must be met when providing sex
19 reassignment? What standards of care have been
20 established for this treatment? Does the board
21 supervise quality control and satisfactory outcomes
22 for doctors and clinics offering these services?
23 What is a satisfactory outcome? These are all
24 questions that need to be asked when you decide the
25 rules for transgender treatment.

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1 I think other countries and judicial
2 systems are well ahead of the United States in
3 making this determination. In the wake of the Bell
4 versus Tavistock verdict, as you heard from
5 Dr. Biggs, the NHS has reversed course in its
6 transition treatment advice. Florida should take
7 the lead from this decision.

8 A summary review of transgender medical
9 research concludes there's no support for medical
10 intervention for gender confused minors. Medical
11 transition procedures do not reduce youth suicide.
12 Childhood gender dysphoria usually dissipates by
13 adulthood. And the dramatic increase in gender
14 dysphoria in the recent past is likely driven by
15 social factors.

16 My recommendation to the rules committee is
17 that cross-sex medical and surgical treatment should
18 not be supported by organized medicine, the Board of
19 Medicine, the legislature, or insurance companies.
20 Thank you for what you're doing.

21 CHAIRMAN ZACHARIAH: Dr. Drass, thank you
22 so much.

23 ATTORNEY MCNULTY: I'm going to ask the
24 crowd to please be controlled. What we're trying to
25 do is to allow everybody to make comments, so please

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1 contain your -- we've got to control this, so that
2 we can allow everybody to have their time. So I'm
3 going to call Jude Spiegel (phonetic), and again, if
4 the crowd starts disrupting the speaker, you're
5 going to be asked to leave.

6 Jude Spiegel.

7 UNIDENTIFIED SPEAKER: They went to the
8 restroom real quick. Can we come back to them?

9 ATTORNEY MCNULTY: Okay. Then we'll call
10 the next, Ada Lopez (phonetic). And a reminder,
11 Ada, you have only three minutes.

12 ADA LOPEZ: Hello, my name is Ada Lopez and
13 I thank the board for giving me a chance to speak.
14 I'm a proud mom of a transgender son. Our child
15 attended Catholic school from pre-K through eight.
16 He was in the Girl Scouts, sang in the choir, was an
17 alter server. He used his recess time to raise
18 money for Operation Smiles. Those were the things
19 he was involved in at that time. He insisted on
20 being the first one to arrive at school every day.
21 He worked as a safety patrol. He used to volunteer
22 to stay after to help the teachers clean their
23 rooms. He was passionate about books, astronomy.

24 All of that started to change at the age of
25 13. He became reclusive, did not want to leave his

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1 room. He did not want to go to school. He lost
2 interest in all the things that he loved. We didn't
3 know what to do. He wanted to die. We took him to
4 therapists, doctors. I signed him up for teen club.
5 Even a youth group called Girl Talk. I gave him a
6 kitten. Nothing worked.

7 Finally, he came out to us at the age of 14
8 as a transgender boy. This was something new for
9 us. As a registered nurse, I knew how to look for
10 established national guidelines, recommendations. I
11 learned about WPATH and I took him, at that time, to
12 medical experts right here in Florida, starting with
13 his pediatrician who had known him since birth. We
14 saw endocrinologists, psychiatrists, psychologists,
15 social workers. I was presented with options and
16 made difficult decisions.

17 Today, my son has a new name that matches
18 his gender. He is a very happy 21-year-old college
19 student currently majoring in physics and astronomy.
20 Gender-affirming care made all the difference for
21 him. I am so grateful every day to have him. Next
22 month we're going camping. Now he spends his free
23 time going to the rock-climbing gym with his
24 friends.

25 I ask the board to keep all these

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1 lifesaving WPATH options open for all Floridians. I
2 can't even think of the harm that would have come to
3 him if we hadn't been able to access these
4 treatments. And when it's time to make difficult
5 decisions for parents, other people's opinions don't
6 matter. People want to have access to all the
7 options that can save their child's life.

8 ATTORNEY MCNULTY: Thank you.

9 CHAIRMAN ZACHARIAH: Thank you. Next is
10 Robert Roper (phonetic).

11 ATTORNEY MCNULTY: No, next.

12 CHAIRMAN ZACHARIAH: Next is Robert Roper.

13 JUDE SPEIGEL: You said my name when I was
14 in the bathroom.

15 CHAIRMAN ZACHARIAH: I understand that.
16 You're going to wait.

17 Robert Roper.

18 ROBERT ROPER: My name is Robert Roper.

19 I've been authorized to tell a story of a patient
20 named CG -- that's a pseudonym -- who has been
21 irreversibly harmed by medical transition as a
22 minor. Says this, "Had a rule placing restrictions
23 on gender transition treatments been in place in my
24 street, then I would not have been placed on the
25 fast-track to medical and surgical interventions and

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1 I would not at age 21 be facing a lifetime of
2 sterility and a mutilated body.

3 Like many de-transitioning young people, I
4 was a gender nonconforming child who was on the
5 autism spectrum and suffered from depression and
6 anxiety. At age eight, I did not like stereotypical
7 boy stuff. Instead, I liked girl stuff and the ways
8 girls behaved. Transgender websites told me I was a
9 girl if I like girl things. I began talking with
10 trans identifying people through phone apps.

11 At age 14, I told my parents that I was
12 trans and believed that I was a girl trapped in a
13 boy's body. My parents celebrated my trans identity
14 and took me to see gender-affirming therapists. The
15 therapist immediately affirmed my trans identity
16 without any psychological testing or exploring why I
17 believed I was trans. I then saw an endocrinologist
18 and a gender clinic at Providence Hospital. The
19 endocrinologist prescribed Estradiol and
20 spironolactone.

21 At age 15, I began the hormone regiment. I
22 experienced significant psychological complications
23 from the treatments. I became depressed to the
24 point that I was not getting out of bed. I became
25 too anxious to go anywhere or talk to people and

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1 ended up dropping out of school. I also developed
2 an eating disorder and an addiction to the internet.
3 I was not functioning healthfully, but my parents
4 continued to move me along the gender-affirming
5 path, scheduling surgery at age 17.

6 Soon after turning 18, I was flown to
7 Washington, D.C. where my testicles and penis were
8 removed. I was given a vaginoplasty to create an
9 artificial vagina and receive plastic surgery on my
10 face. At no point was I offered any alternatives to
11 medication and surgery. No one attempted to explore
12 my underlying reasons for my depression and
13 discomfort with my sex.

14 I soon realized that treatments had not
15 improved my life and I discontinued them at age 18.
16 Now at 21, I have a body that is completely ruined.
17 I have worried that my body is now going to be a
18 freak no matter what I do. Even with parental
19 consent, these treatments are putting kids on a path
20 of harm. I was not able to grow up in a healthy way
21 as a result of having been scared by these
22 treatments. I do not want to see other young people
23 harmed in this way. I believe these treatments
24 should be disallowed or seriously restricted for
25 children and young people like myself." Thank you.

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1 ATTORNEY MCNULTY: Jude Spiegel.

2 JUDE SPIEGEL: Hi, I'm Judge Spiegel. I'm
3 a transgender parent of two children and I've known
4 I was transgender since I was very young. I
5 suffered from suicidal ideation from the age of 10
6 to 26 and attempted suicide many times thinking it
7 was wrong to be who I was. I wanted changes I
8 didn't think I could ever have. I didn't feel safe
9 opening up about who I was until later in life. But
10 this isn't about me.

11 Let these decisions remain between parents,
12 children, and their doctors. If rules must be
13 adopted, then please adopt the World Professional
14 Association for Transgender Health Standards of
15 Care. I'm going to read the names of 17 transgender
16 teens I researched who chose suicide over living in
17 a world that refused to acknowledge or accept them.
18 Andrew Elijah Martinez (phonetic), Ash Hafner
19 (phonetic), Avril (phonetic), Blake Brockington
20 (phonetic), Charles Knolls (phonetic), Daniel France
21 (phonetic), Amelia Worth (phonetic), Emmot Castle
22 (phonetic), Fluod (phonetic), Haley Gabrielle
23 Feldman (phonetic), Jordan Howell (phonetic), Kyler
24 Prescott (phonetic), Leila Alcorn (phonetic), Leo
25 Etherington (phonetic), Melanie Rose (phonetic),

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1 Taylor Alesena (phonetic), and Zander Nicholas
2 MaHafeey (phonetic). Thank you.

3 ATTORNEY MCNULTY: Thank you.

4 CHAIRMAN ZACHARIAH: Next is Amie Aderberry
5 (phonetic). Is Amy Aderberry here?

6 Next is January Littlejohn (phonetic).

7 JANUARY LITTLEJOHN: My name is January
8 Littlejohn. I am a Florida mother of three children
9 and a licensed mental health professional. I am
10 here to offer my personal experience, not as a
11 counselor, but as a mom. In the spring of 2020, our
12 13-year-old daughter told us she was experiencing
13 distress over her sex, and she didn't feel like a
14 girl. She had expressed no previous signs of gender
15 confusion and her announcement came shortly after
16 three of her friends at school also claimed
17 transgender identities.

18 Soon afterwards, her mental health
19 spiraled. We worked with a licensed mental health
20 professional to help our daughter explore and
21 resolve co-occurring issues including low
22 self-esteem and anxiety. We also gave her more one
23 on one time, in person activities away from trans
24 influencers, limited her internet use, and declined
25 to affirm her newly chosen name and pronouns. We

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1 set appropriate boundaries and allowed her to choose
2 her hair and clothing but denied harmful requests
3 such as breast binders, puberty blockers, cross-sex
4 hormones, and surgeries.

5 It was clear from conversations that our
6 daughter was uncomfortable with her developing body
7 and had an intense fear of being sexualized. She
8 was filled with deep self-loathing and was in true
9 emotional pain but had been encouraged by peers and
10 influencers to believe that gender identity was the
11 source of that pain. What she really needed was for
12 us to help her make sense of her confusion and
13 remind her that hormones and surgeries could never,
14 ever change her sex or resolve her underlying mental
15 health issues.

16 I shudder to think what could have happened
17 if we had affirmed her false identity and consented
18 to medical treatments as opposed to what we did
19 through watchful waiting which was to lovingly
20 affirm her as she is, beautifully unique, and
21 irreplaceable, and undeniably female.

22 After several years, our daughter has
23 desisted and is on a path to self-love. I have
24 spoken to many parents in Florida, and they are not
25 being informed of all treatment options when they

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1 seek help for their child. Many times they are
2 being convinced by medical professionals that
3 affirmation and medicalization is their only option
4 to avoid the impending suicide of their child.
5 Suicide is told to these parents as if it is a
6 guaranteed outcome versus a risk factor for these
7 kids.

8 Unfortunately, gender dysphoric children
9 are being encouraged through activism and peer
10 pressure to disassociate from their bodies and to
11 believe their body parts can simply be removed,
12 modified, or replaced. The irreversible
13 consequences of medical transitioning including loss
14 of sexual and reproductive function cannot be fully
15 understood by children or teens who lack the
16 necessary cognitive maturity or experience.

17 These children deserve ethical, evidence-
18 based treatment that helps them explore and resolve
19 the true source of their distress. Please stop
20 enabling doctors to chemically castrate and cut off
21 the health organs of children and teens. Thank you.

22 ATTORNEY MCNULTY: Next, George Lopez.
23 George Lopez (phonetic).

24 Cory Hill (phonetic).

25 Okay. I have a card. Mr. Lopez, would you

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1 like to address the boards?

2 Okay. Cory Hill.

3 Jennifer Engles (phonetic).

4 JENNIFER ENGLES: I'm a licensed mental
5 health counselor in the state of Florida. I speak
6 for myself and my own experiences and education. I
7 have been counseling transgender youth since 2013,
8 and transgender people aged 13 and older, generally
9 make up between 60 to 80 percent of my active client
10 caseload at any time in my practice. I would not be
11 encompassing the full scope of my career if I did
12 not come here today to advocate for my clients'
13 mental health and wellbeing.

14 Some of the ethics of my profession,
15 according to the American Counseling Association's
16 code of ethics, are to do no harm, to work for the
17 good of the individual, and to respect the rights of
18 one to control their own life. The American Medical
19 Association's code of ethics echoes these themes. I
20 have both of these here. Please allow those of us
21 who specialize in working with certain issues to
22 continue to do so unimpeded. Most professionals who
23 work with the transgender community in any capacity
24 have been trained in gender-affirming care per the
25 WPATH standards of care, which I have here, version

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1 eight. It is for you if you would like this copy.

2 So we do this because it is a worldwide
3 standards of care that is best practice that has
4 been used for 43 years and through 8 editions. So
5 they do continue to evolve. This is not a static
6 document from 43 years ago. The research is
7 unbiased, apolitical, and well documented to be in
8 the best interest of the client or patient. What is
9 different about Florida's transgender citizens that
10 our Department of Health feels the need to determine
11 standards of care that are different from the entire
12 rest of the world?

13 Please do not make your decision for
14 political reasons. My clients, even the young ones,
15 are well aware that they are being used as political
16 pawns, and they are already being harmed by
17 discussions like the one we are having today. Today
18 the Department of Health and Board of Medicine are
19 not upholding the ethic of do no harm. They hear
20 you. They hear us. They are hurt.

21 Per WPATH, "Therapists and medical
22 providers are already discussing potential risks and
23 benefits of hormone therapy in order to write
24 referral letters." We do this. I have a form that
25 I fill out that I go through, check boxes of what I

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1 discuss. How many transgender people have you had
2 in depth conversations with regarding their lived
3 experiences? If you had the insight I have gained
4 from getting to know hundreds of transgender people
5 as a therapist, friend, advocate to the community,
6 and could understand how amazing transgender people
7 are and how much they truly contribute to all facets
8 of society, you would want to do everything you
9 could to help them thrive.

10 What if transgender people are just real
11 and just exist in greater numbers currently because
12 they have more reason for hope for a fulfilling and
13 authentically lived future? I want to be clear, I
14 do not tell my clients what choices to make about
15 their lives. I help them and their families to make
16 their own decisions.

17 CHAIRMAN ZACHARIAH: Well, thank you so
18 much. Next is Bob Framingham (phonetic).

19 BOB FRAMINGHAM: Members of the board, my
20 name is Bob Framingham and I have been personally
21 impacted by the harms of gender-affirming care
22 through watching my son transition. My son was
23 educated in Christian private schools from
24 kindergarten to grade eight, was an average,
25 well-behaved student. He played baseball little

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1 league, was pretty good. He expressed no confusion
2 over sex during childhood or adolescents. However,
3 he was socially awkward and did have mental health
4 issues.

5 Grades 9 through 12 he attended SAIL public
6 school in Tallahassee. SAIL is a very progressive
7 art school, and this is where he was exposed to the
8 false idea that he could have been born into the
9 wrong body. He earned a brown belt in Taekwondo and
10 is an Eagle Scout. At age 18, he could do 20 pull-
11 ups with one hand. Now he can't lift 40 pounds
12 because of his therapy in order to help him grow
13 breasts.

14 He was diagnosed with borderline
15 personality and severe depression in 2023. His
16 mental health issues began around age 14 shortly
17 after he started at school. It was clear that he
18 suffered from low esteem and self-hate. Tyler
19 announced that he was transgender at age 22 and
20 began transitioning for 6 years. This has not
21 improved his quality of life or resolved his mental
22 health issues. He dropped out of college, has no
23 meaningful romantic relationships, and he's not
24 anorexic. Clearly, there's a disconnect between
25 Tyler's brain and his body.

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1 He intends to alter his body, but I really
2 think he needs to alter his mind. I am deeply
3 concerned that his mental health will further
4 deteriorate once he comes to the realization that
5 making irreversible changes to his body will not fix
6 his pain.

7 So I would urge you to create a rule that
8 will protect children from making irreversible life-
9 changing decisions when their brains are not fully
10 developed. I would encourage you to put safeguards
11 in place even for adults seeking transition, like
12 counseling to address other mental issues that may
13 be the root cause of the confusion prior to any
14 surgery or hormonal intervention.

15 And I would suggest that having a true
16 informed consent where patients are fully informed
17 of the consequences of taking hormones, including
18 the rate of regret and the high risk of suicide 7 or
19 10 years after transition. Thank you very much.

20 ATTORNEY MCNULTY: Next, I have George
21 Lopez, Cory Hill, and Lindsay who would be next in
22 line, but they've chosen not to speak. But they are
23 opposed to the rule.

24 Next, I'll call Cassie.
25 Gus.

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1 Kevin Astle.

2 KEVIN ASTLE: Good afternoon. My name is
3 Dr. Kevin Astle. I'm an assistant professor with
4 the University of South Florida Taneja College of
5 Pharmacy. My statements today do not represent the
6 views of my employer. I hold several credentials
7 and board certifications including board certified
8 pharmacotherapy specialist. So in this role, I'm a
9 medication expert and I have the expertise to be
10 able to determine when medications are appropriate
11 and to evaluate the literature that's available for
12 medications.

13 I could preach to you about the
14 recommendations and rules that you are setting forth
15 today and how they contradict the recommendations of
16 all the major medical associations in the United
17 States, but you all are already aware of that. One
18 of the points discussed today is the informed
19 consent process and how for the children that you
20 want to continue on therapy that have already
21 engaged in gender-affirming care need this enhanced
22 informed consent process. That is already
23 occurring. That, along with the recommendations
24 made today, are evident that the guidelines have not
25 been reviewed. That the board here does not know

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1 what is actually being practiced in medical care
2 today and that these standards being proposed by the
3 board are outside of the standard practice in the
4 world.

5 Another point brought up today was for
6 research. You know, there's 49 states in the
7 country, let's let them do the research. What does
8 that say to our institutions here in the state of
9 Florida? That we're second class to the rest of the
10 United States? That the University of Florida, a
11 top five public institution where I'm a proud alumni
12 of, does not deserve to engage in research? Or
13 myself at the University of South Florida we cannot
14 engage in research for this topic just because we
15 live in the state of Florida? That will make us
16 second class to the rest of the United States and
17 that is not what we want to do.

18 And then finally on that, you talk about
19 not wanting to impair progress. This discussion
20 today, the fact that we're having this is impairing
21 progress, so that is all that's being done. This
22 country was founded on the principle of individual
23 rights and freedoms. Today you're making actions to
24 violate those freedoms for Floridians. You have the
25 right to choose whether or not you want to provide

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1 gender-affirming care in your practice. You have
2 that choice and that decision. You have the choice
3 and decision whether you should pursue gender-
4 affirming care yourself or for your children. Your
5 actions today are going to take that right away for
6 Floridians all across the state. And is that your
7 decision to make?

8 As a Board of Medicine, you're here to
9 guide medical practice. You're not here to
10 determine what is medical practice and what is not.
11 Your actions today would be in violation of your
12 role. You know, you're here to allow for safe
13 practice, not to dictate what is medical care and
14 what is not. When you graduated from medical
15 school, you took an oath to do no harm. These
16 decisions today will completely violate that oath,
17 and I think upon that your medical license should be
18 reviewed and should be considered to be revoked if
19 you pass this legislation. Thank you.

20 CHAIRMAN ZACHARIAH: Next is Patty Sullivan
21 (phonetic). Before -- you can come to the podium.
22 You will be the last speaker for the day. Let me
23 finish. Don't shout, you're not going to win. What
24 we're going to do, we'll give you an email for the
25 state of Florida. You send your information and

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1 whatever information you send will be a part of the
2 record.

3 UNIDENTIFIED SPEAKER: (Indiscernible) out
4 of the 100 or 1000 of people that are sitting in
5 here that vote.

6 CHAIRMAN ZACHARIAH: You know what -- okay.
7 Okay. Okay, that's fine.

8 Okay. Ms. Patty Sullivan, you may proceed.

9 UNIDENTIFIED SPEAKER: Their blood is on
10 your hands. Their blood is on your hands.

11 CHAIRMAN ZACHARIAH: That's okay. Let's
12 have some decency and quorum here.

13 Patty Sullivan, you may proceed.

14 PATTY SULLIVAN: Hi. My name is Patty
15 Sullivan and I'm with Parental Rights Florida. And
16 just a quick caveat since it was brought up, the
17 American School Counselors Association, the American
18 Medical Association, the American Pediatrics
19 Association, this is why this board is needed to
20 bring clear evidence-based rules and guidelines and
21 standards. The past president of the American
22 School Counselors Association in August in 2022 at a
23 national conference basically said, "Here in Florida
24 we have these laws made, and you need to learn the
25 rules, so that you can break the rules." So this is

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1 why you all are needed, and your expertise is needed
2 to bring these clear evidence-based standards.

3 I spent thousands of hours researching to
4 understand why specific Florida based and nationally
5 advocacy groups consistently opposed commonsense
6 family friendly legislation in Florida. I am a
7 Florida citizen. I'm a Florida mom. The research
8 that I did, hours and hours, confirmed these non-
9 medical organizations push gender-affirming medical
10 interventions even though real research shows the
11 majority of these children will resolve distress
12 after puberty.

13 UNIDENTIFIED SPEAKER: Bullshit.

14 PATTY SULLIVAN: Many of these parents with
15 gender dysphoric children are not being presented
16 with this critical information, nor are they being
17 given all the treatment options available to them to
18 treat their child's gender dysphoria such as
19 watchful waiting and counseling. If what is being
20 forced on these children and these families is so
21 valiant, why are these groups, why were they hiding,
22 and lying, and deceiving, and putting these support
23 guides behind the scenes and keeping parents out of
24 the loop. I have a school psychologist on video
25 telling administrators how not to tell the parents,

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1 through my research.

2 Why are these groups still pushing
3 irreversible medical transition procedures on
4 children when they know that the research shows that
5 the rate of completed suicide increases to 19 times
6 that of the normal population post transition?
7 Children with gender dysphoric issues deal with
8 profound and complex emotional issues. I had issues
9 that resolved from a childhood, and I'm married 34
10 years.

11 The consequences to a child making
12 permanent life altering decisions, taking drugs that
13 alter their moods and bodies, and then having their
14 genitals and breasts mutilated is beyond
15 comprehension.

16 The Florida Medical Board can put clear,
17 evidence-based rules, guidelines, and standards in
18 place and bring clear consequences for those who
19 would flagrantly break these rules and laws. And
20 the time for courage is now. I commend you and I
21 support you. Please do this and bring pause. Thank
22 you.

23 ATTORNEY MCNULTY: Thank you.

24 CHAIRMAN ZACHARIAH: Well, thank you so
25 much. The timing for the public comments have

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1 ended.

2 UNIDENTIFIED SPEAKER: Excuse me, Board of
3 Medicine, if --

4 CHAIRMAN ZACHARIAH: We'll take a
5 five-minute recess.

6 UNIDENTIFIED SPEAKER: I'm a State House
7 Representative here in Orlando. These are my
8 constituents, they deserve to speak.

9 CHAIRMAN ZACHARIAH: I understand that. I
10 understand that. You should know better. You are a
11 Representative. You know how this -- you represent
12 the House once in the state of Florida, so you
13 should obey the same rules. And the meeting is
14 adjourned for the next five minutes.

15 UNIDENTIFIED SPEAKER: You cut public
16 comment by one hour in Fort Lauderdale and you're
17 doing this shit again. We see you. We see everyone
18 of you and as long as you continue --

19 UNIDENTIFIED SPEAKER: We respectfully ask
20 for more time.

21 (Recess taken)

22 CHAIRMAN ZACHARIAH: Okay. Do you have a
23 quorum now? Yeah. We have a quorum. Let's talk
24 about the closing and the administrative matters.
25 Let's start with drafting the rule.

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1 Ed, do you want to start?

2 EXECUTIVE DIRECTOR TELLECHEA: We still
3 need some guidance on this issue regarding the
4 enhanced consent process. What do you want to see
5 in the consent?

6 MR. ROMANELLO: So do you think, Ed, that
7 you have enough specificity for the rule unrelated
8 to the consent form?

9 EXECUTIVE DIRECTOR TELLECHEA: You are
10 talking about the prohibition on the procedures for
11 people under 18?

12 MR. ROMANELLO: Yes.

13 EXECUTIVE DIRECTOR TELLECHEA: And making
14 it prospective?

15 MR. ROMANELLO: Yes.

16 EXECUTIVE DIRECTOR TELLECHEA: I have
17 enough on that.

18 MR. ROMANELLO: Okay.

19 EXECUTIVE DIRECTOR TELLECHEA: The enhanced
20 consent process though is what we're going to need
21 some more specifics on. What specifically you want
22 to see in that enhanced consent process.

23 MR. ROMANELLO: Got it. So I would
24 propose, as Doctors Biggs and Kaltiala -- I'm sorry,
25 as Doctors Dayton, Janssen, and McNamara propose,

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1 that any consent be predicated on a multi-
2 practitioner basis. Right. They all proposed a
3 multidisciplinary approach.

4 DR. ACKERMAN: Multidisciplinary panel. We
5 usually refer to it as a multidisciplinary panel.

6 MR. ROMANELLO: There you go.

7 DR. ACKERMAN: And we can say specifically
8 who should be on that panel.

9 MR. ROMANELLO: Right. So consisting of
10 pediatrics, psychiatry, endocrinology. And they
11 both spoke -- or all three of them spoke about
12 support systems and kind of mental health
13 counseling. And I think it was Dr. McNamara who
14 suggested a licensed clinical social worker when
15 Dr. Diamond was asking if you recommend those
16 surgical procedures to their patients and they said,
17 "Well, it would depend upon what the social worker"
18 -- you know, in part. So if we're going to have a
19 multidisciplinary panel, then I would suggest it's
20 pediatrics, psychiatry, endocrinology --

21 DR. DIAMOND: Pediatric endocrinology.

22 MR. ROMANELLO: Pediatric endocrinology and
23 a licensed clinical social worker.

24 DR. ACKERMAN: So can I just make a small
25 just recommendation? I don't think you need a

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1 psychiatrist but having a psychologist or licensed
2 clinical social worker, I think that's what I'm
3 hearing from them that would fill that niche.

4 ATTORNEY MCNULTY: So I'm a little unclear
5 about the role of a social worker.

6 DR. ACKERMAN: Well, a social worker is a
7 counselor like a --

8 ATTORNEY MCNULTY: No, I know what they do.
9 Just how that individual would integrate into this
10 multispecialty team and at what phase?

11 DR. ACKERMAN: Well, I think we heard from
12 them all that there was a psychological component to
13 this, and so the multidisciplinary panel, having a
14 psychological component to that. Because you have
15 the medical component with the pediatrician, the
16 endocrinologist component with the pediatric
17 endocrinologist, and the psychological component
18 with either a clinical psychologist or LCSW.

19 ATTORNEY MCNULTY: So where does the social
20 worker --

21 DR. ACKERMAN: That's the LCSW.

22 ATTORNEY MCNULTY: Yeah. But again, the
23 role of the social worker in that process.

24 DR. DERICK: To maybe evaluate the support
25 network for the individual.

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1 ATTORNEY MCNULTY: Okay.

2 DR. ACKERMAN: To assess, and to give
3 counseling, and to share with the panel that the
4 patient has been properly assessed.

5 ATTORNEY MCNULTY: Or, you know,
6 Dr. Derick, I think you answered my question. To
7 make sure that the individual has the appropriate
8 family support. Because some of these children, you
9 know, may not be in a two-parent family, you know,
10 they may be wards, have guardians. So the social
11 situation of the child I think answers my question.

12 CHAIRMAN ZACHARIAH: I have a question for
13 Dr. Hunter. Dr. Hunter, you deal with these things.
14 Do you think they should have a psychiatric
15 evaluation, or some psychiatrist involved in this
16 decision making?

17 DR. HUNTER: The level of mental
18 healthcare, whether it's psychology, psychiatry, I
19 think that's up for debate. One thing that I think
20 any consent needs to recognize and needs to share
21 with the patient and the family is the level of
22 evidence and what the systematic reviews have shown.
23 The NICE reviews out of England on puberty blockers
24 and cross-sex hormones are the best English language
25 reviews. The Swedish reviews are only summarized in

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1 English. They have not been translated from the
2 Swedish language to the English language with full
3 reviews. But any informed consent needs to disclose
4 the degree of evidence or lack thereof, whether who
5 that's coming from.

6 I agree it needs to be a multidisciplinary
7 process. That's what the Dutch said they would do.
8 And that needs to be -- the informed consent is not
9 a simple process in this setting. It has to include
10 surgery. I think it needs to include surgery
11 because once you're on the path of social
12 transition, there is good evidence that social
13 transition maintains that identity and changes the
14 desistence rates.

15 Once that's started, then you're on puberty
16 blockers. We've heard that puberty blockers lead 98
17 percent chance, 95 percent chance of cross sex
18 hormones. Now we're in the irreversible territory.
19 What percentage of those kids go on to surgery? So
20 for a 12, 13, 14-year-old to understand that, they
21 would then need to understand the surgical risks
22 because they're starting on a pathway that may not
23 go back, that may be irreversible.

24 So the consent process would have to
25 involve a surgeon, I believe, too, for the family to

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1 understand. The 12-year-old, 13, 14 year old might
2 not understand that but the parents, I think, are
3 due that knowledge of what the evidence review show
4 and the full gamut of what may proceed over the next
5 4, 5, 6 years.

6 DR. DIAMOND: Mr. Chair?

7 CHAIRMAN ZACHARIAH: Yes.

8 DR. DIAMOND: So again, going through these
9 different components, prospective rule I think is
10 clear. Enhanced consent, pediatrician, pediatric
11 endocrinologist, and I would say either a
12 psychologist or a licensed clinical social worker.
13 With respect to the point that Dr. Hunter is making,
14 I don't think I would be in concurrence that a
15 surgeon needs to be involved. I think that would be
16 very, very difficult, you know, just logistically.

17 I can understand that, and I appreciate
18 exactly where he's coming from but the logistics of
19 that may be difficult, so I would eliminate that
20 from the enhanced consent.

21 The third thing we were discussing is
22 whether or not to proceed with a research exemption.
23 And as know, Mr. Romanello made a motion, and it was
24 seconded. Dr. Hunter essentially made an amendment,
25 and I am supportive of that amendment. And in terms

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1 of language to help you, I would be of the opinion
2 that there's an exception that minors can be treated
3 with GHRH agonist or cross-sex hormones but only
4 under the auspices of a university sponsored/IRB
5 approved longitudinal trial in which the parents
6 give consent, the child gives assent, and there's a
7 continuing condition of receiving that intervention
8 that the child continue on that trial. And further,
9 that that proposed study must be presented to the
10 rules of the legislative committee for its approval
11 as a first step. Is that enough specifics for you?

12 EXECUTIVE DIRECTOR TELLECHEA: Yes. I
13 don't think you have the authority for that under a
14 standard of care rule.

15 DR. DIAMOND: So how would we go and try
16 and craft an exemption if that is the --

17 EXECUTIVE DIRECTOR TELLECHEA: I think you
18 need to remove the approval by the board.

19 DR. DIAMOND: Remove the approval of --

20 EXECUTIVE DIRECTOR TELLECHEA: Having the -
21 - coming before the board to have that type of
22 process approved.

23 DR. DIAMOND: So your contention would be
24 that my language would be sufficient except for that
25 it requires approval by the Rules and Legislative

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1 Committee; is that correct?

2 EXECUTIVE DIRECTOR TELLECHEA: I think that
3 would be -- yeah.

4 DR. DIAMOND: Okay. I'll stand with that.

5 UNIDENTIFIED SPEAKER: I would.

6 DR. HUNTER: I would just add that that
7 research is required to follow everyone well into
8 adulthood. That's the NHS language.

9 ATTORNEY MCNULTY: Is there an age?

10 DR. HUNTER: They just say -- the NHS
11 language -- they're still crafting their research,
12 but they do specifically say --

13 DR. DIAMOND: So Dr. Hunter, the issue that
14 we may have, while the child is receiving such
15 intervention, that's easy. But how do you go when
16 the person has now exceeded the age of majority and
17 is no longer perhaps receiving hormonal therapy, how
18 can it be required or mandated that the
19 participation continue?

20 DR. HUNTER: Well, you said no longer
21 receiving hormonal therapy. These transgender
22 patients need hormonal therapy for the rest of their
23 lives, so --

24 DR. DIAMOND: But also, we're not
25 regulating the care of individuals once they have

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1 reached majority.

2 DR. HUNTER: Correct. But this is where I
3 need clarification. This board is here for all
4 citizens of Florida, correct?

5 DR. DIAMOND: Of course.

6 DR. HUNTER: Not just those under the age
7 of 18.

8 DR. DIAMOND: But the motion on the table
9 is treatment of minors with gender dysphoria. My
10 particular position is that for persons that have
11 reached the age of maturity, that no intervention is
12 necessary.

13 DR. HUNTER: If we were going to give an
14 exception to research, I think we would want
15 research that is going to be valid and reveal data
16 that's legitimate and that would require long term,
17 longitudinal follow up.

18 DR. DIAMOND: I'm 100 percent with you.
19 How would we do that? How could we -- how could we
20 -- how could you affect that?

21 DR. HUNTER: That's going to be how well
22 the research is written. And that's beyond the
23 authority of this board.

24 DR. DIAMOND: I guess what you'd have to do
25 is maybe like any other study, if you sign up, we

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1 are asking in good faith that you agree to
2 participate in X period of time. But you know what,
3 if you drop off, it's a free country, we can't do
4 anything about that. I mean, perhaps that's the
5 best way to approach it. There's no way to mandate
6 that, of course.

7 DR. HUNTER: No.

8 CHAIRMAN ZACHARIAH: You know, Dr. Diamond,
9 I just want clarification. You said they either get
10 a psychologist on the case or a social worker. Is
11 that true? Because --

12 DR. DIAMOND: Well, I think that was what
13 -- I think that was what Dr. Hunter was saying is
14 that would meet his requirements.

15 Is that sufficient for you, Dr. Hunter? A
16 psychologist or a LCSW? Or was that not your
17 intent?

18 DR. HUNTER: Well, a related but separate
19 question. What does the current rule say just about
20 informed consent in general?

21 DR. DIAMOND: I don't think it specified.

22 EXECUTIVE DIRECTOR TELLECHEA: We don't
23 have rule that says -- about informed consent in
24 general. With the exception of for medical
25 marijuana and I think for --

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1 ATTORNEY MCNULTY: And cataract.

2 Cataracts.

3 EXECUTIVE DIRECTOR TELLECHEA: -- and for

4 cataract surgery. That's it.

5 DR. HUNTER: Okay.

6 EXECUTIVE DIRECTOR TELLECHEA: See that's

7 what I'm trying to get to. You know, when we did

8 those informed consent forms, we sat there, and we

9 drafted these forms in multiple meetings and we're

10 not getting that right now. We're getting the broad

11 outlines as what you want to see as part of your --

12 you know, the people, the entities that are going to

13 participate in the informed consent.

14 But if you all want or are expecting an

15 actual informed consent document to be used, you

16 know, or you're expecting an informed consent

17 procedure to be used, I'm going to need to know what

18 all those elements of that informed consent, what

19 those expectations are, so that they can be put in

20 the rule, so that the people that you are

21 regulating, the physicians who are involved in this

22 will know what those expectations are.

23 UNIDENTIFIED SPEAKER: Mr. Tellechea, we

24 don't have elements of the medical marijuana consent

25 in the rule, we just publish the standard form to

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1 use, right? I mean, the rule -- you don't go back

2 into the rule, there's not elements in the rule.

3 It's just here's the approved form.

4 ATTORNEY MCNULTY: But the rule adopted and
5 incorporated by reference the form, but that's part
6 of the rule.

7 UNIDENTIFIED SPEAKER: Why wouldn't we do
8 the same thing here? Why would we try to now draft
9 a form by committee? We've given -- I think we've
10 given the broad brushstrokes. Can you come back
11 with a proposed form that we can discuss? You've
12 heard about pediatric endocrinology, licensed
13 clinical social worker --

14 EXECUTIVE DIRECTOR TELLECHEA: We can work
15 and try to bring something back.

16 ATTORNEY MCNULTY: But what we wouldn't
17 have is the standards that you want, like all the
18 studies, the this, that, and the other, the
19 different prongs of it. For those other forms,
20 there were many meetings and people would work on
21 specific language that is inside the form. But for
22 example, you indicated you wanted to have the
23 certain risks associated with certain treatments.

24 MR. ROMANELLO: Yes.

25 ATTORNEY MCNULTY: But we don't know what

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1 those are. We don't know, the lawyers don't know
2 what those are.

3 MR. ROMANELLO: Yep. Agreed. I think that
4 Dr. Hunter had started to expand upon what some of
5 the risks associated with the therapies are, and I
6 would defer to my other physician colleagues to
7 modify or add to that list.

8 CHAIRMAN ZACHARIAH: Yeah, go ahead.

9 UNIDENTIFIED SPEAKER: I don't mean to
10 divert from this discussion but, you know, one thing
11 I heard was consistently from the experts the issue
12 of behavioral health and psychiatric diagnoses. And
13 I'm wondering if it would behoove us to have at
14 least two psychological evaluations.

15 I agree with the multidisciplinary team,
16 but hearing the testimony today, the fact that the
17 behavioral health conditions are so prevalent, would
18 it be appropriate to actually have the concurrence
19 include two behavioral health evaluations, clinical
20 psychologist, psychiatrist?

21 DR. PAGE: I agree with your statement. I
22 would support that.

23 CHAIRMAN ZACHARIAH: Go ahead. Go ahead.

24 DR. PAGE: No. I would support what you're
25 saying, like we have to make sure -- you know,

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1 address the underlying mental health issue that
2 could have triggered this gender dysphoria.

3 CHAIRMAN ZACHARIAH: Yeah. See but one of
4 the reasons I ask the question, if you listen to the
5 testimony of the experts and from the public,
6 psychiatric issues was a major role in that. It
7 really was, in almost all of them. And I strongly
8 -- one thing I strongly believe is that these minors
9 should have a psychiatrist or a psychology
10 evaluation. Not to be all -- what does a social
11 worker know about psychological issues? They're not
12 trained in that. No, they're trained in, you know,
13 homes and other issues.

14 EXECUTIVE DIRECTOR TELLECHEA: They're
15 talking about licensed clinical social workers.

16 DR. ACKERMAN: Yeah. They're trained in
17 psychological issues.

18 CHAIRMAN ZACHARIAH: Well, so far, their
19 psychological training, I have no problem. But my
20 concern is majority of them have significant
21 psychological issues and they must get some kind of
22 psychologic evaluation to make sure that that can be
23 resolved in some other fashion.

24 DR. ACKERMAN: And LCSWs do that. Not just
25 psychologists, LCSWs. They don't just arrange for

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1 homecare, they also do counseling and evaluations.

2 CHAIRMAN ZACHARIAH: Okay. If they're
3 trained to do so, I have no problem with that.

4 DR. DERICK: So if I'm understanding this
5 correctly, if a parent and a child desire to undergo
6 transitioning in the current proposed rule, they
7 would be able to do so but only at an institution as
8 part of a clinical trial with an IRB approval. And
9 that if you are someone who is currently undergoing
10 therapy, then this is where this informed consent
11 comes in in a minor.

12 DR. DIAMOND: That's correct.

13 DR. DERICK: Where there would be -- not a
14 cessation of treatment, but during the continuation
15 of treatment that they would be then reformed with
16 consent with this multidisciplinary team that's
17 chosen by the -- somebody, I don't know who that
18 would be. The person who was currently providing
19 care to them. And then the studies would be
20 presented to those people for consideration and then
21 they would be allowed to continue their therapy if
22 they chose to do so. Is that correct?

23 ATTORNEY MCNULTY: So what I'm hearing is
24 it's almost like we've got a staged evaluation.
25 Should we look at consent at each phase of the

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1 evaluation and therapy?

2 DR. DIAMOND: Well, I'm not sure I'm
3 understanding correctly. My understanding is, is
4 that the motion as intended was that as of a certain
5 date, these interventions are prohibited unless it's
6 under the strict auspices of a clinical trial,
7 analogous to what our colleagues in the United
8 Kingdom are doing.

9 Having said that, for individuals who are
10 currently receiving intervention, we recognize that
11 there may be actually some harm to stop, and
12 therefore, we are going to say there is an
13 opportunity to continue, but as a condition to
14 continue, there must be a documentation of this more
15 enhanced consent that occurs within a certain period
16 of time. That was my understanding of how
17 Mr. Romanello was trying to phrase it.

18 Nick, did I get that right?

19 MR. ROMANELLO: Yes.

20 ATTORNEY MCNULTY: And might as well, I
21 guess what I didn't clarify is as each of these
22 therapies evolve in advance, would an additional
23 consent, or at least requirement that the risks
24 associated with those therapies be -- you know, be
25 given, understood, and consented to? So as the

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1 individual progress, as the child progresses through
2 each phase of the therapy, the consent is already
3 there but do we want to add the additional consent
4 for the risk of the medication --

5 DR. DIAMOND: I want to understand. So
6 you're referencing a -- for example, a 12-year-old
7 who may be currently on GHRH agonist therapy, and
8 that the parent and the child express a wish to
9 continue. They've gone through and done the enhance
10 consent process. And then are you saying that it is
11 your intent that if that child were to then, and the
12 parents were then to have an interest in going on to
13 cross sex hormones that there would be a second
14 component of enhanced consent? Is that what you're
15 saying?

16 ATTORNEY MCNULTY: Yeah. At least a
17 comprehensive explanation of the consequences of
18 those drugs. Now, whether it's has part of the
19 first consent --

20 DR. DIAMOND: I don't know if that's going
21 to add anything further to what we're doing.

22 ATTORNEY MCNULTY: Okay.

23 MS. JUSTICE: Do we need to address that in
24 this rule? I mean, that has to occur already anyway
25 because --

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1 UNIDENTIFIED SPEAKER: It should.

2 MS. JUSTICE: Right. I mean, you're giving
3 a new treatment and arguably, that patient is not in
4 the same stage or condition that they were when they
5 initiated the prior treatment. So informed consent
6 is -- we don't need to address that in this rule, I
7 don't think. I don't mean informed consent period,
8 I mean at each phase.

9 ATTORNEY MCNULTY: Hearing the testimonies
10 from some of these individuals was pretty compelling
11 to the consequences --

12 MS. JUSTICE: I agree.

13 ATTORNEY MCNULTY: -- and you know, just
14 trying to make sure that we capture --

15 MR. ROMANELLO: But what I think
16 Ms. Justice is alluding to is if you're on puberty
17 blockers today and a year from now you're
18 recommended to start initiating cross sexual
19 hormones, that would require a separate consent form
20 because that's a new modality of treatment. And
21 then if you go three years down the line and you're
22 recommending surgical intervention, that would
23 require yet another -- so you're always going to
24 have those ongoing consent requirements, separate
25 and apart from --

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1 ATTORNEY MCNULTY: Maybe the simpler time,
2 or at least to try to get around this is just list
3 what that consent, or at least the consent that's
4 provided, what that has to contain. Right. Which
5 you've done. Instead of actually drafting the form.

6 DR. HUNTER: I think one of the problems
7 with the -- and I think everybody has a problem
8 worldwide in this consent area is there is so much
9 that is unknown. So to give a valid informed
10 consent requires the patient's understanding and
11 their capacity. Okay. It's -- we all question, as
12 a profession, the capacity of somebody under the age
13 of 18 to consent, let alone you mix in mental health
14 issues. So that's an issue. But the understanding
15 is the hard part because there is so much unknown
16 about this therapy.

17 So to provide an -- that's what makes it,
18 in my opinion, experimental, because there is so
19 much that is unknown and that's why it's moving back
20 into the experimental realm in Sweden, Finland,
21 England, as we've heard. So the ability to give
22 informed consent is nearly impossible.

23 DR. DIAMOND: Mr. Chair, if there's no
24 further discussion, perhaps we could call the
25 question?

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1 CHAIRMAN ZACHARIAH: Yeah. Because we only
2 have 10 more minutes. So what -- we can call the
3 question but what I really would suggest that let's
4 ask Mr. Tellechea what else does he need to do his
5 job?

6 DR. DIAMOND: Today.

7 EXECUTIVE DIRECTOR TELLECHEA: Well, I'm
8 going to need someone to sit down with me and
9 explain what you want to put in the informed
10 consent, because you're not giving me enough at this
11 point in time.

12 I mean, Donna? I mean --

13 ATTORNEY MCNULTY: I mean, I agree. Unless
14 you -- I mean, I agree overall with Ed. The other
15 option, which I think Dr. Schwemmer raised, was
16 instead of having like this detailed board form for
17 the informed consent, do you just want the elements
18 in your rule?

19 DR. DIAMOND: Elements, elements.

20 EXECUTIVE DIRECTOR TELLECHEA: Right. But
21 you need to tell me what the elements are.

22 ATTORNEY MCNULTY: But they need to be very
23 specific for everything.

24 MR. ROMANELLO: So the first element is
25 that it is a multidisciplinary panel that you are

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1 going to get the consent from, and that
2 multidisciplinary panel will include pediatric
3 endocrinology, pediatrician --

4 DR. ACKERMAN: And either a clinical
5 psychologist or licensed clinical social worker.

6 MR. ROMANELLO: -- and either a clinical
7 psychologist or a licensed clinical social worker.

8 ATTORNEY MCNULTY: Behavioral health, two
9 psych opinions?

10 MR. ROMANELLO: Yes. So --

11 ATTORNEY MCNULTY: Wait, wait. This is the
12 informed consent we're talking about?

13 MR. ROMANELLO: Yes.

14 ATTORNEY MCNULTY: So you want two of them
15 on there?

16 MR. ROMANELLO: Yes.

17 CHAIRMAN ZACHARIAH: Did he say two
18 separate people?

19 ATTORNEY MCNULTY: Two psychological
20 evaluations.

21 EXECUTIVE DIRECTOR TELLECHEA: Is this
22 going to be a consent form that the patient and the
23 family is going to read and sign off on?

24 DR. DERICK: I think the intention is that
25 certain types of physicians would be involved in

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1 provided the information that would be consented
2 upon. I just think it does seem kind of complicated
3 for people already undergoing therapy who have
4 already consented to this treatment then be
5 reconsented with a very specific group of people.

6 DR. DIAMOND: I agree with Dr. Derick.
7 These folks are undergoing treatment. The intent, I
8 believe, from Dr. Hunter and Mr. Romanello is to
9 simply say, "Hey, the rule allows you to continue
10 but please understand that you need to be aware of
11 these complexities." And there needs to be sign off
12 with the parent, the patient, of course, and I would
13 say a pediatrician, endocrinologist, and either a
14 psychologist or a LCSW and stop there. I wouldn't
15 go beyond that. I mean, I just wouldn't.

16 DR. DERICK: So you're saying you wouldn't
17 dictate what those people would be consenting about
18 but that they would just need to be consented with
19 those specialists.

20 DR. DIAMOND: They need to go and verify
21 that to the best of their professional abilities,
22 that the patient and the family are aware of the
23 risks, benefits, and alternatives of treatment as we
24 do whether it be cancer treatment or anything else.

25 DR. DERICK: For the record, I'm not aware

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1 of how that's different from what's currently
2 happening. Because these are the specialists who
3 are treating this patient population and they're
4 consenting the patients.

5 DR. HUNTER: I think the trouble we're
6 having is what the Dutch described in their studies
7 and in their papers is that informed consent in this
8 area is not a form, it's a long process. And they
9 talked about it being at least six months. I think
10 some of the reference is longer than that. It's a
11 process where they meet with all these people, and
12 they understand.

13 MS. JUSTICE: That's right.

14 DR. HUNTER: Understand the limitations.
15 Let me float this idea, because we're -- I see three
16 points that we're sort of coalescing around. One,
17 that psychological care be the standard. Number two
18 is that there be a moratorium on puberty blockers,
19 cross sex hormones, and surgery under 18. And
20 three, that a clinical trial be the only way to go
21 forward under 18.

22 The problem we're having is the problem
23 that everybody else is having is the kids that are
24 already being transitioned. And maybe we remain
25 silent on that expect to say when the clinical

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1 trials do exist, those kids need to be enrolled in
2 those trials. Because that's where an informed
3 consent process that is IRB approved, they'll spend
4 hours, and hours, and hours, and hours on that.
5 Okay. And maybe we remain silent on the kids
6 already in this system, but when we rehash that
7 issue at later meetings.

8 MR. DIAMOND: My bias would be to not do it
9 that way. These are people that have already
10 commenced under a certain understanding or set of
11 understandings. And I think that to require them to
12 go and then participate in a clinical trial, I think
13 that may be a bit too much. I fully get what you're
14 saying, it solves certain problems, but it may
15 create additional issues.

16 CHAIRMAN ZACHARIAH: Dr. Di Pietro.

17 DR. DI PIETRO: Trying to step back and
18 take a big picture view on this, I'm starting to
19 think about the problems that might happen. And the
20 biggest problem I can see beyond a lot is who is
21 ultimately responsible for the patient's care in
22 this informed consent. So is it the pediatrician?
23 Is it the pediatric endocrinologist? Like who is
24 responsible for making sure that the boxes have been
25 checked?

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1 DR. DIAMOND: Well, typically it would be
2 the individual who is actually prescribing the
3 medication.

4 DR. DI PIETRO: So it would -- okay. So
5 that's -- you know --

6 MR. ROMANELLO: So Mr. Chair, in the -- as
7 we're starting to get time compressed --

8 CHAIRMAN ZACHARIAH: Yes.

9 MR. ROMANELLO: -- can I suggest that we
10 consider the motions separate and apart from the
11 consent which we have not fully coalesced and come
12 to a consensus on? But we did have a motion and a
13 second and Dr. Diamond offered an amendment which I
14 would gladly accept.

15 DR. DIAMOND: Well, that was Dr. Hunter,
16 but I seconded it.

17 MR. ROMANELLO: Okay.

18 DR. PAGE: I have a question before you
19 move on. So in your motion you're talking about
20 conducting clinical trials. So do we need to
21 elaborate more on that? Like which institutions are
22 going to be allowed to do clinical trials? Can
23 anybody just do their own clinical trials in their
24 office or how do we go about that?

25 DR. DIAMOND: Well, like I said, in my

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1 comment I thought it would need to be an IRB
2 approved clinical trial at a university affiliated
3 center. Those are the two main components.

4 DR. ACKERMAN: Approved by the rules
5 committee?

6 DR. DIAMOND: No. Mr. Tellechea said that
7 would be problematic and we dropped that.

8 EXECUTIVE DIRECTOR TELLECHEA: You've got
9 to keep in mind, these are standard of practice
10 rules, all right. We can't create research studies
11 through standard of practice rules. We have to set
12 -- these are the regulations that the doctors who
13 are performing these procedures must adhere to. So
14 going off and trying to approve studies and all that
15 that's going to go way beyond your rulemaking
16 authority in this particular area.

17 MR. ROMANELLO: And what Doctors Hunter and
18 Diamond had come up with, an IRB approved study at
19 an academic institution without approval of laws and
20 rules I thought you said would have met --

21 EXECUTIVE DIRECTOR TELLECHEA: Yeah.
22 That's fine.

23 MR. ROMANELLO: That's what we're going
24 to --

25 EXECUTIVE DIRECTOR TELLECHEA: I know. But

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1 Dr. Ackerman was coming back around to that issue,
2 and I was trying to --

3 DR. ACKERMAN: Sorry, I was just trying to
4 clarify.

5 CHAIRMAN ZACHARIAH: So is the board ready
6 to vote on this motion?

7 DR. DIAMOND: Yes.

8 ATTORNEY MCNULTY: We need to maybe read it
9 back.

10 EXECUTIVE DIRECTOR TELLECHEA: Just to
11 clarify, we're not going to be dealing with informed
12 consent now. That's somewhere down the line we'll
13 deal with that.

14 MR. ROMANELLO: Yes.

15 EXECUTIVE DIRECTOR TELLECHEA: Okay. So my
16 understanding is that you're going to put the
17 prohibition on the puberty blockers, the
18 cross-hormone therapy, and the surgery under the age
19 of 18, for anyone under the age of 18, unless it's
20 being done within the auspices of the language that
21 you used, a university affiliated --

22 UNIDENTIFIED SPEAKER: IRB approved --

23 DR. DIAMOND: IRB approved.

24 EXECUTIVE DIRECTOR TELLECHEA: -- IRB
25 approved --

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1 DR. DIAMOND: University affiliated
2 clinical trial.

3 EXECUTIVE DIRECTOR TELLECHEA: Which you're
4 going to give me that specific language later on.
5 That's what I'm hearing at this point in time.

6 DR. DIAMOND: And that the rule is a
7 prospective rule.

8 EXECUTIVE DIRECTOR TELLECHEA: And it's
9 prospective. Yes.

10 ATTORNEY MCNULTY: Early, Dr. Diamond, I
11 think one board member mentioned that you also
12 wanted it in the rule that the drugs remain
13 available for treatment of other medical disorders
14 and that once the person reaches 18, no restrictions
15 on this. Did you want that in the rule?

16 DR. DIAMOND: Well, I think the easier way
17 to do is say that this rule applies exclusively to
18 minors with gender dysphoria. Make it easy. And I
19 think by doing that, there's no need to address
20 persons who reach the age of majority or other
21 medical conditions.

22 MR. ROMANELLO: Right.

23 CHAIRMAN ZACHARIAH: So we have a motion.
24 So restated the motion, seconded. Any further
25 discussion?

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1 DR. DI PIETRO: Sorry, so I just need to
2 reclarify. So we're off on informed consent and
3 we're back to IRB approved research for under 18?

4 MR. ROMANELLO: Yes.

5 DR. DERICK: I think there are three
6 elements.

7 DR. DI PIETRO: Yeah. Because for me,
8 they're not -- they're not separate issues because I
9 can't -- it would be very difficult for me to vote
10 on just that because the informed consent issue and
11 the absence of research is a whole different
12 element. So I'm just trying to clarify because I
13 feel like they're two completely separate issues.

14 CHAIRMAN ZACHARIAH: You know what, we have
15 a motion, the board second. Somebody had to vote on
16 it because it's past 1 o'clock, the meeting has to
17 end.

18 MS. PAGE: No. But I'm sorry, before we
19 vote, I agree with her comment. I think the
20 informed consent is very important.

21 EXECUTIVE DIRECTOR TELLECHEA: Then vote
22 against it. We need to vote now. We have a hard
23 stop on this meeting. It was noticed until 1
24 o'clock, so we have to --

25 CHAIRMAN ZACHARIAH: We have to stop the

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1 meeting at 1 o'clock. So we have a motion,

2 seconded. All in favor, say aye.

3 (Multiple ayes)

4 Any opposed?

5 (Multiple nays)

6 MR. ACKERMAN: They can't make motions.

7 CHAIRMAN ZACHARIAH: Let's see a motion in
8 favor?

9 (Multiple ayes)

10 Any opposed?

11 (Multiple nays)

12 So two opposed?

13 MR. ACKERMAN: Three opposed.

14 CHAIRMAN ZACHARIAH: Can we have the hands
15 up, the ones who opposed?

16 Okay. All in favor? Hold on, hold on.

17 Ma'am, would you please quiet. I'm conducting the
18 meeting. You are not conducting the meeting.

19 Okay. All in favor of the motion, raise
20 your hand. You don't have to hear it.

21 Okay. All opposed?

22 Okay. And the motion carries, thank you so
23 much and the meeting is adjourned.

24 (END OF AUDIO RECORDING)

25

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1 CERTIFICATE OF TRANSCRIPTIONIST

2 I certify that the foregoing is a true and
3 accurate transcript of the digital recording
4 provided to me in this matter.

5 I do further certify that I am neither a
6 relative, nor employee, nor attorney of any of the
7 parties to this action, and that I am not
8 financially interested in the action.

9

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Julie Thompson

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Julie Thompson, CET-1036

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Jane Doe

vs.

Joseph Ladapo

Taped Transcription

November 04, 2022



Med Def_000876

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAP0,

6 Defendant.

7

8 CASE NO. 423CV114RHMAF

9

10

11

12

TRANSCRIPTION OF AUDIO RECORDING

13

JOINT MEETING

14

FLORIDA BOARD OF MEDICINE

15

FLORIDA BOARD OF OSTEOPATHIC MEDICINE

16

NOVEMBER 4, 2022 / 2:02 P.M.

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TRANSCRIBED AUDIO RECORDING BY:

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Julie Thompson, CET

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25 Job No.: 322529

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1 Thereupon,
2 The following proceeding was transcribed from an
3 audio recording:

4 * * * *

5 CHAIRMAN DIAMOND: Good afternoon. My name
6 is Dr. David Diamond. I have the privilege of being
7 the Chair of the Florida Board of Medicine. To my
8 right is Dr. Sandra Schwemmer, the Chair of the
9 Florida Board of Osteopathic Medicine.

10 At this time it's 2 o'clock on November the
11 4th. I'd like to call to order this meeting of the
12 Joint Boards of the Florida Board of Medicine and
13 the Board of Osteopathic Medicine.

14 Can we please take a roll call?

15 MS. STRICKLAND: Dr. Diamond?

16 CHAIRMAN DIAMOND: Present.

17 MS. STRICKLAND: Dr. Ackerman?

18 CHAIRMAN ACKERMAN: Present.

19 MS. STRICKLAND: Dr. Barsoum has been
20 excused.

21 Dr. Chandra has been excused.

22 Dr. Derrick has been excused.

23 Dr. Hunter.

24 DR. HUNTER: Present.

25 MS. STRICKLAND: Dr. Pages.

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1 DR. PAGES: Present.

2 MS. STRICKLAND: Dr. Pimentel?

3 DR. PIMENTEL: Present.

4 MS. STRICKLAND: Dr. Vila?

5 DR. VILA: Present.

6 MS. STRICKLAND: Dr. Wasylik?

7 DR. WASYLIK: Present.

8 MS. STRICKLAND: Dr. Zachariah has been

9 excused.

10 Ms. Garcia?

11 MS. GARCIA: Present.

12 MS. STRICKLAND: Ms. Justice?

13 MS. JUSTICE: Present.

14 MS. STRICKLAND: Mr. Romanello has been

15 excused. Also present are Mr. Paul Vasquez,

16 Executive Director for Board of Medicine; Ed

17 Tellechea, board counsel; Donna McNulty, board

18 counsel; myself; Sherry Strickland, program

19 operations administrator; Surrey Williams,

20 Regulatory Specialist III; Brad Dalton, public

21 information officer.

22 Chair, you have a quorum.

23 CHAIRMAN DIAMOND: Thank you so much. At

24 this time, I'd like to ask Mr. Paul Vasquez, the

25 Executive -- oh, I'm sorry. I beg your pardon.

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1 Go ahead.

2 CHAIRWOMAN SCHWEMMER: Ms. Terrell, would
3 you take roll for the Board of Osteopathic Medicine?

4 EXECUTIVE DIRECTOR TERRELL: Yes, ma'am.
5 Dr. Schwemmer?

6 CHAIRWOMAN SCHWEMMER: Present.

7 EXECUTIVE DIRECTOR TERRELL: Dr. Mendez?

8 DR. MENDEZ: Present.

9 EXECUTIVE DIRECTOR TERRELL: Dr. Gadia?

10 DR. GADIA: Present.

11 EXECUTIVE DIRECTOR TERRELL: Dr. Pietro?

12 DR. PIETRO: Present.

13 EXECUTIVE DIRECTOR TERRELL: Dr. Kirsh?

14 VICE-CHAIR KIRSH: Present.

15 EXECUTIVE DIRECTOR TERRELL: And Ms.

16 Jackson has been excused. Also present, myself,
17 Executive Director of the Board of Osteopathic
18 Medicine, Danielle Terrell; Carol Taylor, program
19 operations -- program office administrator; and
20 Derick Nieves, a Regulatory Specialist III.

21 And, Chair, you do have a quorum for the
22 Board of Osteopathic Medicine.

23 CHAIRWOMAN SCHWEMMER: Thank you.

24 CHAIRMAN DIAMOND: Thank you very much. At
25 this time, I'd like to ask Mr. Paul Vasquez, the

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1 Executive Director of the Florida Board of Medicine
2 to make some remarks.

3 EXECUTIVE DIRECTOR VASQUEZ: Thank you,
4 Chair. Good afternoon. It's Friday, November 4,
5 2022, at 2:02 p.m. My name is Paul Vasquez. I'm
6 the Executive Director of the Florida Board of
7 Medicine. This is a duly noticed meeting of the
8 Boards. This is a public meeting and is being
9 recorded. The audio will be available on the
10 Board's websites next week.

11 I'll now go over some instructions, so this
12 meeting will be successful, and the board members
13 will be able to take care of the matters that are
14 before them today.

15 There's a court reporter in the meeting.
16 If you speak to the boards, it's important that you
17 state your name for the record. When appropriate,
18 the chair will ask for public comments. Therefore,
19 please refrain from speaking during the meeting
20 until the appointed time. Please remember, this is
21 a public meeting, and it's being recorded. Any side
22 conversations and activities may be recorded and
23 become part of the public record.

24 At this time, please silence all electronic
25 devices, and one housekeeping issue for the Boards,

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1 just remember when you're speaking to have your
2 microphones on for the court reporter.

3 The Boards of Medicine and Osteopathic
4 Medicine are apolitical bodies that have the primary
5 mission of protecting the people of the state of
6 Florida. As with any issue before them, the Boards
7 intend to look at the available science and
8 appropriate standard of care while putting aside any
9 personal feelings on the issues before them today.

10 In terms of how the meeting will be
11 conducted, the expectation is that we will have a
12 civil discourse while discussing the issues on
13 today's agenda. We require that everyone refrain
14 from making any disruptive comments or taking any
15 disruptive actions during the duration of the
16 meeting. The Boards reserve the right to remove any
17 individual who chooses to disrupt the progress of
18 the meeting. Please conduct yourselves accordingly.

19 Public comment at this meeting will be
20 limited and will come at the end of the meeting.
21 The public comment process will be as equitable as
22 possible. However, it is evident that not everyone
23 who wishes to speak will be able to speak at this
24 meeting.

25 The Florida Board of Medicine and Board of

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1 Osteopathic Medicine invite and encourage interested
2 parties to provide comment on matters before the
3 Boards.

4 The following guidelines will apply to
5 public comments. Interested parties will be given
6 an opportunity to provide comment on matters before
7 the Boards after an agenda item is introduced.
8 Interested parties may provide comments on the
9 record during the meeting, or they can waive
10 speaking and indicate their position on the issue,
11 which will also become part of the record.
12 Appearance forms have been provided to facilitate
13 this process.

14 In terms of how the appearance forms will
15 be handled. They're being collected. They're being
16 separated by position, and they're being randomized
17 and will be drawn randomly based on the positions.

18 Interested parties will be limited to three
19 minutes to provide comment, which may only be
20 extended by the Chair, if time permits, based on the
21 number of proposed speakers. If an interested party
22 is part of a larger group of persons, you're
23 requested to identify one individual who will speak
24 on behalf of the group, if possible. Interested
25 parties may use pseudonyms if they do not wish to

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1 identify themselves on the record.

2 The progress of the meeting will include a
3 discussion of draft rule language related to the
4 practice standards for the treatment of gender
5 dysphoria, discussion and vote by the Boards, and
6 public comment.

7 In terms of progress after this meeting, if
8 language is developed and proposed, it will be
9 published in the Florida Administrative Register,
10 which will include any instructions for further
11 activities related to rulemaking process pursuant to
12 Chapter 120. Thank you, Chair.

13 CHAIRMAN DIAMOND: Thank you very much. At
14 this time, I'd like to ask Mr. Ed Tellechea, board
15 counsel, to make a few remarks to discuss the
16 process on how things proceed should a rule be
17 adopted.

18 ATTORNEY TELLECHEA: Thank you -- excuse
19 me. Thank you, Mr. Chair. If there is -- today,
20 there will be language that will be -- that is being
21 presented to both of the Boards. If the Boards at
22 any point in time decide to adopt -- approve this
23 language, we have a vote either approving the
24 language as is or amended. We will -- then we will
25 take the language back, and we will publish it in

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1 the Florida Administrative Register.

2 It will appear -- and then once it
3 publishes in the Florida Administrative Register,
4 and correct me if I'm wrong, Donna, I think you have
5 21 days -- excuse me -- you have 21 days in order to
6 request a rule hearing. If somebody requests a rule
7 hearing, then the rulemaking process is put on hold
8 until the rule hearing takes place.

9 A rule hearing will be much like some of
10 the meetings that we've already had, where the
11 individuals who requested the rule hearing and
12 others who are present can make public comment
13 regarding the proposed rule language itself.

14 If the rule hearing occurs, the Board can
15 change the rule language based on the public
16 comments or they can go ahead and affirm the
17 existing rule language and move forward with the
18 rulemaking process. And once the rule goes into
19 effect, of course, the rules can be challenged.

20 In total when you're looking at rulemaking,
21 realistically, based upon the time frames once rule
22 language is published, we're talking about anywhere
23 between 60 to 90 days before it becomes effective,
24 depending on the circumstances.

25 CHAIRMAN DIAMOND: Thank you very much.

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1 Ladies and gentlemen, as we commence
2 today's meeting, I wish to use my position as Chair
3 to make some remarks.

4 In early June, we received notification
5 that the State intended to present the medical
6 Boards with a formal petition to initiate rulemaking
7 on the subject of gender dysphoria, and that this
8 petition would be presented during our August 5th
9 board meeting in Tampa.

10 From the onset, I directed the Board staff
11 that, given the deep sensitivities and the
12 complexities of this issue, we approached this
13 matter in a manner that not only was fair but was
14 perceived as being fair.

15 As such, during that August 5th meeting, as
16 we hosted our Surgeon General and others
17 representing the position of the State, I insisted
18 that equal time and position be granted to experts
19 from the University of Florida, Dr. Holler, and Dr.
20 Dayton, who held an opposing position. I asked, as
21 would Aristotle, that we approach this subject with
22 reason free of passion. I believe that all members
23 present found the ensuing discussion productive with
24 three take-home messages.

25 First, from oral testimony, we learned that

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1 at the major centers in Florida, so-called bottom
2 surgery is not offered for minors, and that so-
3 called top surgery is infrequently offered to
4 minors. Although, there have been instances in
5 Florida where females as young as 15 years old have
6 undergone mastectomy.

7 Second, from written testimony, we learned
8 that there are substantive differences between the
9 large medical societies and our European colleagues
10 in the treatment of minors with gender dysphoria.
11 To say that there is a singular unquestioned
12 standard of care is simply not accurate.

13 And lastly, the chief point of agreement
14 amongst all the experts, and I must emphasize this,
15 is that there is a pressing need for additional
16 high-quality clinical research.

17 Subsequently, we took public comment. The
18 selection of comments was randomized in an
19 alternating yea, nay fashion, with the exception
20 that I use my discretion to ensure that State
21 Representative, Anna Eskamani, whom I knew stood in
22 opposition to the petition, had a chance to speak.
23 I did this out of respect for her office. The vast
24 bulk of the meeting was dignified and productive,
25 and ultimately the Board voted to initiate

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1 rulemaking.

2 The task then fell upon the Joint Rules and
3 Legislative Committee chaired by Dr. Zachariah to
4 consider and possibly develop rules language. This
5 committee meeting was initially scheduled for
6 September 30th, but due to the hurricane, it was
7 rescheduled to October 28th.

8 In preparation for that meeting, I directed
9 the staff to invite subject matter experts with
10 differing viewpoints and representing essentially
11 three cohorts. The first cohort being Florida-
12 licensed pediatricians or pediatric endocrinologists
13 who actively treat minors with gender dysphoria.

14 The second cohort being scientists, both
15 American and international, with expertise in the
16 extent clinical data.

17 And the third cohort being representatives
18 of the large American clinical societies.

19 Mr. Paul Vasquez, to my left, the Executive
20 Director of the Board, worked assiduously on this
21 directive. We were pleased that ultimately
22 representatives from the University of Florida, the
23 University of Oxford, Yale University, University of
24 Turku in Finland, and the Children's Hospital in
25 Chicago, as well as a private practice

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1 endocrinologist from California, joined us at that
2 committee meeting.

3 A formal invitation was also extended to a
4 large medical society known to be opposed to the
5 state's position, namely the Endocrine Society.
6 That society declined our invitation. Formal
7 invitations were also sent but declined by
8 physicians actively practicing its transgender care
9 clinics at Nicklaus Children's Hospital, Miami, at
10 Johns Hopkins All Children's Hospital in St.
11 Petersburg, and at the Joe DiMaggio Children's
12 Hospital in Hollywood.

13 We also received contact from several
14 accomplished pediatric endocrinologists practicing
15 here in Florida, who stated their discomfort with
16 the guidelines espoused by the Endocrine Society,
17 WPATH and the American Academy of Pediatrics. These
18 physicians, of course, were invited to speak on
19 October 28th, but each declined. They cited a
20 concern that their positions in various medical
21 societies and indeed their actual employment would
22 be jeopardized should they speak.

23 I found this culture of intimidation, be it
24 real or perceived, to be antithetical to the spirit
25 of medicine and more poignantly, profoundly sad.

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1 During the October 28th rules committee
2 meeting, Dr. Zachariah took additional public
3 comment. Many of the comments representing both the
4 affirmative and negative positions were emotionally
5 powerful. To all of those who came and expressed
6 their opinions with dignity and courage, we members
7 of the Board salute you.

8 Further to our subject matter experts who
9 cited data at adduced their sources, the Board also
10 extends our thanks. This is how science should
11 work, vigorous free -- I'm sorry -- vigorous debate,
12 free of intimidation.

13 A motion by Mr. Romanello and then amended
14 by Dr. Hunter to include a research exemption was
15 ultimately passed. Today, the task falls upon this
16 joint meeting of the Boards of Medicine and
17 Osteopathic Medicine to consider the rules committee
18 proposal.

19 The proposal has the following elements.
20 First, the rule is limited exclusively to the
21 treatment of minors with gender dysphoria.

22 Second, the rule is prospective.

23 Third, once the rule is effective, sex
24 reassignment surgery or any other procedure that
25 alters primary or secondary sexual characteristics

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1 for the treatment of gender dysphoria in minors
2 would be prohibited.

3 Fourth, once the rule is effective, those
4 minors who have already commenced puberty-blocking
5 hormone or hormone antagonist therapy for the
6 treatment of gender dysphoria may be continued on
7 hormonal therapy.

8 Fifth, once the rule is effective, puberty-
9 blocking hormone and hormone antagonist therapy for
10 the treatment of gender dysphoria in minors who have
11 not yet commenced such therapies would be
12 prohibited.

13 Sixth, and very importantly, the proposal
14 included an exception for clinical research.
15 Specifically, non-surgical treatment for the
16 treatment of gender dysphoria may be conducted under
17 the auspices of an institutional review board-
18 approved investigator-initiated clinical trial at a
19 Florida Medical School. The clinical trial must
20 include provisions for long-term longitudinal
21 assessment of the patient's physiologic and
22 psychologic outcomes.

23 Today, I stand in support of the rules
24 committee resolution, as I feel that it is a
25 thoughtful navigation between Scylla and Charybdis,

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1 as was faced by Odysseus. First, the resolution is
2 limited only to minors.

3 As such, the Rules Committee recognizes
4 that our legal and medical tradition speaks to a
5 difference in the mental capacity between minors and
6 adults with respect to making medical decisions,
7 some of which in this context may produce
8 irreversible physiologic and psychologic changes.

9 Second, the Rules Committee recognizes that
10 surgery to alter one's sexual characteristics,
11 including mastectomies, penectomies, and neo
12 vaginectomies carries the highest risk of immediate
13 irreversible physiologic effects and ought to be
14 approached differently than drug intervention.

15 Third, the Rules Committee recognized that
16 the discontinuation of hormonal intervention for
17 patients who have already commenced such treatment
18 would pose important complexities and, therefore, is
19 not restricted.

20 So let me be clear. Any person who opines
21 that this resolution, if passed in its current form,
22 would terminate ongoing care is incorrect.

23 Fourth, and perhaps most importantly, the
24 Rules Committee recognized -- and this was made
25 clear during testimony -- that the best treatment of

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1 minors with gender dysphoria is not known.

2 The resolution represents an effort to
3 generally emulate what is being done by Britain's
4 National Health Service and by others elsewhere,
5 which is to make available non-surgical treatment,
6 but to do so solely under the auspices of high-
7 quality investigator-initiated clinical trials.

8 So again, let me be clear, any person who
9 opines that this resolution if passed in its current
10 form would ban access to care is incorrect.

11 Although, it may be the intent of the Boards to
12 ensure that dissemination of high-quality data on
13 the epidemiology and the outcomes of these
14 investigations, board counsel has indicated that is
15 not presently within our purview to mandate a data
16 reporting requirement.

17 Therefore, should the draft rule be
18 adopted, I then would propose a resolution to be
19 presented to the Speaker of the Florida House and
20 the President of the Florida Senate. This
21 resolution would request that the legislature pass a
22 reporting mandate, whereby each clinical trial
23 principal investigator must transmit to the Boards
24 of Medicine and Osteopathic Medicine an anonymized
25 summary of the clinical data at six-month intervals.

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1 Without a reporting requirement, investigators could
2 elect not to share published data, and this would,
3 of course, be contrary to our intent.

4 We understand that the legislature would in
5 no way be bound to act on such a resolution, but it
6 is my sense that a reporting requirement is
7 absolutely essential to a good faith research
8 exemption.

9 At this point, I'm going to open up the
10 discussion to members of the two Boards. Once a
11 motion -- a call -- the question is called, we will
12 go and have a vote from the Board of Medicine
13 immediately followed by the Board of Osteopathic
14 Medicine, and then we will proceed with public
15 comment.

16 If there are any publicly elected officials
17 with us today, please make yourself known to me, as
18 I will extend the courtesy to ensure that you have
19 an opportunity to speak. And as far as public
20 comment is concerned, it will be randomized, meaning
21 selected out of the hat, AB, AB, until the public
22 comment is completed.

23 At this point, I open the floor for
24 discussion. Thank you very much.

25 DR. ACKERMAN: Dr. Diamond.

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1 CHAIRMAN DIAMOND: Please, you're recognize
2 Mr. -- Dr. Ackerman.

3 DR. ACKERMAN: I want to thank you for your
4 very thorough explanation of the -- of what's
5 transpired over the past six months. I think it was
6 extremely accurate and I think you made it very
7 clear as what the intent of Rules Making is and what
8 the outcome of the rules are. And I want to voice
9 my support completely of the resolution put forth by
10 the Rules Making Committee.

11 CHAIRMAN DIAMOND: Dr. Hunter, I believe
12 you had some comments.

13 DR. HUNTER: I'm going to pass right now.

14 CHAIRMAN DIAMOND: Dr. Vila, you're
15 recognized.

16 DR. VILA: Thank you. I want to echo those
17 comments. I appreciate what the Board has gone
18 through hearing testimony -- extensive testimony,
19 and then all of the letters that have been submitted
20 that we've looked through. I was not at the Rules
21 Committee meeting, but I watched the entire video of
22 it. And that even further added to the body of
23 knowledge and discernment that I've gone through.

24 And after hearing extensive testimony from
25 physician experts on the irreversible harm due to

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1 puberty blocker medications as well as the hormone
2 therapy, and after testimony that other countries
3 have restricted access to medications, after written
4 testimony from the author of a study that found a
5 significant percentage of patients who transition
6 later choose to detransition and, thus, have a
7 significant percentage that have suffered
8 irreversible harm.

9 Given the lack of testimony from expert
10 proponents of hormone therapy that there are
11 adequate selection criteria that have sufficient
12 specificity to avoid harm. And after testimony from
13 expert proponents of these treatments that, in fact,
14 they are relatively rare in minors and in -- thus,
15 our rules would not substantially deviate from the
16 care that they are providing.

17 And finally, and most significantly, the
18 in-person testimony of multiple patients who were
19 irreversibly harmed by hormonal treatments. In my
20 25 years of hearing testimony before this Board, I
21 don't think I've ever seen that many patients talk
22 about that much harm being done to them.

23 And so given these facts, I am not
24 supportive of this -- of item two in the proposed
25 rule that allows for these treatments to be

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1 administered under even IRB approved protocol. I
2 don't think that they're safe, and that they cause
3 irreversible harm to a significant number of
4 patients.

5 Now, if you want to do any research, I
6 suggest that you move it to those minors that are
7 already undergoing treatment, if we want to ask the
8 legislature to provide the data. But I want you to
9 know that I'm not supporting, and I would move to
10 strike item two in the resolution.

11 CHAIRMAN DIAMOND: Thank you, Dr. Vila.
12 Anyone else like to speak, please?

13 DR. ACKERMAN: Is that a motion that needs
14 a second?

15 CHAIRMAN DIAMOND: Well, I think we're
16 going to go and continue --

17 DR. ACKERMAN: Okay. I just heard him say,
18 "I moved."

19 CHAIRMAN DIAMOND: Would you like to
20 propose that as a formal motion, Dr. Vila?

21 DR. VILA: Mr. Chair, it depends how you
22 want to conduct the meeting. If you'd like to hear,
23 I will intend to make that motion. If you'd like me
24 to make it now, I will.

25 CHAIRMAN DIAMOND: Would anyone like to

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1 make any comments before that motion is made?

2 Dr. Vila, please.

3 DR. VILA: Okay. I may -- I move to strike
4 item two in the proposed standard of practice for
5 the treatment of gender dysphoria in minors.

6 CHAIRMAN DIAMOND: Do I hear a second on
7 the motion?

8 DR. HUNTER: Seconded.

9 CHAIRMAN DIAMOND: There's a second. It's
10 now open to -- for discussion on that motion.

11 DR. HUNTER: Dr. Diamond?

12 CHAIRMAN DIAMOND: Yes, sir.

13 DR. HUNTER: I want to read this into the
14 record. Dutch researchers pioneered youth
15 transition for gender dysphoria. They published
16 several papers culminating in a 2014 paper that
17 described the outcome for 55 youths they
18 transitioned.

19 The Dutch protocol is now what we call
20 affirmative care, puberty blockers, cross-sex
21 hormones, and breast and genital surgeries. The
22 Dutch protocol was deemed a success because the
23 youth continued to function well after surgery.
24 This affirmative model of care has spread wildly in
25 the last eight years.

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1 The Dutch protocol is the foundation youth
2 transition was built on. It is flawed. It is based
3 on weak evidence. These are some of the problems
4 with the Dutch study.

5 Many concerns have been raised about its
6 methodology. It was a case series, a small cohort
7 of 55 teenagers. There was no control group. The
8 follow-up period was only 18 months. This short
9 period should be of concern, and most importantly,
10 there has been no long-term data reported on these
11 55.

12 The Dutch have been asked for their long-
13 term data. In a June, New York Times article,
14 Dr. DeVries, the lead author, said the Dutch has
15 lost contact with 50 percent of their early cohort.
16 Dr. DeVries was interviewed on an American podcast
17 in January. She made it clear that their patients'
18 lives are much more complicated than the original
19 studies outcomes suggests.

20 The Dutch, to their credit, were concerned
21 about false transitions. Transitions that would
22 later be regretted. False transitions would be the
23 worst possible outcome. Today, we call that regret
24 and detransition.

25 The Dutch had inclusion and exclusion

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1 criteria hoping to limit false transitions. I want
2 to emphasize two of these criteria.

3 Early onset gender dysphoria was a
4 requirement for transition. Early onset was
5 described by the Dutch in one paper as gender
6 dysphoria "from toddlerhood." And there had to be
7 no active mental health issues. Mental health
8 problems excluded a teenager from transition.

9 The very patients the Dutch excluded, late
10 onset, post pubertal, gender dysphoric youth with
11 comorbid mental health issues are now the majority
12 of youth being transitioned. We are transitioning
13 the very population the Dutch excluded because they
14 feared harm.

15 Affirmative care with transition is now
16 touted as the cure for mental health problems. Just
17 eight years ago, mental health problems excluded
18 someone from transition. Our profession has
19 abandoned the Dutch criteria, and these criteria
20 were never based on hard evidence, only good
21 intentions.

22 Now we have objective, unbiased, systematic
23 reviews, the most prominent being from Swedish and
24 British experts. These systematic reviews tell us
25 the evidence for youth transition is poor quality

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1 and with very low certainty for benefit. However,
2 we are told that more and more evidence supports
3 hormonal and surgical transition. The quality of
4 this research is extremely questionable. I want to
5 cite one recent example.

6 In September, just two months ago, in JAMA
7 Pediatrics, there was a study reported from
8 Northwestern University in Chicago, 70 patients were
9 compared; 36 had a double mastectomy and 34 did not.
10 The patients ranged in age from 13 to 24 years.

11 The authors concluded that mastectomy was
12 beneficial and should not be delayed in youth. What
13 led them to that conclusion? The finding that three
14 months after surgery, a mere 90 days, the 36
15 patients as young as 13, 14, and 15 years were happy
16 with their flat chests. And it was not just 36 that
17 had surgery; it was 42. They lost 9 percent of
18 their surgical cases to follow-up, 9 percent in
19 three months. It is absurd, meaningless, to draw
20 any conclusions after three months.

21 This paper is indicative of the quality of
22 research we have in this field, published in our
23 most prestigious journals. We have a serious
24 problem. The testimony last week from those who
25 have detransition is evidence of that.

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1 Finland, Sweden, and England have changed
2 course. They recognize harms are occurring; that
3 the evidence is poor; that the Dutch protocol should
4 not have been adopted and scaled to the extent that
5 it has.

6 At our last meeting, I suggested we carve
7 out an exception for research. After much thought,
8 I can no longer support that idea. I do not believe
9 the Board is authorized to regulate medical
10 research. That authority lies with other federal
11 and state agencies. The Board's duty is to regulate
12 the general practice of medicine. And we can do
13 that; we should do that, and allow others to address
14 research in this field. But I want to say something
15 about human medical research.

16 Ethical principles of human medical
17 research were first articulated in the Nuremberg
18 Code. Then in the World Health Organization's
19 Declaration of Helsinki and further described in the
20 United States Belmont Report, which followed the
21 terrible revelations discovered with the Tuskegee
22 syphilis experiments.

23 For those that conduct future research in
24 this area of medicine, the following questions must
25 be answered. Can minors consent to transition? Can

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1 minors with active mental health problems consent?

2 Can this research with hormones and surgery
3 be done safely and ethically when we know these
4 treatments have negative effects on normal
5 physiology, when these treatments probably have
6 negative effects on an adolescent's psychosocial
7 development and their neurodevelopment to include
8 their executive decision-making?

9 Can research with hormones and surgery be
10 done safely and ethically when we know these
11 treatments will be -- will lead to loss of sexual
12 function, when we know these treatments will lead to
13 infertility? These ethical questions are very
14 important, but it's also critical that researchers
15 ask why so many young people are suffering from
16 gender dysphoria. Depending on the survey, between
17 2 and 10 percent of youth now describe themselves as
18 gender diverse. Many are suffering and need help.

19 Researchers need to ask why this is
20 happening. Why has the incidence of gender
21 dysphoria skyrocketed? We would ask this question
22 for any other condition. These questions need to be
23 answered, not just by the medical profession, but by
24 society at large.

25 Children and youth with gender dysphoria

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1 are suffering. They need care, the best possible
2 care, excellent care. We need to return to the
3 community standard of care for treating distress.
4 And that is psychotherapy. Ethical, compassionate
5 psychotherapy that respects the child's experience.
6 Let me say that again. Ethical, compassionate
7 psychotherapy that respects the child's experience.

8 This is what Europe is doing. Our
9 colleagues in Great Britain, Sweden, Finland, and
10 elsewhere agree change is needed. Less harm needs
11 to be done; safety and ethics need to prevail. I'm
12 confident the Board of Medicine will do the right
13 thing.

14 CHAIRMAN DIAMOND: Thank you very much. So
15 we have a motion from my friend and colleague,
16 Dr. Vila striking paragraph two. It was seconded by
17 my friend and colleague, Dr. Hunter.

18 I personally feel that a research exemption
19 is necessary and I share, Dr. Hunter, many of your
20 concerns. And, Dr. Vila, I share many of your
21 concerns in good faith.

22 My perspective is this. I'm an oncologist,
23 and every day we are presented with new
24 investigational medicines or other interventions.
25 And I as a clinical investigator must approach this

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1 in agnostic fashion. I do not know if a new
2 medicine is equivalent to the standard, better or
3 worse. To say that I know the truth is incorrect.

4 So, therefore, if we are in agreement that
5 there's substantive dispute, what is the best
6 treatment for minors with gender dysphoria? I say,
7 let us study it. Let us study it well. Let us use
8 the advantages that we have of having distributed
9 high-quality medical schools throughout the state,
10 and let us be the light to the world to determine
11 what is the best care for these folks. Otherwise,
12 we will never know.

13 So that is my general position, recognizing
14 that I share many of your concerns, Dr. Vila and
15 Dr. Hunter. I open it for the additional
16 discussion.

17 Hearing none, would -- someone would like
18 to call the question to vote on Dr. Vila's motion?

19 DR. WASYLIK: I'll call the question. Mike
20 Wasylik.

21 CHAIRMAN DIAMOND: Very good. Do I have a
22 second on the motion?

23 Do I have a second on Dr. -- on --

24 ATTORNEY TELLECHEA: You already had a
25 motion. You had a second. Please call the

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1 question.

2 CHAIRMAN DIAMOND: Calling the question.
3 All in favor of Dr. Vila's motion, please raise your
4 hand. And again, this is to vote -- I would be very
5 clear. This is -- the motion at hand is to strike a
6 research exemption. So if you're in favor of
7 striking a research exemption, please raise your
8 hand.

9 All in -- all against the motion, raise
10 your hand. Let's do a count.

11 ATTORNEY TELLECHEA: No. That's
12 (indiscernible).

13 CHAIRMAN DIAMOND: Okay. Everybody is
14 going to vote.

15 CHAIRWOMAN SCHWEMMER: This -- with this is
16 just for the Board of Medicine voting.

17 CHAIRMAN DIAMOND: Okay. We're going to
18 start with the Board of Medicine, and then we'll do
19 Osteopathic Medicine.

20 So all the members of the Board of Medicine
21 who are in support of Dr. Vila's resolution to
22 strike the research exemption, please raise your
23 hand. All those against the resolution on the Board
24 of Medicine, raise your hand.

25 Dr. Vila's motion carries.

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1 Dr. Schwemmer?

2 CHAIRWOMAN SCHWEMMER: Thank you,
3 Dr. Diamond. So we have the same motion before the
4 Board of Osteopathic Medicine. All in favor of
5 removing item two from the rule, raise your hand,
6 removing the research component of the rule.

7 Opposed?

8 Dr. Diamond, it appears --

9 CHAIRMAN DIAMOND: You have to vote also.

10 CHAIRWOMAN SCHWEMMER: I'm voting, opposed.

11 CHAIRMAN DIAMOND: Okay. Mr. Tellechea,
12 how do we proceed?

13 ATTORNEY TELLECHEA: Well, I really have
14 not encountered this situation before where you have
15 one board who's going to be having a rule that would
16 be inconsistent with the second board on such a
17 matter.

18 So your choices are you can move forward --
19 you can move forward with approving the rule
20 language as amended by the Board of Medicine, and
21 the Board of Osteopathic Medicine can move forward
22 with approving their rule language. You will have
23 two inconsistent rules. DOs will be regulated
24 differently than MDs on this matter, or you can go
25 back to the drawing board and see if you can reach a

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1 compromise that everybody would agree with.

2 CHAIRMAN DIAMOND: So it seems to me that
3 perhaps we should go and bifurcate and do individual
4 votes on the amended motion for the Board of
5 Medicine and for the unamended motion for the Board
6 of Osteopathic Medicine. And then we move forward,
7 and we will try and determine how to work through
8 this.

9 CHAIRWOMAN SCHWEMMER: I agree.

10 ATTORNEY TELLECHEA: Well, if you want to
11 go back to the drawing board and how to work -- and
12 work through this, you can either not approve either
13 one of the rule languages and go back and try to
14 work through it, or as you suggested, you can
15 approve both of them, you know, Board of Medicine as
16 amended, Board of Osteopathic Medicine as is, and
17 then somewhere down the line try to reach some
18 consistency.

19 DR. ACKERMAN: I have a question for
20 Mr. Tellechea. Are there other examples of
21 different rules from the two different boards? You
22 said nothing of this magnitude, so give us some
23 examples of what sort of things.

24 ATTORNEY TELLECHEA: No. I don't know.
25 When it comes down to standard of care issues --

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1 DR. ACKERMAN: Uh-huh (affirmative).

2 ATTORNEY TELLECHEA: -- the Board of
3 Medicine and the Board of Osteopathic Medicine have
4 always been consistent with their rules.

5 CHAIRWOMAN SCHWEMMER: So examples of that
6 would be your standard of care, like in your office
7 surgery rules. You know, these physicians work side
8 by side often in different facilities. So that's --
9 those are examples where they work side by side.
10 But that said, I mean, the Boards do not have to
11 have the same rule.

12 DR. ACKERMAN: We do recognize that --

13 CHAIRWOMAN SCHWEMMER: Normally you do when
14 it comes to standard of care.

15 DR. ACKERMAN: We do recognize that
16 osteopathic physicians and allopathic physicians
17 approach some diseases a little bit differently.
18 And that's not necessarily that one is wrong and one
19 is right. It's just different ways of approaching
20 something.

21 DR. VILA: Yeah. Mr. Chair --

22 CHAIRMAN DIAMOND: Dr. Vila, you're
23 recognized.

24 DR. VILA: -- I think the Board of Medicine
25 ought to vote to do what they think is right and

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1 leave it to the Board of Osteopathic Medicine to
2 then consider that question before them, right.

3 So we vote, we put that question before
4 them, and they can go back and decide. Or it may be
5 that in this situation it wouldn't be horrible to
6 have two different rules. I mean, this is a very
7 kind of a narrow area, and they may be after some
8 more thought, we'll change; or maybe we will after
9 some more thought change.

10 CHAIRMAN DIAMOND: So would you --
11 Ms. Garcia?

12 MS. GARCIA: Yes. Hi. I think we need to
13 come to a compromise, something that we could all
14 agree on because it's going to cause chaos if we
15 have different rules. I'm looking at it, obviously,
16 from a, you know, legal perspective and my
17 experience, but I think we need to come up with
18 something that works.

19 CHAIRMAN DIAMOND: So in that spirit, I
20 would ask the following question: are there any
21 circumstances, Dr. Vila, that you could craft that
22 would allow some type of research exemption that
23 would make you feel more comfortable?

24 DR. VILA: Why don't we consider it for
25 area three -- for item number three? Why don't we

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1 recraft that, so that minors being treated with
2 puberty -- currently being treated puberty blocking
3 agents may continue so far -- and move that wording
4 into item three?

5 CHAIRMAN DIAMOND: Dr. Schwemmer?

6 CHAIRWOMAN SCHWEMMER: If I could comment,
7 I think our Board, you know, I don't think we looked
8 at that. There may be studies in the future. I
9 think the motion before the Board was to remove the
10 part two, the non-surgical.

11 CHAIRMAN DIAMOND: Yes. It is -- and I'm
12 asking Dr. Vila, does he -- can he go and craft any
13 ideas.

14 Again, what I would like to ask the members
15 of the Boards to consider: can we come up with any
16 additional language that may be able to thread this
17 needle, so that we can go and get some answers to
18 these pressing clinical questions.

19 Dr. Hunter, did you have a comment?

20 DR. HUNTER: Would it -- is this too simple
21 of interpretation? If there were two different
22 rules, would it just be that all research in Florida
23 would have to be done by DOs?

24 CHAIRMAN DIAMOND: I don't think that's
25 workable.

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1 DR. HUNTER: Well, that's what would be the
2 effect of it.

3 CHAIRWOMAN SCHWEMMER: Right.

4 CHAIRMAN DIAMOND: That's not -- that's not
5 workable.

6 ATTORNEY TELLECHEA: Yeah.

7 CHAIRMAN DIAMOND: Please.

8 DR. VILA: What's wrong with that?

9 UNIDENTIFIED SPEAKER: It's in rules.

10 CHAIRWOMAN SCHWEMMER: Dr. --

11 CHAIRMAN DIAMOND: Dr. Di Pietro?

12 DR. PIETRO: To Dr. Vila's point, when he
13 was saying if we could basically make number two
14 fall under number three, I just don't think it's
15 going to enough time. Whoever's currently
16 transitioning, that's not going to be enough time to
17 research those individuals.

18 Is that what you were talking Dr. Vila?

19 DR. VILA: I'm sorry. Yeah. That's what I
20 would say. And, you know, there can be a mechanism
21 where, you know, you transition them into -- to coin
22 a phrase.

23 DR. PIETRO: That's it.

24 DR. VILA: You transition them into
25 research protocols, and in those research protocols,

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1 they can continue to obtain the medications they
2 were previously obtaining. So anyone who's
3 currently on a medication would continue to get it,
4 and then over the course of six months would be
5 enrolled into a research protocol.

6 CHAIRWOMAN SCHWEMMER: And the issue with
7 the review studies, they may not be able -- they may
8 not exist to allow those individuals. If we put
9 that section into three, they may not be able to
10 find those clinical studies to enroll in.

11 DR. PIETRO: Right.

12 CHAIRWOMAN SCHWEMMER: So that's the other
13 matter.

14 DR. PIETRO: I mean, I appreciate trying to
15 make it work, but I just, you know, we all know how
16 long clinical research takes. I mean, it takes
17 years. I just -- I don't think that's -- it's a
18 viable option.

19 CHAIRWOMAN SCHWEMMER: So --

20 CHAIRMAN DIAMOND: Hold on. All right.
21 I'm thinking this through a little bit. I think
22 what we need to do is this. We're not going to
23 resolve this now. I would like to go and have each
24 of the Boards vote on the motions.

25 So in front of the Board of Medicine, we

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1 would be voting upon the motion as amended by
2 Dr. Vila, which means as written with paragraph two
3 struck.

4 And then we will ask our colleagues on the
5 Board of Osteopathic Medicine to vote on the
6 entirety of the rule as it currently stands.

7 DR. VILA: Okay. I move to call the vote
8 as amended.

9 CHAIRMAN DIAMOND: Thank you.

10 DR. ACKERMAN: I second that.

11 ATTORNEY TELLECHEA: Okay. There is no --
12 you need to make a motion. If your intent is for
13 the motion to be approved, the proposed rule
14 language with number -- Subsection 2 stricken and
15 renumbered appropriately, that should be your
16 motion. That --

17 DR. VILA: Thank you. Mr. Tellechea,
18 that's my motion.

19 CHAIRMAN DIAMOND: I have a motion. I have
20 a second.

21 All in favor from the Board of Medicine on
22 Dr. Vila's motion, please raise your hand. All in
23 -- all against the motion?

24 The motion carries.

25 Dr. Schwemmer?

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1 CHAIRWOMAN SCHWEMMER: Similarly, at this
2 point we're voting on the rule as presented, 64B(8)
3 --

4 ATTORNEY MCNULTY: 64B15-14.014. Excuse
5 me. That's page 5 of your material. And that
6 includes the Subsection 2; is that correct?

7 CHAIRWOMAN SCHWEMMER: That's correct.

8 ATTORNEY MCNULTY: So is --

9 UNIDENTIFIED SPEAKER: I'll second that.

10 ATTORNEY MCNULTY: Seconded.

11 CHAIRWOMAN SCHWEMMER: I need the motion
12 first.

13 DR. PIETRO: I'll make a motion, motion to
14 approve the proposed draft rule language 64B15-
15 14.014, which includes Subsection 2 in regards to
16 the non-surgical treatments for treatment of gender
17 dysphoria in minors may continue to be performed
18 under the auspices of an IRB approved investigator
19 initiated clinical trial conducted at any of the
20 Florida medical schools.

21 CHAIRWOMAN SCHWEMMER: Is there a second?

22 UNIDENTIFIED SPEAKER: Second.

23 CHAIRWOMAN SCHWEMMER: All in favor
24 signified by yea?

25 MEMBERS: Yea.

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1 CHAIRWOMAN SCHWEMMER: Yea. Anyone
2 opposed?

3 No opposition heard. The motion carries.

4 CHAIRMAN DIAMOND: Okay. So going forward,
5 we're going to be revisiting this, of course, and
6 ideally we'll be able to develop some resolution
7 between these two competing rules.

8 ATTORNEY TELLECHEA: Just to clarify
9 instructions from --

10 CHAIRMAN DIAMOND: Please.

11 ATTORNEY TELLECHEA: -- from the Boards.
12 Do you want us to go ahead and publish the language
13 that just passed?

14 CHAIRMAN DIAMOND: Well, I think it's
15 incumbent upon us to do that so that we can
16 disseminate this to the public and receive
17 appropriate comment.

18 ATTORNEY TELLECHEA: Okay. I just clarify
19 because we're going to publish one version, and
20 Osteopathic Medicine is going to publish another
21 version.

22 CHAIRMAN DIAMOND: I don't think we have a
23 choice. Donna?

24 ATTORNEY MCNULTY: And before you do that,
25 you need to ask the questions and the --

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1 CHAIRWOMAN SCHWEMMER: Yes, sir?

2 ATTORNEY MCNULTY: -- the cert questions.

3 CHAIRMAN DIAMOND: Right.

4 CHAIRWOMAN SCHWEMMER: You want to go --

5 ATTORNEY TELLECHEA: We'll get there, but

6 --

7 ATTORNEY MCNULTY: Well.

8 ATTORNEY TELLECHEA: -- we're moving

9 forward with publishing the language?

10 CHAIRMAN DIAMOND: Yes.

11 ATTORNEY TELLECHEA: Okay. All right.

12 UNIDENTIFIED SPEAKER: Mr. Tellechea, my
13 question would be: in the environment in which we're
14 having a joint board meeting, so that the purpose to
15 discuss this as a house of medicine as opposed
16 strictly boards, why would it not be appropriate to
17 take the vote in block? Why would it be not
18 appropriate for the votes to be together?

19 Is it because there would be two separate
20 rules regardless, right? Because there's going to
21 be two separate chapters, two separate rules.

22 ATTORNEY TELLECHEA: Two votes have to be
23 taken because you're two separate rules --

24 UNIDENTIFIED SPEAKER: Two separate rules
25 and two separate boards.

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1 ATTORNEY TELLECHEA: -- and two separate
2 boards.

3 UNIDENTIFIED SPEAKER: Okay.

4 ATTORNEY TELLECHEA: Yes.

5 UNIDENTIFIED SPEAKER: Just clarifying
6 that.

7 CHAIRMAN DIAMOND: Very good. At this
8 point --

9 DR. HUNTER: Dr. Diamond?

10 CHAIRMAN DIAMOND: Dr. Hunter?

11 DR. HUNTER: Is a question for
12 Mr. Tellechea. Do the boards have the authority to
13 regulate research in the state of Florida? And do
14 we have the authority to be certain that -- or take
15 action if it's deemed unsafe or it's --

16 ATTORNEY TELLECHEA: No. You have the
17 authority to regulate the physicians who are -- if
18 there are physicians, MDs or DIs that are performing
19 the research, you have the authority to regulate
20 them in their individual capacity as members of the
21 profession.

22 This rule doesn't do that. It just says
23 that you cannot, you know, treat for gender
24 dysphoria unless it's under -- the physicians cannot
25 do that unless they are doing it under appropriate

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1 research program.

2 That's all it does. Now, it doesn't tell
3 you how to conduct a research program. It's not
4 telling University of Florida or University of Miami
5 or Nova Southeastern how to do it, they're just tell
6 -- they're just saying the doctors if you're going
7 to do this type of procedure, if you're going to do
8 -- if you're going to have this kind of practice,
9 you have to do it under one of these types of
10 research programs.

11 CHAIRMAN DIAMOND: Very good.

12 CHAIRWOMAN SCHWEMMER: Okay.

13 CHAIRMAN DIAMOND: At this point I'd like
14 to move it forward and go on to public comment.
15 We're going to begin --

16 ATTORNEY TELLECHEA: Well, hold on. Before
17 we go forward, we need to do the --

18 CHAIRMAN DIAMOND: Oh, the --

19 ATTORNEY TELLECHEA: Yeah.

20 CHAIRMAN DIAMOND: We need to do the --
21 Thank you.

22 ATTORNEY TELLECHEA: Okay. So for the
23 board -- do we want to do Board of Medicine first?

24 CHAIRMAN DIAMOND: Sure.

25 ATTORNEY TELLECHEA: Okay. Will the

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1 proposed rule amendment have an adverse impact on
2 small business, or will the proposed rule amendment
3 be likely to directly or indirectly increase
4 regulatory cost to any entity in excess of \$200,000
5 in the state of Florida within one year after the
6 implementation of the rule?

7 DR. VILA: Move no.

8 CHAIRMAN DIAMOND: Do I have a second?

9 DR. ACKERMAN: Second.

10 CHAIRMAN DIAMOND: All in favor, please say
11 yea.

12 MEMBERS: Yea.

13 CHAIRMAN DIAMOND: Any opposed?

14 Carries. Please continue.

15 ATTORNEY TELLECHEA: Should any part of
16 this rule be designated as a minor violation?

17 DR. VILA: Move no.

18 CHAIRMAN DIAMOND: Do I have a second?

19 DR. ACKERMAN: Second.

20 CHAIRMAN DIAMOND: All in favor, please say
21 yea.

22 MEMBERS: Yea.

23 CHAIRMAN DIAMOND: Motion carries. Next?

24 ATTORNEY TELLECHEA: Does the board want to
25 add a sunset provision to this rule?

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1 CHAIRMAN DIAMOND: And your recommendation
2 is?

3 DR. VILA: Move no.

4 ATTORNEY TELLECHEA: The Board has --

5 CHAIRMAN DIAMOND: Okay.

6 ATTORNEY TELLECHEA: -- the governor's
7 office has requested that on rules that are not
8 mandatory, rules that are discretionary, that the
9 Board of Medicine provide a sunset provision to the
10 rule. On those cases that are -- on those rules
11 that are mandated by statute, he -- his position was
12 not -- you do not require a sunset provision. This
13 is a standard of care rule. This is not mandated by
14 statute.

15 DR. VILA: Understood. But given the
16 predicate under which the rule is being passed and
17 that is that there's demonstrated substantial harm
18 being caused to minors, I don't see that a sunset
19 was appropriate on this rule. And I move no.

20 DR. ACKERMAN: I second that.

21 CHAIRMAN DIAMOND: All in favor?

22 DR. ACKERMAN: Yea.

23 DR. VILA: Yea.

24 CHAIRMAN DIAMOND: Any opposed to the
25 motion? Motion carries.

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1 ATTORNEY TELLECHEA: Okay.

2 CHAIRWOMAN SCHWEMMER: My turn.

3 CHAIRMAN DIAMOND: Go ahead, Dr. Schwemmer.

4 CHAIRWOMAN SCHWEMMER: Thank you,

5 Dr. Diamond. So for members of the Board of

6 Osteopathic Medicine, we'll read the statement of

7 estimated regulatory costs. I'll begin. I move

8 that the proposed rule will not have an adverse

9 effect on small business and will not likely to

10 directly or indirectly increase regulatory cost to

11 any entity in excess of \$200,000 in the aggregate in

12 Florida within one year after the implementation of

13 the rule. Is there a second?

14 UNIDENTIFIED SPEAKER: Second.

15 CHAIRWOMAN SCHWEMMER: Any discussion? All

16 in favor signified by yea?

17 MEMBERS: Yea.

18 CHAIRWOMAN SCHWEMMER: Opposed?

19 No opposition heard. The motion carries.

20 And secondly, I move that a violation of

21 this rule or any part of this rule be considered a

22 minor violation. No, will not.

23 Any discussion?

24 All in favor signify by yea?

25 MEMBERS: Yea.

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1 CHAIRWOMAN SCHWEMMER: Opposed?

2 No opposition heard. This motion carries
3 unanimously.

4 And finally, I move that a sunset provision
5 is unnecessary for this rule because this rule is in
6 the best interest of the health, safety, and welfare
7 of the citizens of the state of Florida.

8 UNIDENTIFIED SPEAKER: I would like to
9 second.

10 CHAIRWOMAN SCHWEMMER: Second?

11 UNIDENTIFIED SPEAKER: Second.

12 CHAIRWOMAN SCHWEMMER: Any discussion?

13 UNIDENTIFIED SPEAKER: I think that because
14 the rule is controversial, that it should be brought
15 up for reevaluation.

16 CHAIRWOMAN SCHWEMMER: So --

17 UNIDENTIFIED SPEAKER: Given a certain
18 amount of time --

19 CHAIRWOMAN SCHWEMMER: You can vote no.

20 UNIDENTIFIED SPEAKER: I do --

21 CHAIRWOMAN SCHWEMMER: So all in favor of
22 no sunset signify by yea? Yea.

23 ATTORNEY TELLECHEA: So --

24 CHAIRWOMAN SCHWEMMER: (Indiscernible)

25 DR. DUCATEL: No.

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1 CHAIRWOMAN SCHWEMMER: No. No sunset.

2 ATTORNEY TELLECHEA: Okay. Clarify the
3 motion.

4 CHAIRMAN DIAMOND: Clarify the motion.

5 ATTORNEY MCNULTY: I'd like to clarify the
6 motion. So the question is --

7 CHAIRWOMAN SCHWEMMER: Okay. Go ahead.

8 ATTORNEY MCNULTY: I will make it's
9 simpler. Do you want to have a sunset provision of
10 this rule? Does somebody make any motion?

11 UNIDENTIFIED SPEAKER: I believe that there
12 should be a sunset -- I make the motion that there
13 should be a sunset and given a 36-month period of
14 time for that to take place.

15 CHAIRWOMAN SCHWEMMER: Is there a second?
16 The motion fails.

17 We'll try it again. Donna?

18 ATTORNEY MCNULTY: So for second time, do
19 you want to add a sunset provision to this rule?

20 UNIDENTIFIED SPEAKER: Yes. You're
21 following the question?

22 They just voted on that.

23 ATTORNEY MCNULTY: They just voted, but now
24 we're doing it in reverse.

25 ATTORNEY TELLECHEA: You did and it was the

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1 same motion.

2 UNIDENTIFIED SPEAKER: Yeah, same motion.

3 CHAIRMAN DIAMOND: You just asked people to
4 raise their hands.

5 ATTORNEY TELLECHEA: You just asked the
6 same question.

7 CHAIRWOMAN SCHWEMMER: So do we need
8 another vote? I don't believe.

9 ATTORNEY TELLECHEA: Yes.

10 CHAIRWOMAN SCHWEMMER: Okay.

11 ATTORNEY MCNULTY: Okay.

12 CHAIRWOMAN SCHWEMMER: So let's --

13 ATTORNEY MCNULTY: So the vote is, are you
14 adding a sunset -- I mean, do you move that there's
15 a sunset provision be added to this rule?

16 ATTORNEY TELLECHEA: Just say, all those
17 who are opposed to a sunset provision, raise your
18 hand.

19 CHAIRMAN DIAMOND: Motion carries.

20 ATTORNEY MCNULTY: Motion carries.

21 And then the basis of that, Dr. Schwemmer,
22 you stated is based -- it's not based on -- it's
23 based on the health, safety, welfare of the citizens
24 of the state of Florida?

25 CHAIRWOMAN SCHWEMMER: Yes.

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1 ATTORNEY MCNULTY: All right.

2 CHAIRMAN DIAMOND: Very good. At this
3 point we're going to transition to comment. What
4 we're going to do is the following. First, I
5 understand we have two representatives of the people
6 here. Mr. Nathan Bruemmer, who is an assistant to
7 the Commissioner of Agriculture, Nikki Fried. And
8 we're going to invite Mr. Bruemmer to speak for
9 three minutes. And then I understand that we have
10 State Representative, Anna Eskamani and we're going
11 to invite her to speak for three minutes.

12 No, no, no, no. And then what we're going
13 to do --

14 UNIDENTIFIED SPEAKER: (Indiscernible)

15 CHAIRMAN DIAMOND: What's she saying?

16 UNIDENTIFIED SPEAKER: She's saying if
17 there's any other representative --

18 CHAIRMAN DIAMOND: Are there any -- I'm
19 sorry -- are there any other representatives that I
20 should be aware of?

21 UNIDENTIFIED SPEAKER: Yeah.

22 UNIDENTIFIED SPEAKER: State Elect
23 Representative, Rita Harris, is also here.

24 CHAIRMAN DIAMOND: Rita Harris?

25 UNIDENTIFIED SPEAKER: No. She's a

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1 candidate.

2 CHAIRMAN DIAMOND: Are you a candidate or
3 have you been elected?

4 UNIDENTIFIED SPEAKER: She won.

5 UNIDENTIFIED SPEAKER: She won.

6 UNIDENTIFIED SPEAKER: All right. Okay.

7 UNIDENTIFIED SPEAKER: All right. You know

8 --

9 (Indiscernible)

10 CHAIRMAN DIAMOND: Have you taken office
11 yet, ma'am?

12 RITA HARRIS: No.

13 CHAIRMAN DIAMOND: You have not taken
14 office yet. Okay. All right.

15 So, Mr. Bruemmer, we're going to call you
16 first.

17 And then, Representative Eskamani, we're
18 going to have you go second.

19 And then afterwards what we're going to do
20 is we will be taking a public comment, randomized,
21 pro and con the opposition, and that will be handed
22 to me by Dr. Schwemmer. We'll do AB, AB, eight on
23 each side, and then the meeting will adjourn.

24 So, Mr. Bruemmer, you are called first.

25 DR. VILA: Mr. Chair?

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1 CHAIRWOMAN SCHWEMMER: And just --

2 DR. VILA: Mr. Chair, before --

3 CHAIRMAN DIAMOND: Yes.

4 DR. VILA: -- you begin the testimony
5 portion, do you have a plan for a certain amount of
6 time or is this going to be -- is there going to be
7 timed at all?

8 CHAIRMAN DIAMOND: Each person that's
9 called will have three minutes. We ask that you
10 respect your time, and we will be going AB, AB in
11 randomized fashion.

12 So Mr. Bruemmer, please come to the
13 microphone and you're recognized for three minutes.
14 Please go ahead, sir.

15 NATHAN BRUEMMER: Chairs, members, my name
16 is Nathan Bruemmer. I serve in Commissioner Nikki
17 Fried's administration as our state's only statewide
18 appointed LGBTQ official. As an advocate for our
19 agency, a big part of what we do is inform and draw
20 folks in to engage within the dozens of divisions
21 and programs.

22 This position was put in place because of
23 an awareness of the unique needs in serving LGBTQ
24 Floridians. And I'd like to draw both Boards back
25 to the role of government within what we legislate

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1 and what we do when we execute rules through that
2 power. That there is procedure and process and a
3 necessity for transparency and trust in that
4 process. That is our charge and our duty, whether
5 elected or appointed, paid or volunteer, those
6 purposes and goals must be honored. And that will
7 affect service delivery when this process is done
8 and executed, whatever decision you make.

9 So how this process has progressed to date
10 and where it goes forward is something I want to
11 reflect back to you all as an agency that is here to
12 protect consumers as you are as well.

13 I also want to address this notion that
14 I've heard consistently through commentary about
15 protecting children. I've heard protect children
16 and protect families, but really who has gotten on
17 the mic and been allowed to speak is really coming
18 in predominantly from one perspective. Please allow
19 (indiscernible). There are many Floridians and many
20 families who have felt silenced. Please allow them
21 that opportunity.

22 And there's another rhetoric I've heard
23 about protecting ourselves from ourselves, in
24 essence limiting our liberties and our freedoms to
25 make our healthcare decisions with our experts, with

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1 our medical providers, with our teams. And I'm very
2 concerned by the decision today, the shift in course
3 in this IRB research. Those that proposed it did so
4 because the arguments have been that we don't have
5 enough research.

6 This change in reasoning now says we do,
7 it's definitive, and what I'm hearing is more
8 exclusion, removal of healthcare without even an
9 option to propose we encourage research. That
10 silencing of the information to inform our medical
11 decisions is equally concerning.

12 And I'd also encourage you all in moving
13 forward if you choose to reflect on the IRB research
14 that you do so with a very proactive support of
15 mental healthcare services for our LGBT Floridians
16 because the outcome of this process will harm
17 Floridians. Please put information and resources
18 back with the people.

19 CHAIRMAN DIAMOND: Thank you so much.

20 NATHAN BRUEMMER: Thank you very much.

21 CHAIRMAN DIAMOND: Thank you very much,
22 Mr. Bruemmer. We appreciate your public service.

23 Next, we have State Representative, Anna
24 Eskamani. It's nice to see you again.

25 ANNA ESKAMANI: Thank you. Thank you

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1 Chairs.

2 CHAIRMAN DIAMOND: You have three minutes,
3 please proceed.

4 ANNA ESKAMANI: Thank you so much. I
5 appreciate the opportunity.

6 So first you said there wasn't enough
7 research and now you're saying you don't want to do
8 any research, which again, further demonstrates why
9 people are so mad in this space. And it pains me to
10 say this, but this rule is not being drafted in the
11 best interest of trans people or the trans people's
12 lives in mind. We have trans people in this room,
13 parents of trans kids in this room, and they will
14 not be erased.

15 And the fact that you can't even decide on
16 a sunset rule, once more demonstrates that you're
17 not be willing to look at the impact of such a rule
18 to potentially analyze its impact to say it is
19 causing harm. That's what a sunset exists for.
20 This entire core process of even these meetings has
21 been based upon the unfortunate culture wars that
22 surrounds our society today, Twitter accounts and
23 bots. And the evidence that Florida has assembled
24 in the experts on this through the past meetings
25 have been discredited biased compromised or have

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1 made questionable statements, and that's me being
2 nice about it.

3 If you're going to do this four days before
4 a major election, also be aware that the Republican
5 party, Florida, is spamming the entire state with
6 antiqueer mailers and advertising. We're not
7 standing here today on the Friday before November
8 8th by chance.

9 This is 2022, not the 1970s. I expect the
10 legislature to be a political being, not the Board
11 of Medicine. It is our job collectively as public
12 servants to do no harm. And that is why people are
13 here in opposition to your bill. And we've -- rule
14 and we've been here in opposition for every meeting
15 since. Providers already have standards in place.
16 So let me be clear. If the -- if your goal is to
17 adopt rules that reflect the needs of those
18 impacted, then I would recommend the standards of
19 the World Professional Association of Transgender
20 Health, which have established standards of care,
21 which are based on the best available science and
22 expert professional consensus, not a bunch of online
23 trolls.

24 And finally, I just want to add that laws
25 that deny lifesaving healthcare to trans people are

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1 absolutely rooted in misinformation and contrary to
2 extra medical standards that guide gender
3 information. You mentioned earlier that you want
4 people who experience gender dysphoria to have care.
5 This role does not do that.

6 So, please, join us in opposing this rule,
7 opposing the politicization of healthcare. We
8 really, really don't need this right now. Thank
9 you.

10 CHAIRMAN DIAMOND: Thank you very much.
11 Does anyone -- very good.

12 Did anyone have any questions for our first
13 two speakers?

14 CHAIRWOMAN SCHWEMMER: No.

15 CHAIRMAN DIAMOND: Very good. Next, I've
16 been handed two names, and we'll go AB, AB. The
17 first name that was handed to me by Dr. Schwemmer is
18 Dr. Diane Gowski. And that will be followed by Amy
19 -- is that a Rachel?

20 CHAIRWOMAN SCHWEMMER: Rachel.

21 CHAIRMAN DIAMOND: Amy Rachel. So Diane
22 Gowski, we ask for you to come forward, speak for
23 three minutes.

24 And if Amy Rachel, you could be ready to
25 speak too, please. Please go ahead.

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1 CHAIRWOMAN SCHWEMMER: If you start in
2 queue, we'd like to be able to process as many -- we
3 want to listen to everybody, so we're just trying to
4 do this --

5 CHAIRMAN DIAMOND: We're not listening to
6 everybody we're listening -- please go ahead.

7 DR. GOWSKI: Thank you very much. All
8 right. Thank you very -- can you hear me?

9 CHAIRMAN DIAMOND: Go ahead.

10 DR. GOWSKI: Not sure it's on. Thank you
11 very much. There are only two sexes - male and
12 female. We can reason this -- there are reason,
13 medical fact, common sense, and biblical truth.

14 CHAIRMAN DIAMOND: Listen -- excuse me.
15 We're going to toll your time. Again, we're trying
16 to conduct this the best we can. If you cannot
17 conduct yourself appropriately --

18 CHAIRWOMAN SCHWEMMER: Yes.

19 CHAIRMAN DIAMOND: -- you'll be requested
20 and required to leave.

21 Ma'am, it's your time.

22 DR. GOWSKI: Thank you.

23 CHAIRMAN DIAMOND: Please go ahead.

24 DR. GOWSKI: You allow me to quote Genesis
25 Chapter 1. "God created man in the image of

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1 himself. In the image of God, he created him, male
2 and female, he created them." We are made by God.
3 He is our only creator. Unfortunately, what
4 transgender ideology, in my opinion, has created is
5 a lie.

6 The truth is that no matter how much a
7 confused minor, a confused youth with gender
8 dysphoria identifies with the opposite sex, a person
9 cannot change into the opposite sex. Illusions can
10 be -- sorry -- illusions can be crafted, appearances
11 can deceive, but Florida -- in Florida, doctors need
12 to practice reality-based medicine. So called --

13 CHAIRMAN DIAMOND: Hold on. Excuse me.
14 Security, please escort that person out.

15 UNIDENTIFIED SPEAKER: That brown
16 transgender woman.

17 CHAIRMAN DIAMOND: This is not how we
18 conduct business in a civilized society. Please go
19 ahead.

20 DR. GOWSKI: So-called gender-affirming
21 care, social transitioning puberty blockers, cross-
22 sex hormones, and mutilating surgeries are not
23 authentic healthcare. They cause harm, some of
24 which is irreversible to our minors and thus need to
25 be prohibited from the practice of medicine in

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1 Florida. Do no harm, our Hippocratic Oath, serves
2 us well as we continue to follow it.

3 The children of Florida need and deserve
4 your protection against all forms of child abuse,
5 including those under the guise of medical practice.
6 So-called gender-affirming care is medicalized child
7 abuse. Whether it is intentional or unintentional,
8 whether it's realized or not. So-called sex
9 reassigned, the surgeries are unjustifiable
10 unnecessary. The natural course of gender
11 expression for 85 percent more of children will be
12 to align with their biological sex. They need to go
13 through puberty, not have their puberty blocked.
14 They need to be able to develop normally. So I
15 thank you for supporting this rule, for standing for
16 the truth and protecting the vulnerable children in
17 Florida.

18 CHAIRMAN DIAMOND: Thank you very much.
19 Amy Rachel, you are next. You have three minutes.

20 And before you continue, please have -- we
21 please ask Erin Brewer, you'll be next.

22 Go ahead. You're recognized.

23 AMY RACHEL: Thank you. Good afternoon,
24 and thank you to the Board of Medicine for this
25 opportunity and for your time and attention. My

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1 name is Amy Rachel and my pronouns are she and her.

2 I was born and raised in the great state of Florida.

3 I'm a woman, a lifelong Christian, and I'm proud to

4 be transgender.

5 I'm speaking to ask you to abide the whole

6 WPATH standards of care. I'm not creating a

7 separate set of standards just for the state of

8 Florida. This is my third attempt to try to offer

9 my public comment in one of your meetings. And I

10 was horrified at the meeting one week ago to witness

11 the skewed public comments where preference was

12 given to non-residents who had been flown in to

13 offer their stories of these transition and comment

14 was cut off shortly, thereafter, with hardly any

15 trans people or parents and trans youth given an

16 opportunity.

17 That said, I was struck by how many

18 speakers evoked do not harm as the previous speaker

19 had. And I want to speak to that. Harm is a

20 relative thing. A bilateral mastectomy might be

21 harmful to a woman, but it might be beneficial to a

22 man with gynecomastia.

23 Similarly, testosterone-driven puberty

24 might be harmful for a cisgender girl while healthy

25 for a transgender boy. You cannot apply a

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1 unilateral motion of harm to this kind of medicine.

2 From one modern version of the Hippocratic

3 Oath, I will apply for the benefit of the sick all

4 measures that are required, avoiding those twin

5 traps of overtreatment and therapeutic nihilism.

6 Denying trans youth even the possibility of access

7 to medical care is therapeutic nihilism. There are

8 already protections against overtreatment in the

9 existing WPATH standards of care. Are there risks

10 and bad outcomes? Yeah, of course.

11 All medicine has risks. Lack of medical

12 treatment also has risks. The best numbers we have

13 estimate those that began medical transition, of

14 those that began medical transition between one and

15 three percent detransitioned. The numbers also tell

16 us that the large majority of those who detransition

17 do so due to external factors, lack of money,

18 resources, and support, the pressures of social

19 stigma upon transgender people and the like.

20 The highest estimates of those who

21 detransition because they determined they were

22 mistaken, is about one-third of those who

23 detransition. And here's the important part, which

24 often goes unsaid.

25 Most of those people did not express regret

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1 for their transition. Despite what the testimony at
2 last week's rules committee led -- would lead one to
3 believe, regretful detransition is exceedingly rare.
4 Something most of the people in this audience last
5 week knew, which is why there was so much outrage at
6 the disproportionate time granted to those stories.

7 The reality is that the majority of -- the
8 vast majority of those who have access to medical
9 transition have good, short, medium, and long-term
10 outcomes. But based on last week, you'd never know
11 that. For the record, I share that outreach.

12 I was a trans adolescent, and I had no
13 information except that what I was feeling was wrong
14 or impossible. So I felt isolated. I felt
15 defective and broken. This led me to develop
16 depression, anxiety, and PTSD. I went through a
17 puberty counter to my gender, which has led to my
18 experiencing debilitating gender dysphoria. The
19 testosterone my body produced led to a disconnect
20 with my body as the testosterone irreversibly shaped
21 my body in horrifying ways. I was harmed by lack of
22 access to affirming medical care.

23 CHAIRMAN DIAMOND: Thank you very much. We
24 -- I let you go a little bit long. Thank you so
25 much for coming.

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1 AMY RACHEL: I'm available for questions if
2 you have them.

3 CHAIRMAN DIAMOND: Thank you so much. Next
4 is Erin Brewer. You're recognized for three
5 minutes. Please go ahead.

6 ERIN BREWER: Dear board members, thank you
7 for your time.

8 CHAIRMAN DIAMOND: Oh, excuse me. Before
9 you continue -- and that you'll be followed by --
10 I can't read this.

11 CHAIRWOMAN SCHWEMMER: Cecil Stone.

12 CHAIRMAN DIAMOND: Cecil Stone, please come
13 up. I'm sorry. Go ahead, ma'am.

14 ERIN BREWER: My name is Erin Brewer. I'm
15 a former trans kid. As a child, I was insistent,
16 consistent, and persistent that I was a boy
17 following a sexual assault. I'm not alone. I've
18 talked to dozens of girls who like me, developed a
19 transgender identity in order to run away from the
20 difficult feelings they had after a sexual assault
21 or other trauma.

22 I have no doubt if the option to take
23 puberty blockers and cross-sex hormones, I would
24 have done everything I could have to obtain them,
25 including threatening suicide. It would have been

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1 so much easier for me to kill myself as a girl and
2 become a boy rather than work through the underlying
3 issues that triggered my gender dysphoria.

4 In the short term, I likely would have felt
5 better. Testosterone is a controlled substance and
6 almost anyone who takes it initially feels a sense
7 of euphoria. It would have boosted my confidence
8 and increased my energy. It would have allowed me
9 to completely disassociate for myself as a girl and
10 create a new persona who could pretend that the
11 horrible trauma that triggered my gender dysphoria
12 had happened to somebody else.

13 But in the long term, it would have
14 reinforced all the mistakes and beliefs that caused
15 me to develop gender dysphoria. That being a girl
16 was bad; that it was my fault; that those men hurt
17 me; that my body was a mistake, or that it was too
18 dangerous to be a girl, or that I was inherently
19 flawed and the only way to survive was to become a
20 different person. I never would have realized that
21 my transgender identity was a coping mechanism.

22 I am grateful to my school counselors and
23 therapists who helped me understand my transgender
24 identity was a result of the sexual assault. Not
25 because I was born in the wrong body. I shudder to

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1 think of what my life would have been like if I had
2 been encouraged to medically transition. Puberty
3 blockers would have retarded my growth and
4 development. Cross-sex hormones would have caused
5 my healthy body to be dysfunctional.

6 The combination of both puberty blockers
7 and cross-sex hormones would have left me sterile.
8 In the short term, these interventions allow
9 children to avoid the difficulties they're facing.
10 Whether they are grappling with homophobia,
11 struggling with autism, or trying to recover from
12 significant trauma.

13 It is natural for children to try to do
14 what they can to shut down difficult feelings, which
15 is why it is our job to stop children from using
16 drugs and alcohol to numb their pain. It is our job
17 as adults to give children the message that no
18 matter how intense their feelings are, they can work
19 through them without dissociating from their bodies
20 and becoming a different person. Because of the
21 loving and caring, supportive therapists and
22 teachers, I got the care I desperately needed when I
23 was processing what happened to me. They gave me
24 the gift of healing.

25 I'm so incredibly grateful. All children

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1 with gender dysphoria who are struggling deserve the
2 same gift. And I thank you so much for granting
3 that gift here today to the children of Florida.

4 CHAIRMAN DIAMOND: Thank you very much.

5 Next we have Cecil Stone. You're
6 recognized. You have three minutes. And following
7 Cecil Stone will be Becky Nutt. You're recognized.

8 CECIL STONE: Thank you, Chair. Thank you
9 for the time. I'm a male assigned at birth. In
10 other words, I identify as cisgender. I'm
11 heterosexual monogamous, white, and of the boomer
12 generation; aka I'm an old white guy.

13 I'm the leader of private club with 13,989
14 peer board physicians. Our club has well over
15 17,000 members with membership in every state in the
16 union in several countries. Because we run an
17 inclusive space, we have a very heavy percentage of
18 transgender and gender non-conforming folks. And as
19 the leader of the club, I speak with almost every
20 human that walks in the place. I say all of that to
21 say I have probably spoken to more gender non-
22 conforming folks than most of you all.

23 When someone realizes that their gender
24 assigned at birth does not align with their true
25 gender, it's not a relief. It's normally very

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1 shocking. We need to support these people. We need
2 to not make care more difficult to find or even
3 illegal for them to find. As medical professionals,
4 you're required to do no harm. We all know this.

5 Restricting care for trans people,
6 including kids, will assuredly increase the suicide
7 among this population. As is widely reported in
8 every -- nearly every targeted population survey
9 that's ever been published.

10 Out of the thousands of transgender folks
11 and gender non-conforming folk that I've spoke with,
12 I've only had one person that even considered
13 detransitioning. To give you a little bit more
14 knowledge, I literally travel the country talking
15 about alternative sexualities and alternative
16 lifestyles. So I've spoke with a lot of people.

17 I noticed earlier that one of the speakers
18 only spoke about a very select subset of transgender
19 folk because you guys speak with the folk that come
20 see you. You don't necessarily speak with the wide
21 cross-section.

22 I speak with a very broad section of
23 transgender and gender-conforming folk. Therefore,
24 my experience is highly different than yours. The
25 sample that shows up at political meetings,

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1 obviously, is a very narrow, small sample.

2 I strongly urge you to not add this new
3 language to your rules. As I truthfully believe and
4 the data shows that this will increase child suicide
5 and will do much more harm to Floridians than you
6 can possibly imagine. I strongly suggest that you
7 not only reject this rule, but that you add language
8 that will help people who have realized that they
9 are trans and also provide care for their parents to
10 learn how to support their child through transition.
11 Thank you very much for your time.

12 CHAIRMAN DIAMOND: Thank you.

13 Next is Becky -- next is Becky Nutt,
14 please. Next is Becky Nutt. That'll be followed by
15 Megan Holleran. And this represents our third pair
16 of speakers. You're recognized.

17 BECKY NUTT: Yes. I'm Becky Nutt, and I am
18 a mother, a grandmother, a very concerned citizen.
19 And I just want to thank you for your work, your
20 courage because it takes a lot of courage now.

21 I'm very concerned for our children and
22 what they have to grow up in now. And a child -- I
23 mean, a child has to be 18 years old to go out and
24 just -- and to vote. But a child can make a
25 decision whether they need to be transformed to a

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1 male or a female? I don't think so.

2 I watched my children grow up. I know that
3 they would not have been mature enough to make a
4 decision like that at 18 or 16 or younger. I want
5 to see our children be able to have the help they
6 need. But I want it done with science and research,
7 wisdom and discernment.

8 They are not emotionally, spiritually, or
9 physically ready for decisions like that. And I
10 think it takes a multitude of people to help them
11 through decisions like that. And I encourage you to
12 continue coming -- going forward with this. Thank
13 you.

14 CHAIRMAN DIAMOND: Thank you. Next is
15 Megan Holleran, and Megan Holleran will be followed
16 by Julie Framingham -- Julie Framingham. So Julie
17 Framingham could be prepared to speak. We'd
18 appreciate that.

19 Megan Holleran, you are recognized for
20 three minutes.

21 MEGAN HOLLERAN: Hi, good afternoon. My
22 name is Megan Holleran, and I'm a licensed mental
23 health counselor in Florida, in Vermont with a
24 decade of clinical experience working with teens.
25 And I've had the privilege of working with trans and

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1 non-binary youth and their guardians. My clinical
2 experience tells me that when a teen is affirmed in
3 their identity, they become happier. Their
4 depression and anxiety caused by a life where
5 they're not seen as who they are and at many times
6 told they are sick, their suicidal ideation
7 diminishes and disappears and they begin to thrive.

8 I can also tell you from my personal
9 experience, I've witnessed people I love transition
10 in their teens, and they're happy now. Where there
11 was once a suicidal isolated unresponsive teen after
12 validation and professional support blooms a teen
13 who is engaged, wants to live and participate in
14 life. It is more than hope; it is actualization.

15 I guess I came here to say, I don't
16 understand. Why wouldn't you adhere to U.S. and
17 international standards of care? Why would you
18 focus on a small percentage of detransitioners or
19 professionals who do not have appropriate
20 credentials? I think we're all begging you to do
21 the right thing.

22 Do no harm. Let parents of trans kids have
23 the right to choose what is best for their child.
24 If you don't, some of these teens will kill
25 themselves. Because they could not access the care

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1 they need. I don't want to be a therapist, a family
2 member, or frankly a human who's watching these
3 deaths that could have been prevented right here and
4 now. Thank you.

5 CHAIRMAN DIAMOND: Thank you very much.

6 Next, we have Julie Framingham. That will
7 be followed by Sarah Parker, and this will be
8 representing our fourth pair of speakers.

9 JULIE FRAMINGHAM: Good afternoon. My name
10 is Julie Framingham, and I've been personally
11 impacted by the harms of gender transition
12 treatments through watching their effects on my son.

13 My 28-year-old son has been identifying as
14 transgender for the past 6 years. He suffered from
15 depression as a kid and has been diagnosed with
16 borderline personality disorder. He began taking
17 cross-sex hormones, and his mental health has only
18 worsened. His depression and anxiety has grown to
19 the point that he dropped out of university, and he
20 is now anorexic and severely underweight.

21 He has refused to get therapy, even though
22 he acknowledges that therapy he received in the past
23 was helpful because he believes medical transition
24 is the only answer causing his mental illness to go
25 untreated and harm to his physical health.

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1 I have also been authorized to tell the
2 story of a mother named Jackie Crowley, whose
3 daughter has experienced irreversible bone density
4 loss due to puberty blockers. My husband and I were
5 repeatedly told that the puberty blockers, our
6 preteen daughter was clamoring for, were the answer
7 for her anxiety and distress about her changing
8 body.

9 Gender-affirming mental health and medical
10 professionals assured us that exceeding to our
11 daughter's demand for puberty blockers was necessary
12 for her mental health. The issue of suicide was
13 raised several times in a coercive manner. We were
14 repeatedly assured that the puberty blockers were
15 completely reversible.

16 Based on these assurances, we consented to
17 our daughter receiving a puberty-blocking implant.
18 She had previously been diagnosed with depression,
19 autism spectrum disorder with sensory issues,
20 dyslexia, and dysgraphia.

21 She also had experienced social trauma.
22 However, none of these issues was addressed by
23 healthcare professionals once they determined that
24 she had gender dysphoria, nor did they offer any
25 other treatment options.

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1 I learned through my own research that
2 puberty blockers were shown to cause loss of bone
3 density and diminished cognitive development. When
4 we raised the issue, the doctors responded that they
5 had been prescribing the blockers for many years to
6 treat precocious puberty, and the reported bone loss
7 was nothing to worry about.

8 I had a bone density scan done for my
9 daughter. It revealed that she had an 11 percent
10 loss of bone density in (indiscernible), 14 percent
11 loss in the other, and a 7 percent loss in the
12 lumbar region. She has developed osteopenia at a
13 time in her life when her bone density should be
14 increasing and her bodybuilding a reservoir, a
15 strong developing bones as an important protection
16 against osteoporosis and adulthood.

17 The physician, nevertheless, requested that
18 she continue on to cross-sex hormones. That is
19 testosterone. We were not informed this would
20 likely sterilize our child. She continues to have
21 loss of bone density that will significantly affect
22 her physical and -- physical health and growth, and
23 have lasting effects possibly for the rest of her
24 life. I urge the board to adopt a rule that will
25 protect young people like our daughter.

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1 CHAIRMAN DIAMOND: Thank you very much.

2 Next is Sarah Parker, and that will be followed by
3 Prisha Mosley. So Sarah Parker, you are recognized,
4 and we would ask that Prisha Mosley be prepared to
5 speak. Thank you.

6 SARAH PARKER: Hi, my name is Sarah Parker.
7 Well, that's really loud. My name is Sarah Parker,
8 and I'm the president of Women's Voices of Southwest
9 Florida. I was the one that interrupted your
10 meeting. I interrupted it because there were people
11 that we know. Because I went on their Twitter. I
12 went on their Facebook page that were flown out of
13 state -- flown into state. They were on many tours.
14 They called themselves the Queen Grifter. They were
15 flown out. When I know that I and my friends and my
16 family and my people that I'm standing with drove
17 over three hours to be here. I'm a voter. I'm a
18 damn constituent, okay.

19 With that being said, you're not going to
20 listen to logic. I'm not a doctor. Like who am I,
21 right? I'm just going -- I'm a student. I'm
22 nothing. I'm a mother though. I'm a mother that
23 had a child that was in the NICU for 52 days, and I
24 sat with my child for every last one of those 52
25 days. And, you know, when the doctors would come to

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1 me, I would have several different doctors come to
2 me and tell me, "We need to do this. We need to do
3 that." I got to make that decision, wow, about my
4 own child, and I want my child to be able to do -- I
5 want to be able to do that with my child again if
6 they decided they are trans.

7 You guys are talking about children and all
8 that and you all know about the abortion ban. So a
9 15-year-old can't decide that they want to be trans,
10 but they can be forced to have a child. They're --
11 that responsible. So, again, like I know you guys
12 aren't going to listen to anything opposite, which
13 is why we didn't email you. We didn't waste our
14 time, but I do have 1 minute and 37 seconds to read
15 out all your contributions.

16 Diamond, the board chairperson and
17 radiation oncologist Winter Park, Florida,
18 contribute 2000 to DeSantis first campaign for
19 governor 2018.

20 Scot Ackerman, you wrote a check of 3000 to
21 DeSantis campaign 2018, roughly a year before you --
22 he appointed you to board. It's kind of weird,
23 right? He totally earned that.

24 Ravi Chandra, you are the biggest
25 (indiscernible). I don't know which one you are,

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1 but I wish I was. That was \$25,000 you gave to
2 friends of Ron DeSantis. Then you also gave another
3 3000 to the Governor's reelection campaign.
4 DeSantis appointed you to the Board last year,
5 that's also adorable.

6 Eleonor Pimentel -- sorry, again, if I mess
7 up your name, you only donated 50 bucks, then you
8 wrote another 100. You might not be doing that good
9 in your business. I understand.

10 Medical practice on the Hector Vila, Jr.,
11 20,000, again, to run the same test and then
12 reappointed Vila to the board in 2019.

13 What you're telling me is, first of all, I
14 probably need to get into the civil law. That's
15 what you're telling me first off. Now I don't need
16 to go to family anymore. What you're telling me is
17 that these seats are bought. You guys are bought.
18 You were bought. You sold out Florida. You have
19 stepped on your Hippocratic Oath, and you know it.
20 We know it and that's fine. Skeletor (phonetic),
21 you can keep smiling at me. That's completely fine.

22 Everyone in this room, and I promise you,
23 your names, your emails, your phones, your emails,
24 your phones, everything will be published, and you
25 will not live the moment down. Every person that

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1 kills themselves because of this that I know, I will
2 make sure their family contacts you. The blood is
3 on your hands.

4 CHAIRMAN DIAMOND: Next is Prisha Mosley.
5 This will be followed by Kimberly Park -- I'm sorry
6 -- Kimberly Cox.

7 Kimberly Cox, if you could be ready and
8 this will represent our fifth pair of speakers.
9 You're recognized. Please go ahead.

10 PRISHA MOSLEY: Hi, my name is Prisha
11 Mosley. I was 15 years old when I learned what
12 trans was from other kids online. I found this
13 community through the pro-anorexia community and was
14 quickly loved, bombed, and indoctrinated. I had a
15 turbulent home life and no friends. I was suffering
16 from anorexia and borderline personality disorder as
17 well as a recent rape.

18 I was also told -- I was told -- when I was
19 told that all of my problems, like my self-hatred
20 and suicide, the whole ideation were the result of
21 being in the wrong body, I wholeheartedly believed
22 it. I was in treatment for my personality disorder
23 and eating disorder at this time, but my doctors did
24 not communicate. I was in the hospital frequently
25 to get stitches due to cutting and hospitalized even

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1 longer for my inability to eat.

2 At first, I was affirmed by the fact that
3 testosterone was increasing my appetite. I thought
4 I was recovering. However, my suicidal thoughts and
5 behaviors persisted. I dealt with severe anger
6 issues and increased pulsivity. My voice became
7 changing within two months, and there were changes
8 to my genitals even sooner.

9 I began to lose my hair. I now suffer from
10 being disproportionate and clumsy because T took
11 away my hips and gave me large shoulders. My neck
12 and shoulders burn all of the time. I can no longer
13 sing. I lost my beautiful singing voice and the
14 ability to sing professionally and in the community.
15 I cannot even cry or raise my voice. I was
16 silenced.

17 Also as a result of the testosterone, I had
18 a ovarian cyst for years, which caused pain and
19 irregular bleeding. I have vaginal atrophy. I do
20 not know if I can ever have kids. What is worse is
21 I was put on these treatments when I myself was a
22 kid. Eventually, my mental and emotional symptoms
23 worsened. None of the medical treatments being
24 dangled in front of me were helping, and I began to
25 feel even more hopeless.

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1 I made the decision to detransition at 22.
2 I was not medically supported in my decision. I
3 quit testosterone cold turkey, which made me
4 extremely sick. I moved over a thousand miles away
5 from everyone I know and love to do this by myself.
6 Now, I deal with constant pain and shame.
7 I struggle to be social and have relationships.
8 Dating is impossible, and my heart is broken. I'm
9 fighting for the life I could have had. My
10 birthright was taken away from me. I fully support
11 you creating a rule that prohibits doctors from
12 prescribing these treatments to young people under
13 18.

14 CHAIRMAN DIAMOND: Thank you.

15 Next, we have Kimberly Cox. And Kimberly
16 Cox, you'll be followed by Zoe Hawes. So if Zoe
17 Hawes could be prepared.

18 Kimberly Cox, you're recognized for three
19 minutes, please proceed.

20 KIMBERLY COX: My name is Kimberly, and I'm
21 with the Women's Voices of Southwest Florida. I'm
22 gathering my strength to speak here today by looking
23 at a picture of my child because I'm the parent of a
24 non-binary teen. The teen who has a family issue of
25 clinical depression. But my child has a loving and

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1 caring, accepting environment and to thrive in their
2 home. But I know that it takes more than just
3 parents to give children the ability to fully
4 thrive.

5 I, like all other parents, have to take
6 certain things into consideration when choosing
7 schools and doctors and therapists for my children.
8 But I must ensure that my child has extra
9 precautions. A safe doctor, a safe school, a safe
10 therapist.

11 And by "safe" I mean that their caregivers
12 are in support of evidence-based practices for the
13 non-binary and trans communities. It's just
14 cisgender people get gender-affirming care all the
15 time, and no one bats an eyelash.

16 When I was 17, I wanted a boob job because
17 I haven't fully developed. Everybody said, "Oh,
18 that's great." That's good. You should do that.
19 Do what you should do to make you feel more
20 confident in your body. Nobody batted an eyelash
21 because I'm a cisgendered woman.

22 The care and the choices that this care
23 entails should be made between the parent -- the
24 patient and their families and their doctors.

25 UNIDENTIFIED SPEAKER: Yes.

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1 KIMBERLY COX: It is bias and bigotry that
2 prevents the trans community from getting the same
3 care and respect that their cis counterparts
4 receive. Thanks to my -- the president of my
5 organization, Sarah, I now know that although my
6 child to me is priceless, you all can put a value on
7 their head.

8 More importantly to everybody out there,
9 that's watching and all of the people in this room,
10 if you're a teen or an individual who is thinking
11 about suicide because of this decision today, please
12 know from this mother, you are loved; you are
13 valued, and you are more than worthy. And the men
14 and women that sit here and (indiscernible) like
15 Governor DeSantis and the Nazi regime that he has --

16 CHAIRMAN DIAMOND: No. She's gone. Next?
17 No, you're excused. Security?

18 KIMBERLY COX: Call 988 and talk to
19 somebody.

20 CHAIRMAN DIAMOND: You're done.

21 KIMBERLY COX: If you --

22 CHAIRMAN DIAMOND: We're not calling people
23 Nazis today. We're not calling people Nazis.

24 UNIDENTIFIED SPEAKER: Shame on all of you.

25 CHAIRMAN DIAMOND: Next is Zoe Hawes.

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1 We're not going to have people calling one another

2 Nazis in this room today. Zoe Hawes is present.

3 And Zoe Hawes, you're going to be followed by

4 Kaitlynn -- can you read this?

5 CHAIRWOMAN SCHWEMMER: Danehy-Samitz

6 CHAIRMAN DIAMOND: Kaitlynn Danehy-Samitz.

7 Zoe Hawes, you're recognized. Please

8 proceed.

9 ZOE HAWES: My name is Zoe Hawes. I'm a
10 28-year-old wife and expectant mother now, who at
11 the age of 16 truly believe that every fiber of my
12 being that I was a boy and that transitioning was
13 the solution. Growing up, I experienced a lot of
14 trauma. I was diagnosed with depression and anxiety
15 in middle school, and puberty was awful. I could
16 not accept my body. I wanted to escape.

17 By the age of 16, I was very unstable and
18 suicidal. I ran away from my dad's side of the
19 family, who I knew would not accept me being trans,
20 and I came out to my mom. She was scared I was
21 going to kill myself if she didn't affirm me,
22 because that is the narrative.

23 I was immediately taken to a gender
24 therapist, who within three months heard my story,
25 heard the trauma, and still diagnosed me with gender

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1 dysphoria. Still wrote that letter, recommending I
2 needed to start testosterone injections. So only
3 seven months after coming out at the age of 16, I
4 started T. I believed transitioning was going to
5 fix everything.

6 My period stopped. Facial hair grew.
7 Pretty soon I was passing completely, and I was
8 truly euphoric at first. But my mental health did
9 not improve. I became more suicidal, more unstable,
10 and the anxiety became debilitating. I could not
11 leave my house aside from going to the gas station
12 for months because I was so scared of passing. What
13 if people thought I was a girl.

14 I was in and out of mental hospitals six
15 times while being affirmed as male by my immediate
16 family, while being encouraged in my decision to
17 transition by all of my doctors, multiple
18 psychiatrists. I was later diagnosed with complex
19 PTSD related to not being accepted by my dad's side
20 of the family as a man. I was also diagnosed with
21 OCD at the same time.

22 I desperately wanted surgery and a
23 hysterectomy. That was the thing that was going to
24 fix everything. The thing that would keep me alive,
25 is what I believed, but I could not afford them.

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1 After a suicide attempt in February of
2 2018, I came to realize that just changing my body
3 was not fixing anything. I started working really
4 hard in psychotherapy, but it wasn't enough. I
5 still believed I was male, and I started to get a
6 little better; and then it just wasn't enough.

7 A year later in 2019, Jesus came to me in
8 my bedroom, not in a church. I began to find
9 healing.

10 CHAIRMAN DIAMOND: Please finish your
11 thoughts.

12 ZOE HAWES: I have not been suicidal since
13 stopping testosterone.

14 CHAIRMAN DIAMOND: Thank you very much.

15 ZOE HAWES: Thank you.

16 CHAIRMAN DIAMOND: Next, we have Kaitlynn
17 Danehy-Samitz. This will be followed by Helena
18 Kirschner. If Helena Kirschner could be prepared to
19 speak.

20 Kaitlynn Danehy-Samitz, I apologize. It's
21 hard for me to read your name.

22 KAITLYNN DANEHY-SAMITZ: That's fine.

23 CHAIRMAN DIAMOND: You're recognized.
24 Please go ahead.

25 KAITLYNN DANEHY-SAMITZ: All right. So my

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1 name is Kaitlynn Danehy-Samitz, Katie or Kate to any
2 of my friends. I'm not a doctor. I'm an activist,
3 and I'm here today as the vice president and founder
4 of Women's Voices of Southwest Florida. As a proud
5 queer woman and as an ally to my trans and non-
6 binary siblings here in the state of Florida and
7 across the country.

8 This potential ruling is nothing more than
9 a targeted attack on transgender and non-binary
10 youth. This is the rape of doctor-patient
11 privilege. It is dangerous, regressive,
12 purposefully hateful, and another strong step
13 towards fascism for the state of Florida.

14 Article 1, Section 23 of our Florida
15 Constitution clearly and simply states, so everybody
16 can understand it, that every natural person has the
17 right to be let alone and free from government
18 intrusion into their personal life.

19 So regardless of you all personal feelings
20 or the people who have flown from out of state to
21 read the same thing they read last week when they
22 took time away from actual Floridians fighting for
23 the rights of their friends, family, and selves, I
24 just feel like I need to remind you along with
25 everybody else, that you took a Hippocratic Oath,

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1 not a hypocritical oath.

2 You say that your concern is the welfare of
3 children. I heard a lot last week about genital
4 mutilation, and I'm really surprised that I'm here
5 speaking on gender-affirming care and having to
6 defend gender-affirming care, genital mutilation.

7 Why is circumcision never been brought up
8 into this? I doubt any infant has ever said, "Hey,
9 take my foreskin. I'm not going to want that
10 later." Aside from that, I have a minute and a
11 half. I have a great time. Okay, cool.

12 Transgender and non-binary youth are two
13 and a half times more likely to attempt suicide over
14 other queer youth who themselves are four times more
15 likely when compared to their cisgender and
16 heterosexual counterparts.

17 You all need to realize and accept that if
18 you pass this rule, the death of those children will
19 be on your hands. I'll say it again. You all need
20 to realize that if you pass this rule, that death of
21 those children will be on your hands.

22 And to the trans and non-binary youth that
23 are watching here today, although Kimberly was cut
24 off, if you are having suicidal thoughts, you can
25 dial 988 and speak to somebody. You are not alone.

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1 Okay.

2 And to the children that have been watching
3 and listening to their parents, come up here and
4 misgender them, shame. And you are loved. You are
5 seen. You are respected. We are not done.

6 We will continue to fight and to show up,
7 speak up, stand up for your right to be who you are
8 because, in the freest country in the world, that's
9 exactly what you should be able to do. Keep your
10 laws, keep your God -- keep your God out of my
11 gender, out of my uterus, out of everything. Your
12 God is not my God.

13 CHAIRMAN DIAMOND: Thank you very much.
14 Next is Helena Kirschner. Helena Kirschner will be
15 followed by Shannon -- what's it, Keever?

16 CHAIRWOMAN SCHWEMMER: Keever.

17 CHAIRMAN DIAMOND: Next will be followed by
18 Shannon Keever. This represents our seventh pair of
19 speakers, and we'll be doing eight pairs today.
20 Helena Kirschner, you're recognized. Please
21 proceed.

22 HELENA KIRSCHNER: Thank you. My name is
23 Helena Kirschner, and I'm 24 years old. I'm here
24 today as a detransitioner with grave concerns about
25 the so-called gender-affirming model of responding

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1 to minors and young adults who believe they're
2 transgender.

3 As a young girl, I had no discomfort with
4 being female. What I had was a history of family
5 issues, difficulties fitting in with other girls,
6 eating disorders, self-harm, and depression. When I
7 was 14, I began spending a lot of time online and
8 communities where countless other troubled
9 adolescent girls were encouraging each other to
10 interpret their social, emotional, and body image
11 difficulties as signs of gender dysphoria with the
12 belief that body modification would be a
13 transformative solution.

14 When I took steps in the direction of being
15 trans, I received more positivity and encouragement
16 than I had ever experienced. By age 17, I
17 identified as a trans boy and was fully convinced
18 that my only chance at a happy life would be to take
19 hormones and undergo surgeries to change my body.

20 My school counselor and school therapist,
21 both affirmed my beliefs, and the psychologist told
22 my mother that she was risking my suicide if she
23 would not agree to testosterone treatments. But she
24 thankfully was not intimidated. I went to a Planned
25 Parenthood a few weeks after my 18th birthday. None

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1 of the clinicians were interested in what was behind
2 my desperation to change my body. They told me that
3 because I seemed so sure, they would prescribe the
4 hormones that day.

5 I told the clinicians that I wanted a high
6 dose so I would see more changes in my body. They
7 agreed and prescribed me 100 milligrams of
8 testosterone per week.

9 The mental health effects of testosterone
10 were profound. I began experiencing uncontrollable
11 episodes of rage and paranoia where I was a danger
12 to myself and others. I also became much more
13 suicidal and self-harming. Due to this, I was
14 hospitalized twice.

15 None of the clinicians in the hospital or
16 outpatient centers ever mentioned testosterone as a
17 possible source for my mysterious symptoms. Instead,
18 I was prescribed a litany of psychiatric drugs.
19 This time was so dark that it caused me to question
20 the original promises of a joyful trans life. And
21 after five years of identifying as transgender, I
22 stopped taking testosterone and began the journey of
23 detransitioning. My mysterious new mental illness
24 went away soon after and has never returned. I'm
25 now forever grateful that clinicians were not able

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1 to affirm me any further.

2 I'm very fortunate to have not experienced
3 any obvious physical detriments, but the negative
4 impact of so-called gender affirmative care on my
5 life cannot be understated. Not only was I in
6 serious danger under the influence of testosterone,
7 but the mental process of returning to reality,
8 coping with everything that happened, and facing the
9 mental health issues that were compounded by these
10 experiences has been so difficult. I ask the board
11 to see these dangers of so-called gender affirmation
12 and create a rule, prioritizing, exploring --
13 exploratory therapy, and long-term health over
14 dangerous treatments for these vulnerable young
15 people.

16 CHAIRMAN DIAMOND: Thank you very much.
17 Next, we have Shannon Kever, and that will be
18 followed by Amy Atterberry. So if Amy Atterberry
19 could be prepared to speak, we would appreciate it.
20 Thank you.

21 SHANNON KEEVER: Good afternoon. My name
22 is Shannon Kever, and I'm a registered nurse in
23 Florida; and I'm with Women's Voices of Southwest
24 Florida. I'm in opposition to the rule.

25 Correct me if I'm wrong, but from my

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1 understanding, there's not one trans person on the
2 Board casting a vote on the future of thousands of
3 trans youth in Florida. I mean, I don't want to
4 assume, but from what I've read about you guys, I
5 haven't gleaned that.

6 However, many of you, as my dear friend
7 Sarah pointed out, have contributed to the political
8 campaigns of known trans antagonist Ron DeSantis.
9 It's hard not to draw some conclusions from that, I
10 think.

11 I'm here to speak up for the rights of the
12 trans community, to own their path, to heal the
13 crippling pain of gender dysmorphia. I don't want
14 anyone to transition and regret it. I think that
15 the -- listening to the stories of people who have
16 detransitioned only is evidence that we need to
17 further research, and we need to improve. It's a
18 way to listen and then work toward improvement.
19 That's what we do in medicine, right? Isn't that
20 what we do for our patients? We improve care. We
21 don't just take it away. We don't revoke it. But
22 to vote to detransition people who are already
23 receiving gender-affirming treatment is terrible.

24 We already know that it's not a secret.
25 The Trevor Project has shown us that people who

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1 suffer from gender dysmorphia, if they are not in a
2 supportive environment, they're not in an affirming
3 environment, they are likely -- much more likely to
4 commit suicide than children who are. So revoking
5 their care is criminal. And you -- it's redundant.
6 You'll have blood on your hands, and I hope you care
7 about that. Why did you get into medicine?

8 One thing -- one question I heard earlier
9 was: can minors with active mental health problems
10 consent to transition? If you say no to that, when
11 we already know that gender dysmorphia in itself
12 because of their environment causes depression and
13 anxiety, you're going to shut out so many people,
14 almost everybody who has it.

15 I long for the day when we can live in a
16 world where societal hangups aren't merged with
17 personal medical decisions. And since we're going
18 to quote the Bible, since that's apparently allowed
19 by a physician when a discussion about science,
20 let's talk about the Bible. If a man is caught in
21 the act of raping a young woman who is not engaged,
22 he must pay 50 pieces of silver to her father. Then
23 he must marry the young woman because he violated
24 her, and he will never be allowed to divorce her.

25 I think that shows that we really should be

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1 making decisions based on science and evidence. You
2 need to listen to the trans people here who are
3 telling you that this worked for them. You do need
4 to listen to the people who --

5 CHAIRMAN DIAMOND: Thank you very much.

6 SHANNON KEEVER: -- it didn't work for
7 them.

8 CHAIRMAN DIAMOND: Thank you very much.

9 SHANNON KEEVER: Thank you. Have a good
10 afternoon.

11 CHAIRMAN DIAMOND: Next, we have Amy
12 Atterberry. Amy Atterberry will be followed by
13 Seneca Bristol --

14 CHAIRWOMAN SCHWEMMER: Dickieson
15 (phonetic).

16 CHAIRMAN DIAMOND: -- Dickieson. This will
17 represent our eighth and final pair of speakers.
18 You are recognized, Amy Atterberry for three
19 minutes.

20 AMY ATTERBERRY: My name is Amy Atterberry.
21 I'm a mother and a resident of the state of Florida.
22 I feel like I have told my daughter's story a
23 thousand times, but I will tell her story again
24 today to help validate the need for compassionate
25 care for children who are confused about their

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1 biological sex. My daughter was 14 when she first
2 identified as being male. This happened after she
3 was indoctrinated into gender identity at school
4 unbeknownst to me.

5 I later discovered that she was visiting
6 websites like YouTube and Tumblr, which only
7 furthered her false belief that she could transition
8 into a male.

9 At age 16, a pediatric endocrinologist
10 taught my daughter to inject herself with
11 testosterone without my consent.

12 At age 17, doctors performed a double
13 mastectomy and a radical hysterectomy on my daughter
14 without my consent.

15 She was able to change her name and gender
16 and court at age 17, even though she was not
17 emancipated. Her mental health diagnoses were
18 documented in her medical records, yet doctors chose
19 to poison, sterilize, and mutilate my daughter
20 before she turned 18. More surgeries followed and
21 more surgeries are planned.

22 My daughter was a happy, healthy child with
23 a seemingly bright future. Her health and happiness
24 were stolen by medical and mental health
25 professionals who should have known better. The

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1 trajectory of her life has been permanently altered
2 and not for the better. She is not happy. She is
3 not well. She is not thriving, and she is not
4 living her best life.

5 I think it is important not to place blame
6 on parents of transgender-identifying children
7 regardless of whether parents affirm their
8 children's transgender identity or fight against it.

9 To be clear, I did everything in my power
10 to stop doctors from harming my daughter. However,
11 I understand why terrified parents may choose to
12 trust that affirmative care is the only viable
13 option when they're asked questions like: would you
14 rather have a dead daughter or a son or vice versa?

15 A more honest question would be this.
16 Would you like for us to provide compassionate care
17 for your child, or would you prefer that we poison,
18 sterilize, and mutilate your child?

19 Affirmative care is a very opposite of
20 compassionate care. I would like to sincerely thank
21 the members of this Board for your compassion,
22 intelligence, wisdom, and most of all for your
23 courage in fighting for the health and safety of
24 children.

25 CHAIRMAN DIAMOND: Thank you very much.

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1 Seneca Bristol Dickieson, you're now
2 recognized, and you're going to be our last speaker
3 of the day.

4 SENECA BRISTOL DICKIESON: Hello. My name
5 is Seneca Bristol. I'm the vice president of the
6 youth chapter for Women's Voices of Southwest
7 Florida. I have friends who are transgender and
8 non-binary, and it kills me to see that the state
9 that we were born and raised in is taking their
10 rights away.

11 Congratulations. Because of you, my fellow
12 Floridians and friends will be unable to get the
13 care they need to feel comfortable in their own
14 skin. You have the power to protect them, not only
15 as a doctor, but as an adult, and you choose not to.

16 According to multiple studies, it has been
17 shown that teenage depression and suicide rates went
18 down after given access to gender-affirming care.

19 I'm cisgender, and I can see that the rate of
20 depression in teens will go up if you do this. I
21 see the blood that will be spilled because of you.
22 I see the pain and fear people will be struck with.
23 I see --

24 I just don't get why you refuse to see it
25 too. Maybe it's because you don't care, but we all

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1 care. And we won't stop until Floridians have the
2 right to be who they are.

3 And now I'm going to read something from my
4 friend, she -- that they wrote, who is non-binary.
5 "I know there is no way to convince the Board of my
6 side, what is going through my head right now. My
7 experience as a transgender ally is invalid in your
8 eyes. You don't know what it's like to be in fear
9 of coming out. To see the death tolls rise and rise
10 for transgender youth, to see depression and anxiety
11 take over the minds of those not accepted by anyone
12 but their peers. There is one thing I can be
13 certain of though, we will never be silenced. The
14 only words that can conclude this with is the words
15 of Leia Alcorn (phonetic)." I'm sorry if I'm
16 mispronouncing that.

17 "A 17-year-old transgender girl who
18 committed suicide in 2014. The only way I will rest
19 in peace is if one day transgender people aren't
20 treated the way I was. They are treated like humans
21 with valid feelings and human rights. Gender needs
22 to be taught about in school, the earlier, the
23 better. Sorry. They are treated like humans with
24 valid feelings and human rights. Gender needs to be
25 taught about in schools, the earlier the better.

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1 My death needs to mean something. My death
2 needs to be counted in the number of transgender
3 people who commit suicide this year. I want someone
4 to look at the number and say that's effed up and
5 fix it. Fix society please."

6 CHAIRMAN DIAMOND: Thank you very much.
7 This concludes our business at today's
8 meeting.

9 Do I have a motion to adjourn?

10 CHAIRWOMAN SCHWEMMER: So moved.

11 CHAIRMAN DIAMOND: Second?

12 UNIDENTIFIED MALE: Second.

13 CHAIRMAN DIAMOND: All in favor?

14 MEMBERS: Yea.

15 CHAIRMAN DIAMOND: Any opposed?

16 Motion carries.

17 Thank you very much for coming today.

18 (END OF AUDIO RECORDING)

19

20

21

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CERTIFICATE OF TRANSCRIPTIONIST

I certify that the foregoing is a true and accurate transcript of the digital recording provided to me in this matter.

I do further certify that I am neither a relative, nor employee, nor attorney of any of the parties to this action, and that I am not financially interested in the action.

Julie Thompson

Julie Thompson, CET-1036

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1

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\$	95:12,16	25:10 88:23	23:15 77:7
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Jane Doe

vs.

Joseph Ladapo

Taped Transcription

February 10, 2023



Med Def_001017

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAP0,

6 Defendant.

7

8

9

10

11

12 TRANSCRIPTION OF AUDIO RECORDING
13 FLORIDA BOARD OF MEDICINE
14 RULES HEARING FOR THE STANDARDS
15 OF PRACTICE FOR THE TREATMENT OF
16 GENDER DYSPHORIA IN MINORS
17 FEBRUARY 10, 2023

18

19

20

21

22 TRANSCRIBED AUDIO RECORDING BY:

23 Julie Thompson, CET

24

25 Job No.: 322529

February 10, 2023

Page 2

1 Thereupon,

2 The following proceeding was transcribed from an
3 audio recording:

4 * * * *

5 CHAIRMAN ACKERMAN: Good afternoon. It's
6 good to see you all today. Good to be here today.
7 This is the Rules Hearing for the Standards of
8 Practice for the Treatment of Gender Dysphoria in
9 Minors. Welcome. Welcome here today. My name is
10 Dr. Scot Ackerman. I'm the Chairman of the Board of
11 Medicine.

12 In front of me to my right is Dr. William
13 Kirsh. He's the Vice-Chairman of the Board of
14 Osteopathic Medicine.

15 Dr. Di Pietro will be a few minutes late.

16 So before I begin, I'd like to have a roll
17 call. So, Mr. Paul Vasquez, Executive Director of
18 the Board of Medicine, will you please do a roll
19 call for the Board of Medicine.

20 EXECUTIVE DIRECTOR VASQUEZ: Dr. Ackerman
21 is present.

22 Nicholas Romanello?

23 VICE-CHAIR ROMANELLO: Here.

24 EXECUTIVE DIRECTOR VASQUEZ: Dr. Barsoum is
25 excused.

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1 Dr. Benson?
2 DR. BENSON: Here.
3 EXECUTIVE DIRECTOR VASQUEZ: Dr. Coffman?
4 DR. COFFMAN: Present.
5 EXECUTIVE DIRECTOR VASQUEZ: Dr. Derick is
6 excused.
7 Dr. Diamond?
8 DR. DIAMOND: Present.
9 EXECUTIVE DIRECTOR VASQUEZ: Ms. Garcia is
10 excused.
11 Dr. Hunter?
12 DR. HUNTER: Present.
13 EXECUTIVE DIRECTOR VASQUEZ: Ms. Justice?
14 MS. JUSTICE: Present.
15 EXECUTIVE DIRECTOR VASQUEZ: Dr. Pages is
16 excused.
17 Dr. Pimentel?
18 DR. PIMENTEL: Present.
19 EXECUTIVE DIRECTOR VASQUEZ: Dr. Vila?
20 DR. VILA: Present.
21 EXECUTIVE DIRECTOR VASQUEZ: Dr. Wasylik?
22 DR. WASYLIK: Present.
23 EXECUTIVE DIRECTOR VASQUEZ: Dr. Zachariah
24 is excused.
25 Also President is Paul Vasquez. That's me,

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1 the Executive Director of the Florida Board of
2 Medicine, and Board Counsel, Chris Dierlam.

3 You have a quorum.

4 MR. DIERLAM: Thank you, Mr. Vasquez.

5 CHAIRMAN ACKERMAN: Thank you.

6 Mr. Vasquez.

7 Danielle Terrell, the Executive Director of
8 the Board of Osteopathic Medicine, will you please
9 call a roll for the Board of Osteopathic Medicine.

10 EXECUTIVE DIRECTOR TERRELL: Yes, sir.
11 Dr. Kirsh?

12 VICE-CHAIR KIRSH: Here.

13 EXECUTIVE DIRECTOR TERRELL: Dr. Williams?

14 DR. WILLIAMS: Here.

15 EXECUTIVE DIRECTOR TERRELL: Dr. Mortensen?

16 DR. MORTENSEN: Here.

17 EXECUTIVE DIRECTOR TERRELL: Dr. Ducatel?

18 DR. DUCATEL: Here.

19 EXECUTIVE DIRECTOR TERRELL: Mr. Creegan?

20 MR. CREEGAN: Present.

21 EXECUTIVE DIRECTOR TERRELL: Ms. Jackson is
22 excused. And as you stated, Dr. Di Pietro is
23 delayed in travel, and she will be here shortly.

24 Also, present with us, we have a legal
25 counsel, David Flynn, and myself, Executive Director

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1 of the Board of Osteopathic Medicine, Danielle
2 Terrell. We do have a quorum, sir.

3 CHAIRMAN ACKERMAN: Thank you, Ms. Terrell.
4 So before we begin, Mr. Paul Vasquez, again, he's
5 the Executive Director of the Board of Medicine.
6 Please begin by making some opening comments.

7 EXECUTIVE DIRECTOR VASQUEZ: Good
8 afternoon. It's Friday, February 10, 2023. The
9 time is 1:02 p.m. My name is Paul Vasquez. I'm the
10 Executive Director of the Florida Board of Medicine.
11 This is a duly noticed joint meeting of the Boards
12 of Medicine and Osteopathic Medicine. This is a
13 public meeting and is being recorded. The audio
14 will be available on the board's websites next week,
15 and I'll go over some instructions, so this meeting
16 will be successful and the board members will be
17 able to take care of the matters that are before
18 them today.

19 There is a court reporter in the meeting.
20 If you speak to the board, it is important that you
21 state your name for the record. When appropriate,
22 the Chair will ask for public comments. Therefore,
23 please refrain from speaking during the meeting
24 until the appointed time.

25 Please remember, this is a public meeting

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1 and is being recorded. Any side conversations may
2 be recorded and become part of the public record.
3 At this time, please silence all electronic devices.

4 In June 2022, the Boards of Medicine and
5 Osteopathic Medicine received notice from the
6 Department of Health that it intended to present a
7 petition to initiate rulemaking regarding the
8 treatment of gender dysphoria in Florida.

9 During the Board of Medicine's regular
10 meeting on August 5, 2022, the Board hosted the
11 State Surgeon General and others representing the
12 position of the department. Equal time was granted
13 to experts from the University of Florida, who held
14 an opposing position.

15 Three major points were revealed during
16 that meeting. First, so-called bottom surgery is
17 not offered for minors at major medical centers in
18 Florida, and so-called top surgery is infrequently
19 offered to minors at major medical centers in
20 Florida, though there have been instances in Florida
21 where females as young as 15 years old have
22 undergone mastectomies.

23 Second, there are significant substantive
24 differences between the large medical societies in
25 the United States and their European colleagues

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1 regarding the treatment of minors with gender
2 dysphoria.

3 Third, the chief point of agreement amongst
4 all experts is that there is a lack of high-quality
5 clinical research on the subject of gender dysphoria
6 and its treatment.

7 At the conclusion of the meeting, the Board
8 voted to initiate rulemaking.

9 During the Board of Osteopathic Medicine's
10 regular meeting on August 12, 2022, the Board hosted
11 the State Surgeon General and others representing
12 the position of the department. At the conclusion
13 of the meeting, the board voted to initiate
14 rulemaking.

15 The task then fell upon a joint rules and
16 legislative committee to hold a rule workshop to
17 consider and possibly develop rule language.

18 In preparation for a meeting on October 28,
19 2022, board staff was directed to invite subject
20 matter experts with differing viewpoints, generally,
21 representing three cohorts.

22 Florida licensed pediatricians or pediatric
23 endocrinologists who actively treat minors with
24 gender dysphoria, scientists with expertise in the
25 current clinical data, representatives from a large

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1 American clinical societies, ultimately
2 representatives from the University of Florida, the
3 University of Oxford, Yale University, the
4 University of Turku in Finland, and the Children's
5 Hospital in Chicago, and a private practice
6 endocrinologist from California participated in that
7 meeting. A formal invitation was also extended to
8 the Endocrine Society, which declined the
9 invitation.

10 Formal invitations were also sent but
11 declined by physicians actively practicing at
12 Nicklaus Children's Hospital in Miami, Johns Hopkins
13 All Children's Hospital in St. Petersburg, and Joe
14 DiMaggio Children's Hospital in Hollywood.

15 During the committee meeting on October 28,
16 2022, emotionally powerful public comment was also
17 received representing both the affirmative and
18 negative positions on the issue. Ultimately, a
19 motion was passed to approving draft language for
20 the consideration by the boards.

21 On November 4, 2022, a joint meeting of the
22 Boards of Medicine and Osteopathic Medicine was held
23 to consider the draft language. Again, public
24 comments were received representing both the
25 affirmative and negative positions on the issue.

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1 Ultimately, both boards approved proposal
2 language to establish practice standards for the
3 treatment of gender dysphoria in minors. The
4 language was published in the Florida Administrative
5 Register on November 14, 2022. Following the
6 publication of the language, a number of requests
7 for rule hearing were received by both boards
8 resulting in today's meeting.

9 The Boards of Medicine and Osteopathic
10 Medicine are apolitical bodies that have the primary
11 mission of protecting the people of the state of
12 Florida. As with any issue before the Boards, the
13 board members will look to the available science and
14 appropriate standard of care while putting aside any
15 personal feelings they may have on the issues before
16 them today.

17 In terms of how this meeting will be
18 conducted, it is the Board's expectation that we
19 will have civil discourse while discussing the
20 issues on today's agenda. We require that everyone
21 refrain from making any disruptive comments or
22 taking any disruptive actions during the duration of
23 the meeting.

24 The boards reserve the right to remove any
25 individual who chooses to disrupt the progress of

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1 the meeting, so please conduct yourselves
2 accordingly.

3 This meeting will end no later than 5:00
4 p.m. Public comment will be received during the
5 meeting to the extent possible, depending on the
6 progress of the meeting and the time allotted. The
7 public comment process will be randomized and will
8 be as equitable as possible. However, it is evident
9 that not everyone who wishes to speak will be able
10 to speak given the time constraints of this meeting.

11 If there are any publicly elected officials
12 with us today, please make yourself known to the
13 Chair during public comment to ensure that you have
14 an opportunity to speak. Thank you.

15 CHAIRMAN ACKERMAN: Thank you, Mr. Vasquez.

16 I have a few comments I'd like to make
17 before we start to kind of go over where we as a
18 board have gone from when we first heard about the
19 request for a rule to now. I may say a few things
20 that are redundant with Mr. Vasquez, but please bear
21 with me. And I think these are good things for us
22 all to remember and for you all to -- for those of
23 you who are visiting today and want to speak today
24 to understand where our heads are at as a Board and
25 what in the processes that we've gone through.

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1 So, again, in early June, we were given
2 notice by the state that the state will be
3 petitioning the Boards of Medicine and Osteopathic
4 Medicine, asking us that we develop rules on the
5 subject of gender dysphoria and gender-affirming
6 healthcare. This was presented to us at our August
7 5, 2022, board meeting that we held in Tampa. Our
8 then chair, Dr. David Diamond, who is in --
9 understood that we were -- that there were unique
10 sensitivities related to this issue.

11 So he directed our staff and our counsel to
12 ensure that the process, that we approach this
13 subject in a fair and thorough manner.

14 We heard testimony from many subject matter
15 experts. These subject matter experts were all
16 well-published and well-respected. They're
17 academics from various institutions here in Florida
18 and also academics from all over the world. They
19 shared with us their research, their expertise,
20 their experience, and their knowledge. And we found
21 that they had varied perspectives and varied
22 opinions.

23 We heard from the public as well. We heard
24 from the public on all sides of the issue. The
25 public comment, like these experts, was also very

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1 diverse.

2 At the conclusion of that meeting, we
3 decided to initiate the rulemaking process. And so
4 our Rules Committee met on October 28th, and again,
5 we heard from more subject matter experts, again,
6 with different expertise and with different
7 backgrounds.

8 We also heard from more of the public, we
9 heard more public comment. And again, the subject
10 matter experts and the public had very varied
11 opinions. We then took these varied opinions and
12 perspectives and we processed them and we proposed
13 rules on gender dysphoria and gender-affirming
14 healthcare.

15 So we created these rules, and then on
16 November 4th, these rules were presented to a joint
17 meeting of the Board of Medicine and the Board of
18 Osteopathic Medicine. And those Boards adopted
19 rules for the standard of practice for the treatment
20 of gender dysphoria in minors.

21 The Board of Medicine and the Board of
22 Osteopathic Medicine have very similar rules except
23 for ones -- except for one difference. So I like to
24 just read the rules that we had -- that we put forth
25 at our November 4th joint board meeting that were

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1 approved.

2 So the Board of Medicine and Osteopathic
3 Medicine approved the following. Number 1, the
4 following therapies and procedures performed for the
5 treatment of gender dysphoria in minors are
6 prohibited: sex reassignment surgeries or other
7 surgical procedures that alter primary or secondary
8 sexual characteristics, and puberty blocking hormone
9 and hormone antagonist therapies.

10 Also, minors being treated with puberty-
11 blocking hormone or hormone antagonist therapies
12 prior to the effective date of this rule may
13 continue such therapies.

14 The Board of Osteopathic Medicine had one
15 more rule, and their additional rule was that non-
16 surgical treatments for the treatment of gender
17 dysphoria in minors may continue to be performed
18 under the auspices of institutional review board
19 approval.

20 Investigator initiated clinical trials
21 conducted at any of the Florida medical schools set
22 forth in Florida statute, and that such clinical
23 trials must include long-term longitudinal
24 assessments of the patient's physiologic and
25 psychologic outcomes.

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1 So as you can see, the only difference
2 between the Board of Medicine's -- proposed Board of
3 Medicine's rule and the Osteopathic Board's rule is
4 the exemption for clinical trials.

5 So as per our standard rulemaking practice,
6 we invited formal requests for rule hearing today.
7 We have received six requests for rule hearing, and
8 today we are here to honor those requests and have a
9 formal rule hearing.

10 The purpose of a rulemaking hearing in
11 Florida, as per Florida statute, is twofold. Number
12 1, to allow the agency to inform itself of matters
13 bearing on the proposed rules or modifications
14 thereof.

15 And number 2, to allow the public and
16 specifically individuals and groups having
17 particular interests and/or information to
18 participate in the rulemaking process.

19 To be clear, this is not a rule challenge
20 as provided for Florida statute; that comes later
21 on. This is a rulemaking hearing.

22 So in the past, just to put things in
23 proper context or perspective, the Board of Medicine
24 or the Board of Osteopathic Medicine may propose a
25 rule that would affect the way we treat patients

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1 with pneumonia. And the rule may have some language
2 in it that does -- that's not consistent with what
3 may be general practice or may be in conflict with
4 what some individuals are doing and the way they
5 treat pneumonia.

6 And so people would come to this hearing
7 and help educate us and clarify how things might be
8 done, so we can make some tweaks to the language or
9 tweaks in that rule. But generally, not to come to
10 challenge the rule completely, but just to make some
11 modifications or tweaks to it.

12 So we'll be -- so to begin with -- so
13 that's -- those are my comments. And so we will be
14 hearing today, first, from those who have requested
15 a rules hearing. And then we'll hear from the
16 public. We will not be able to hear from all those
17 who -- all those of the public who made requests
18 because we have a lot of people that made requests,
19 and I want to make sure that we allow time for the
20 Boards of Medicine and Boards of Osteopathic
21 Medicine to have some time for deliberation. So
22 let's go ahead and begin.

23 So I would like to call now the
24 presentation of those who've made requests for a
25 rules hearing. And so we've had six people that

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1 have formally requested a rules hearing. I'm going
2 to allow each of them 10 to 15 minutes to speak.

3 I want to include in that same 10 to 15
4 minutes time for the board to respond to you. If
5 you have any questions for the board, for us to be
6 able to respond specific, you know, to those
7 questions that you may have. I'm not sure if all
8 six of those people or entities are here today to
9 speak to that, but I'm going to going to go through
10 the names as we receive them and as they are in the
11 public record.

12 So the first person that made request for
13 the rules hearing is Mr. James Wright.

14 Are you here, Mr. Wright? Okay.

15 The second person that made requests for
16 rules hearing was Lauren Miller.

17 Ms. Miller, are you here?

18 The third person that made requests for
19 rules hearing is Simone Chriss, the Director of
20 Transgender Right Initiative of the Southern Legal
21 Counsel.

22 Is that Ms. Chriss? Thank you for being
23 here today.

24 SIMONE CHRISS: Yes. Thank you --

25 CHAIRMAN ACKERMAN: The floor is yours.

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1 SIMONE CHRISS: I appreciate it.
2 Hello, everyone. Thank you for the
3 opportunity to speak today. My name's Simone
4 Chriss. I'm the Director of the Transgender Rights
5 Initiative at Southern Legal Counsel. We're a
6 statewide not-for-profit public interest, civil
7 rights law firm that utilizes federal impact
8 litigation to ensure communities that we serve have
9 access to justice and freedom from discrimination
10 and to hold the state accountable for discriminatory
11 laws and policies.

12 I just want to say, to start, I was born
13 and raised in Florida in a small rural town on a
14 farm. I went to the University of Florida for
15 undergrad and law school, and I chose to stay here
16 to practice law and make this my home because I
17 wanted to make this state a better place and protect
18 the rights of folks in my community.

19 Having grown up as a gay teen in a
20 conservative area, I wanted to protect the rights of
21 LGBTQ youth in Florida. But as I stand before you
22 today, I am ashamed to be from Florida. I am
23 ashamed that the rest of the country and the world
24 is watching, while those in positions of power who
25 are entrusted to protect our rights, our health, our

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1 well-being, are weaponizing that power against the
2 transgender community for political gain, and doing
3 so under the guise of protecting children is
4 particularly insidious.

5 Given that we know based on the
6 overwhelming weight of evidence and science, that
7 access to treatment for gender dysphoria is safe,
8 effective, and medically necessary, and stripping
9 children in Florida of access to that care harms
10 them. It in no way protects them.

11 We vehemently oppose the proposed rules
12 based both on the science and evidence, supporting
13 the medical necessity of treatment for gender
14 dysphoria, but also on our own extensive experience
15 working with hundreds of transgender adults and
16 minors in this state and witnessing the tremendous
17 benefits that access to gender-affirming care
18 provides and the devastating consequences that can
19 result when such care is denied.

20 As I'm sure you all are well aware,
21 lawsuits challenging similar bans across the country
22 have successfully struck down or enjoined these same
23 measures. Why is that? It's because our position,
24 that treatment for gender dysphoria is safe,
25 effective, and medically necessary, is based on

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1 science and evidence. It is supported by decades of
2 clinical research.

3 The notion that Florida needs to adopt a
4 standard of care is bizarre to me because there
5 exists a standard of care for the treatment of
6 gender dysphoria. And it's established over decades
7 by the World Professional Association for
8 Transgender Health, the Endocrine Society, and other
9 major medical organizations that we as a -- you all
10 as a medical community, have always trusted and have
11 always looked you for guidance.

12 Bans such as the one being considered by
13 you all today directly contravene the widely
14 accepted authoritative standards and the consensus
15 of every major medical organization in our country.
16 The position that you all have unfortunately chosen
17 to take, on the other hand, is based on fear on
18 disinformation and manufactured outrage about
19 something that most people genuinely just don't
20 understand.

21 The reality is that these bans violate core
22 constitutional rights, including transgender
23 individual's rights under the equal protection
24 clause of the 14th Amendment to the U.S.
25 Constitution to be free from discrimination on the

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1 basis of sex, the fundamental rights of parents
2 under the substantive due process clause to make
3 decisions about medical care for their own child.

4 And for a state that holds itself out as
5 being so deeply concerned about the preservation of
6 parental rights, it feels sublimely ironic that you
7 all are stripping parents of their rights and
8 substituting the judgment of parents and of doctors
9 who are actual experts in the provision of this care
10 for that of the state.

11 I've attended every one of your meetings
12 thus far, and I find it incredibly troubling and
13 disingenuous the way that the Board of Medicine,
14 particularly, has reversed course on the inclusion
15 of the IRB approved investigator initiated clinical
16 trial exception for prospective patients.

17 I find this concerning because as
18 Dr. Diamond, you said yourself during -- I don't
19 remember if it was the October 28th or November 4th
20 meeting, but you said, "The chief point of agreement
21 amongst all the experts" -- and I must emphasize
22 this -- "is that there is a pressing need for
23 additional high quality clinical research." Seven
24 days later to reverse course on that and remove that
25 exception, it just doesn't make sense.

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1 The proposed rule is a cruel and
2 discriminatory measure that is inconsistent with the
3 rights guaranteed to minors, parents of minors, and
4 medical providers under the equal protection clause,
5 the due process clause, the Affordable Care Act, and
6 other laws.

7 The Florida Board of Medicine has a duty to
8 ensure that doctors licensed to practice medicine in
9 the state of Florida are providing high quality
10 evidence-based care to patients.

11 By adopting and enacting the proposed rules
12 that we're here to discuss today, you would be
13 denying Florida medical providers the ability to
14 utilize their own judgment, their own clinical
15 expertise, and mandating that they violate the
16 evidence-based treatment guidelines for the
17 treatment of gender dysphoria. Utilizing this
18 process to categorically exclude the provision of
19 medical care to an entire group of people,
20 transgender minors, will further set dangerous
21 precedent whereby standards of care in the state of
22 Florida can change based on the whim of the Governor
23 and political motivations.

24 I just want to quickly read a note that was
25 sent to me this morning by a client of the parent of

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1 a transgender minor who wasn't able to be here
2 today.

3 She wanted me to share this with you all.
4 "Access to gender-affirming care, including puberty
5 blockers and the embrace of a family who accepts her
6 for who she is have allowed my child to blossom into
7 a girl who loves herself, who is confident, and who
8 just wants to be a happy kid in the state where she
9 has called her home since birth.

10 Barring doctors who have extensive training
11 and medical experience and follow peer review
12 guidelines from working with families to provide
13 life-saving and life-changing care to kids will rob
14 this incredible gift of joyful being not only from
15 trans kids but from their parents and families who
16 love and support them.

17 As the parent of a trans child, I deserve
18 to be able to experience the joy of watching my
19 child blossom into a happy, confident, empowered
20 girl who feels comfortable and confident in her own
21 body." Thank you.

22 CHAIRMAN ACKERMAN: Thank you, Ms. Chriss.

23 Do any of the members of either board have
24 any questions for Ms. Chriss or any comments?

25 Dr. Vila?

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1 DR. VILA: Yeah. Ms. Chriss, thank you for
2 coming today and thank you for all the things that
3 you do to help treat and protect and care for
4 children of the state. I sincerely appreciate that.
5 And I think that's one thing that everyone in this
6 room has in common, that we're here for the
7 children, and we're trying to do the best that we
8 can to protect them.

9 And the thing I'll take exception with is
10 in your statement, you said the overwhelming weight
11 of the evidence is clear that these therapies are
12 acceptable and safe. And that's not true.

13 When you look -- the literature is not
14 clear. It's not clear. And you admitted that
15 because you said -- you agreed with the statement
16 that we needed some more research in these areas,
17 but the clinical data clearly doesn't support the --
18 there's not adequate evidence to support the use of
19 the therapies, the limited therapies that we've said
20 should not be used because of the irreversible harm.

21 So this Board is not against research, is
22 not against care for transgender children. This
23 Board has reviewed hundreds of studies. We've
24 talked to doctors. We've received testimony from
25 both sides of this issue, and the overwhelming data

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1 does not support -- so I take exception to what you
2 said. It just doesn't support. It's not there.
3 There's lots of physicians that feel differently.
4 So in terms of the research, there's still
5 an opportunity to research. What the Board has
6 sought to do is to protect our children from
7 therapies that have irreversible harm; that have
8 been shown to create irreversible harm. So it's a
9 very limited set of therapies that have been
10 restricted, but this Board still wants these
11 patients cared for absolutely. Thank you.

12 CHAIRMAN ACKERMAN: Thank you, Dr. Vila.

13 SIMONE CHRISS: If I may --

14 CHAIRMAN ACKERMAN: Ms. Chriss, you want to
15 respond to that?

16 SIMONE CHRISS: If I may, briefly. Thank
17 you.

18 I appreciate the points that you're
19 raising. However, I have to push back on the notion
20 that there isn't an overwhelming consensus of
21 scientific and medical evidence demonstrating the
22 efficacy of this treatment. And that's a point that
23 I think we're just going to have to agree to
24 disagree on, but there are a handful of experts that
25 you can fly in from other states and other countries

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1 who will come to the conclusion that ACA came to,
2 which is what you all are relying upon. And those
3 folks will say that, but talk to the doctors that
4 practice in Florida; talk to the folks that are
5 actually treating these children. Hear from the
6 children.

7 I mean, I've been at every meeting, and
8 kids who are actually impacted, who have received
9 this treatment and who have -- it has been
10 lifesaving for them. Their voices haven't been
11 heard. And the physicians that are providing
12 evidence-based medicine in this state and who have
13 had overwhelmingly positive results with the
14 patients that they serve, those folks' voices are
15 not being heard.

16 And so I just -- I have to push back on
17 that notion that this is in any way protecting
18 children. Because if that were the case and you all
19 thought that these treatments genuinely were so
20 harmful and damaging, why would there be a clause
21 allowing kids already on this treatment to continue
22 receiving said treatment? Why are these same exact
23 drugs and blockers and hormones provided to treat
24 other conditions? They're solely excluded for
25 gender dysphoria.

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1 There's so many things in this that simply
2 don't make sense and to target just transgender
3 children and exclude them from receiving evidence-
4 based care. And in alignment with authoritative
5 standards, it's hard to see it as anything other
6 than discrimination against transgender children.

7 CHAIRMAN ACKERMAN: Thank you, Ms. Chriss.

8 I want to remind you and the -- and all the
9 public that's here that this Board heard from many
10 physicians around the state and around the country
11 who treat transgender children. And we heard a lot
12 of disparity in their outcomes and their and in
13 their opinions.

14 And so it's not that we didn't hear from
15 these doctors. We did. We heard from lots of kids
16 as well. Lots of children spoke to us. So we
17 processed all that. And thank you for your
18 comments.

19 Is there anything else from any other board
20 members? Thank you, Ms. Chriss.

21 SIMONE CHRISS: Thank you.

22 (END OF AUDIO RECORDING)

23

24

25

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1 CERTIFICATE OF TRANSCRIPTIONIST

2 I certify that the foregoing is a true and
3 accurate transcript of the digital recording
4 provided to me in this matter.

5 I do further certify that I am neither a
6 relative, nor employee, nor attorney of any of the
7 parties to this action, and that I am not
8 financially interested in the action.

9

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Julie Thompson

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Julie Thompson, CET-1036

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Jane Doe

vs.

Joseph Ladapo

Taped Transcription

February 21, 2023



Med Def_001350

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAP0,

6 Defendant.

7

8

9

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11

12 TRANSCRIPTION OF VIDEO RECORDING

13 HOUSE HEALTH AND HUMAN SERVICES

14 FEBRUARY 21, 2023

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22 TRANSCRIBED AUDIO RECORDING BY:

23 Julie Thompson, CET

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25 Job No.: 322529

February 21, 2023

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1 Thereupon,
2 The following proceeding was transcribed from an
3 audio recording:

4 * * * *

5 CHAIRMAN FINE: The Health and Human
6 services Committee will come to order.

7 Sabrina, please call the role.

8 THE CLERK: Chair Fine.

9 CHAIRMAN FINE: Here.

10 THE CLERK: Representatives Persons-
11 Mulicka.

12 VICE-CHAIR PERSONS-MULICKA: Here.

13 THE CLERK: Representative Salzman.

14 REPRESENTATIVE SALZMAN: Here.

15 THE CLERK: Skidmore.

16 REPRESENTATIVE SKIDMORE: Here.

17 THE CLERK: Amesty.

18 REPRESENTATIVE AMESTY: Here.

19 THE CLERK: Anderson.

20 REPRESENTATIVE ANDERSON: Here.

21 THE CLERK: Baker.

22 REPRESENTATIVE BAKER: Here.

23 THE CLERK: Clemons.

24 Cross.

25 REPRESENTATIVE CROSS: Here.

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1 THE CLERK: Dunkley.
2 REPRESENTATIVE DUNKLEY: Here.
3 THE CLERK: Edmonds.
4 REPRESENTATIVE EDMONDS: Here.
5 THE CLERK: Gantt.
6 REPRESENTATIVE GANTT: Here.
7 THE CLERK: Grant.
8 REPRESENTATIVE GRANT: Here.
9 THE CLERK: Koster.
10 REPRESENTATIVE KOSTER: Here.
11 THE CLERK: Massullo.
12 REPRESENTATIVE MASSULLO: Here.
13 THE CLERK: Plakon.
14 REPRESENTATIVE PLAKON: Here.
15 THE CLERK: Rizo.
16 REPRESENTATIVE RIZO: Here.
17 THE CLERK: Snyder.
18 REPRESENTATIVE SNYDER: Here.
19 THE CLERK: Trabulsy.
20 REPRESENTATIVE TRABULSY: Here.
21 THE CLERK: Woodson.
22 REPRESENTATIVE WOODSON: Here.
23 THE CLERK: Yarkosky.
24 REPRESENTATIVE YARKOSKY: Here.
25 THE CLERK: A quorum is present.

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1 CHAIRMAN FINE: Thank you, Sabrina.

2 As we begin, I ask everyone to silence
3 their cell phones.

4 So members, we are going to be having a
5 discussion today, a panel presentation on a subject
6 that has a lot of charged emotions around it. And
7 so before we get into it, I want to lay out some
8 protocol rules that will be inflexible and enforced
9 strictly.

10 First, just so everyone knows, there will
11 not be public comment today. The purpose of today
12 is to hear from the seven experts on both sides that
13 we have invited to come and speak today. The second
14 thing, as it relates to questions, members may have
15 questions. We're going to allow all seven speakers
16 to speak for 10 to 12 minutes each, and at the end
17 of that, we will take questions, you know, should
18 people have any.

19 And then the third thing relates to
20 disruptions. The sergeant staff has been
21 preauthorized to remove people. There will not be
22 warnings. You'll be removed. If I can hear you
23 breathe from my seat, that will be the standard. So
24 I would encourage people to keep that in mind.
25 We're going to have a hearing. We're going to hear

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1 from these folks. It's going to go for as long as
2 it goes, and then we are going to be done. And
3 don't test me. I'm sure you won't like the outcome.

4 All right. Members, today we have a panel
5 of experts today to talk about gender dysphoria and
6 various procedures that are being performed or
7 prescribed on minors as a result. With us today is
8 Dr. Scot Ackerman, the chair of the Florida Board of
9 Medicine, Michael Biggs, a PhD and an associate
10 professor of sociology from the University of
11 Oxford, Dr. Michael K Laidlaw, an endocrinologist,
12 Dr. Stephen B. Levine, a psychiatrist, Chloe Cole,
13 someone who has experienced this personally and will
14 share her story with us, and David Leatherwood with
15 an organization called Gays Against Groomers. We
16 will also have a doctor. I don't think she's here
17 yet. I apologize that I can't pronounce her name,
18 Dr. Sidhbh Gallagher, who is a doctor from Miami.

19 And those are our seven speakers. I would
20 note that of the seven, five are either PhDs or
21 doctors. We only have two non-academics or medical
22 professionals that are here today.

23 In your packet you will find the CVs for
24 each of our clinical and academic panelists. In
25 addition, I want to draw your attention to the last

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1 tab in the packet. This is someone we asked to
2 speak, but she was unable to be here. But I would
3 encourage you to read it. It is an article written
4 by Jamie Reed, who is a lesbian, who describes
5 herself as politically to the left of Bernie Sanders
6 and who has written a whistleblower article on her
7 experience dealing with these issues in the state of
8 Missouri and a copy of the letter that she sent to
9 the Missouri Attorney General. I wish you good luck
10 reading the article. I have tried on about five
11 occasions. I cannot get to the end before I become
12 sick. So I encourage you to read it. It's a good
13 thing to read if you, you know, want something to do
14 here or certainly afterwards.

15 Panelists, I greatly appreciate your time,
16 taking the time to be here with us today. I'm going
17 to ask each of you, like I said, to give some
18 opening remarks, no more than 10 to 12 minutes, and
19 then we'll move to member questions.

20 We're going to start with Dr. Ackerman, who
21 is here in person. You'll notice we have three of
22 our panelists will be joining us remotely, but we're
23 going to start with Dr. Ackerman. Thank you for
24 being here. He's with the Board of Medicine. He's
25 here to brief us on recent actions taken by the

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1 Board of Medicine to regulate certain medical
2 procedures that are being proposed on children.

3 Dr. Ackerman, you are recognized.

4 DR. ACKERMAN: Thank you. Thank you,
5 Chairman Fine, Vice Chairman Persons-Mulicka,
6 ranking members and Committee members for the
7 opportunity to speak with you and appear to you this
8 afternoon. So I have some prepared remarks I'd like
9 to start with this morning -- this afternoon rather,
10 and I look forward to being questioned by you later,
11 if you wish.

12 So my name is Scot Ackerman. I'm a
13 physician. I'm an M.D. I'm a radiation oncologist
14 practicing in Jacksonville, Florida. I'm currently
15 the Chair of the Florida Board of Medicine, and I'm
16 here to speak to you today about the Board's efforts
17 to promulgate rules relating to the standards of
18 practice for the treatment of gender dysphoria and
19 minors in Florida.

20 So as a bit of background, as you know, the
21 Boards of Medicine and the Board of Osteopathic
22 Medicine are apolitical bodies that have the primary
23 mission of protecting the people of the state of
24 Florida. As with any issue before our boards, the
25 Board members look to the available science and

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1 appropriate standards of care while putting aside
2 any personal feelings they may have on issues that
3 are presented before them.

4 In June of 2022, so just about eight months
5 ago, the Boards of Medicine and Osteopathic Medicine
6 received notice from the Department of Health that
7 it intended to present a petition to initiate
8 rulemaking regarding the treatment of gender
9 dysphoria in Florida.

10 During the Board of Medicine's regular
11 meeting on August 5, 2022, the Board hosted State
12 Surgeon General Joseph Ladapo and others
13 representing the position of the department. Equal
14 time was then granted to experts from the University
15 of Florida, specifically from the Department of
16 Pediatrics and Pediatric Endocrinology, who held an
17 opposing position from the department, from the
18 Department of Health.

19 Three major points were revealed to us
20 during that meeting. So three things came out after
21 hearing from the department and from the experts
22 from the University of Florida, and the first thing
23 that came out was this first so-called bottom
24 surgery. Now, bottom surgery is removing the
25 phallus. Bottom surgery would be to add a phallus

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1 to a woman who has a vagina.

2 And so we found out that bottom surgery is
3 generally not offered to minors at major medical
4 centers in Florida, but so-called top surgery is
5 infrequently offered to minors in major medical
6 centers. So top surgery is a mastectomy on a woman
7 or a girl or breast augmentation to a man. So we
8 found out that top surgery is infrequently offered
9 to minors in major medical centers in Florida. And
10 we also found out that there have been instances in
11 Florida where females as young as 15 years old have
12 undergone mastectomies.

13 The second thing that came out was that
14 there was significant substantive differences
15 between large medical societies throughout the
16 United States and in Europe regarding the treatment
17 of minors with gender dysphoria. So there was no
18 singular, unquestioned standard of care. Anyone
19 that says that, we found and we felt that anyone
20 that says there's a single standard of care, that
21 that's just not accurate, that there are multiple
22 differences -- there's substantial differences in
23 the different societies. There's a number of
24 societies that all agree, and there are many
25 societies that have a different opposing opinion.

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1 And third -- am I still on? Yeah. Third,
2 the chief point of agreement amongst all the experts
3 is that there's lack of high-quality research on the
4 subject of gender dysphoria and the treatment of
5 gender dysphoria. So there's no standard of care,
6 and there's high agreement that there's lack of
7 high-quality research.

8 So at the end of that meeting, the Board
9 voted to initiate rulemaking. A week later, the
10 Board of Osteopathic Medicine met, and they hosted
11 the State Surgeon General and others representing
12 the position of the department. And at the
13 conclusion of the Board of Osteopathic Medicines
14 meeting, they also voted to initiate rulemaking.

15 Now, you understand there's two separate
16 boards, the Board of Medicine, the M.D. board, and
17 the Osteopathic Medicine, which is the D.O board.
18 So we put together a joint -- both boards, a joint
19 rules and legislative committee, and we held a
20 workshop to consider and possibly develop rule
21 language.

22 In preparation for our meeting on October
23 28th -- so this joint meeting was October 20th in
24 Dania. And we asked the Board staff to invite
25 subject matter experts with differing viewpoints,

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1 and these subject matter experts represented three
2 separate cohorts. So we brought in Florida licensed
3 pediatricians and pediatric endocrinologists who are
4 actively treating minors with gender dysphoria.
5 That's the first cohort. We also invited scientists
6 who had expertise in the current clinical data, the
7 second cohort. And then we invited representatives
8 from the large American clinical societies, who many
9 of these sites endorse this sort of gender
10 affirmative care.

11 So ultimately, we invite all these people.
12 They didn't all come. Ultimately, we had
13 representatives from the University of Florida, the
14 University of Oxford, Yale University, University of
15 Turku in Finland, and the Children's Hospital of
16 Chicago. And we also had a private practice
17 endocrinologist from California who participated in
18 the meeting.

19 A formal invitation was also extended to
20 the Endocrine Society, and they declined the
21 invitation. We also sent formal invitations to
22 physicians who were actively practicing at many
23 pediatric hospitals in Florida, specifically the
24 Nicklaus Children's Hospital in Miami, Johns Hopkins
25 All Children's Hospital in St. Petersburg, and Joe

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1 DiMaggio Children's Hospital in Hollywood, and all
2 of these chose not to come to our meeting.

3 During the Committee meeting October 28th,
4 there also very emotionally powerful public comment
5 that was received from us from both the affirmative
6 and negative positions on the issue. Ultimately, a
7 motion was passed approving draft rule language for
8 consideration by the Boards.

9 So then on November 4th, we had a joint
10 meeting of the Boards. So those are rules-making
11 Committee. We had a joint meeting of both Boards,
12 and on November 4th, that meeting was held to
13 consider this draft language.

14 Again, we had public comments at that
15 meeting representing both the affirmative and
16 negative position on the issue. And ultimately,
17 both Boards approved proposed language to establish
18 the practice standards for the treatment of gender
19 dysphoria in minors.

20 The language was published in the Florida
21 Administrative Register on November 14th, and then
22 following publication of the language, a number of
23 requests -- we received a number of requests for a
24 rules hearing. So just a couple of weeks ago,
25 February 10th, both the Boards of Osteopathic

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1 Medicine, the Board of Medicine held a joint hearing
2 here in Tallahassee to receive and consider
3 argument, comments, and questions for those that
4 requested rule hearing.

5 I want to point out to you we've got six
6 requests for a rule hearing. And the rule hearing
7 is to hear from people who are experts or who this
8 rule might affect. So they can tell us maybe if we
9 missed something, if we need to tweak our rule or
10 something. We had six people request, and two came
11 to a rule hearing. And so with the two we had, one
12 was someone who came and wanted us just to throw
13 away the rules completely, and the other was the
14 department that came to us wanting the Board of
15 Osteopathic Medicine to remove the research
16 exemption in our rule.

17 So at the conclusion of the meeting, we
18 also heard public comment that day as well. So at
19 the conclusion of the meeting, the Board of Medicine
20 took no action to amend its proposed rule, and the
21 Board of Osteopathic Medicine passed a motion to
22 remove the IRB exemption from its proposed rule. So
23 at the end of the meeting, both Boards had proposed
24 identical rules. And these rules are 64B8-9.019 and
25 64B15-14.014, and they are in your packet under my

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1 name. And they're titled Standards of Practice for
2 the Treatment of Gender Dysphoria in Minors. I
3 could read them to you if you wish. But --

4 Thank you. Thank you, Chair.

5 So the rule promulgated by the Board of
6 Medicine will be submitted for adoption. These
7 rules that you have in your packet will be submitted
8 for adoption on or about later this week, February
9 24th, and it will become effective on March 16th
10 provided a rules challenge is not filed with DOA,
11 the Department of Administrative Hearings.

12 The rule promulgated by the Osteopathic
13 Medicine was republished on February 15th, and it
14 will proceed through the normal rulemaking process
15 for adoption as soon as allowed pursuant to Florida
16 law because, remember, that rule was changed a bit.
17 So that has a little bit different process.

18 And so that's the end of my comments. I'm
19 available either now or later as you wish to answer
20 questions. Thank you.

21 CHAIRMAN FINE: Thank you. And thank you
22 for being here and making the effort. That was a
23 very thorough description. And again, members, the
24 rules are in your packet. That way, you don't have
25 to read them out loud. I'm sure people will have

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1 questions, but, like I said, we're going to let
2 everybody get through their presentations first. So
3 thank you. Thank you, Dr. Ackerman.

4 Now we're going to go to the screens, and
5 we're going to hear from Professor Biggs, who's
6 joining us remotely from the UK, all the way -- it's
7 a little later there than it is here. He will be
8 talking about his research on this issue and the
9 recent shifts in clinical protocols in European
10 countries.

11 Professor Biggs, you're recognized.

12 PROFESSOR BIGGS: Thank you. Thank you
13 very much for this invitation.

14 So I'm an associate professor of sociology
15 at the University of Oxford. Five years ago, a few
16 of my students told me to educate myself on the
17 subject of transgender children, and so I read the
18 literature on gender medicine. I was very surprised
19 by just how poor quality the published research was
20 and also by suspicious absence of some data.

21 So to take one example, the world's largest
22 pediatric gender clinic in London started research
23 on puberty blockers in 2010. In 2018, I discovered
24 that results -- their results had been suppressed,
25 and I campaigned to force the clinic to publish

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1 those results. I've now published original research
2 of my own in journals like Archives of Sexual
3 Behavior, Journal of Sex & Marital Therapy, and the
4 Journal of Pediatric Endocrinology and Metabolism.

5 Because the time is limited, I'm just going
6 to focus on one intervention for children
7 experiencing gender dysphoria, and that is puberty
8 suppression. So puberty blockers are a class of
9 drugs -- gonadotropin-releasing hormone agonists
10 such as Lupron. Lupron is probably the most common
11 brand name you will know in America. These drugs
12 stop the production of sex hormones. For males,
13 these drugs achieve chemical castration, quite
14 literally. The drugs are licensed for a few medical
15 conditions, such as prostate cancer in men and
16 precocious puberty in children. But they've never
17 been licensed to treat gender dysphoria, not in the
18 UK, not in the U.S.A., nowhere in the world.

19 Puberty suppression is intended for
20 juvenile transsexuals, and I use that phrase because
21 that's the title of the article that was published
22 in 1996 to introduce this particular use. A GnRH-a
23 can be administered from Tanner stage two, which is
24 the beginning of puberty. And so that could be a
25 girl, for example, as young as nine years old. Kits

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1 (Indiscernible) for puberty blockers claim
2 that this is analogous to treating precocious
3 puberty, and that's -- precocious puberty is when,
4 for example, a girl, maybe age five, might start
5 developing breasts. But that treatment means
6 delaying a puberty that arrives abnormally early so
7 that the child can undergo puberty at the normal
8 age. By contrast, puberty suppression for gender
9 dysphoria means stopping normal puberty in order to
10 prepare the child to take cross-sex hormones for the
11 rest of their life.

12 Ninety-six percent to ninety-eight percent
13 of children who start on puberty blockers continue
14 on to cross-sex hormones, and that continuing to
15 cross-sex hormones typically happens around the age
16 of 15.

17 Now, the only robust scientific evidence
18 favoring this intervention comes from a longitudinal
19 study of 70 Dutch teenagers. de Vries et al in 2014
20 published outcomes shortly after surgery. So the
21 patients were around the age of 20. Several
22 psychological measures showed improvement, though
23 these measures were taken for us only a subset of
24 patients, sometimes as few as 32 individuals.
25 Gender dysphoria also appeared to decline, but the

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1 latter finding was probably an artifact of the
2 measures of the fact that they switched the measures
3 of dysphoria halfway through the research, as Dr.
4 Levine has been very clear in pointing out.

5 de Vries et al acknowledge that one patient
6 was killed by necrotizing fasciitis during the
7 vaginoplasty. So out of 70 patients -- they started
8 with 70 patients -- that's a death rate exceeding 1
9 percent, which is incredibly high for a group of
10 healthy teenagers. de Vries et al didn't mention
11 that the death was actually a consequence of puberty
12 suppression, as I'll explain a bit later.

13 The Dutch researchers have recently
14 followed up this patient cohort, but they've not
15 published the results. Therefore, we lack any
16 knowledge of the outcomes in the longer term. And
17 this is for a treatment that has been going on for
18 more than a quarter of a century.

19 The only attempt to actually replicate the
20 Dutch study came from the gender clinic in London,
21 which you might know as the Tavistock. So they
22 administered GnRH-a to 44 teenagers. Because they
23 found the results after two years weren't positive,
24 the researchers decided not to publish the results.
25 And as I said, my campaign eventually forced them to

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1 publish their research and revealed that puberty
2 suppression didn't improve psychological functioning
3 and didn't reduce gender dysphoria.

4 There are now a handful of American
5 longitudinal studies, but they're much worse in
6 quality. Instead of replicating the measures
7 pioneered by the Dutch and also repeated by the
8 British teams, each American team of researchers
9 chose a different set of psychological measures.
10 And the studies are also flawed by tiny samples,
11 high rates of attrition, which are unexplained, and
12 dubious statistical methods.

13 So what then do we know about puberty
14 blockers? Well, it's certainly true that early
15 puberty suppression produces a much closer
16 resemblance to the opposite sex. Patients are more
17 likely to pass superficially. However, this benefit
18 disadvantage must be weighed against several serious
19 costs.

20 First, for males, early puberty separation
21 makes subsequent genital surgery more risky and less
22 satisfactory. The penis is so undeveloped that a
23 normal vaginoplasty is usually impossible. A normal
24 vaginoplasty means inverting the penis, but instead
25 a portion -- in this case, a portion of the

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1 intestine has to be used to line this newly created
2 orifice. Leakage from the intestines immediately
3 after surgery is what killed that first Dutch
4 patient, the early Dutch patient at the age of 18.
5 So that was an indirect consequence of puberty
6 suppression.

7 Second, puberty suppression hinders the
8 normal accumulation of bone mass. Up to one-third
9 of teenagers who take GnRH-a for two years end up
10 with abnormally low bone density, putting them at
11 risk of osteoporosis in later life. Sweden has
12 drastically curtailed the use of puberty suppression
13 because one of the patients developed severe
14 osteoporosis at the age of 15, and several more
15 patients also had significant losses or failures in
16 terms of their bone density.

17 And Even more serious are the unknown
18 costs. All the evidence is that early puberty
19 suppression, followed by cross-sex hormones,
20 prevents the development of sexual functioning.
21 There'll be no libido and no capacity to orgasm, or
22 at least that's very likely -- a very likely
23 outcome.

24 What's really astonishing to me is that
25 clinicians who prescribe puberty blockers haven't

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1 bothered to study their effects on sexuality. And
2 in fact, the Dutch team, the lead researcher who I
3 mentioned, de Vries, recently said in an interview
4 that libido -- orgasm was an interesting question,
5 but one that they hadn't studied yet.

6 Also known is the effect on emotional and
7 cognitive development. A recent randomized
8 controlled trial of mice showed that GnRH-a caused
9 mice to manifest high levels of stress and high
10 levels of anxiety. Again, it's remarkable that
11 researchers have never studied the effect of puberty
12 suppression on cognitive measures like IQ.

13 Given the accumulating negative evidence
14 and the continuing failure of clinicians to collect
15 data, the English National Health Service in October
16 2022 released a draft specification for gender
17 services. In a reversal of an existing policy, it,
18 and I quote, "Will only commission GnRH-a in the
19 context of a formal research protocol."

20 And that's what I recommended to the
21 Florida Board of Medicine, that they should adopt
22 the same policy. I would argue that puberty
23 suppression should only be offered in a proper
24 randomized control trial. Obviously, it can't be
25 blind, but with -- there can be a treatment and a

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1 control group, which can be compared. Moreover, any
2 trial must guarantee follow up to continue into
3 adulthood and must guarantee to publish all the data
4 that is collected. Thank you.

5 CHAIRMAN FINE: Thank you. Thank you,
6 Professor Biggs. That was very, very thorough, and
7 I appreciate it.

8 Next, we're going to hear from Dr. Laidlaw,
9 who is here to talk with us about the clinical data
10 on treatments intended to change your sex. He is
11 joining us remotely from California and so thank
12 you. For you, it's a little bit earlier.

13 So Dr. Laidlaw, you are recognized.

14 DR. LAIDLAW: Thank you very much, Chair
15 and all. I have some slides. It's saying I cannot
16 share the content. I don't know if someone could
17 correct that, or I could just start.

18 CHAIRMAN FINE: We're working on it. But,
19 members, if we want to get started, I could also
20 move around if we think I should do that. But I do
21 believe the slides are in your packets. So the
22 folks in the audience can't see them. But if we're
23 going to get started --

24 DR. LAIDLAW: Okay.

25 CHAIRMAN FINE: -- you have your -- and

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1 we're working on it so that you can do that. Why
2 don't we give him like 30 seconds to see if we can
3 make it work, and then we'll --

4 DR. LAIDLAW: Okay.

5 CHAIRMAN FINE: -- start.

6 So what does he need to do now? Can you
7 try sharing your screen?

8 DR. LAIDLAW: Here we go. I think that's
9 -- yeah.

10 CHAIRMAN FINE: There you go.

11 DR. LAIDLAW: Okay. Can everyone see that?

12 CHAIRMAN FINE: All right. There we go.

13 Thank you, sir.

14 UNIDENTIFIED FEMALE: Yes.

15 CHAIRMAN FINE: Thank you, Dr. Laidlaw.

16 DR. LAIDLAW: Okay. Thank you very much.

17 And thank you, Chair and all, for having me here.

18 My name is Dr. Michael Laidlaw. I'm an
19 endocrinologist practicing in Rockland, California,
20 for about the last 15 years in private practice.
21 I've been looking into this area deeply for about
22 the last five years and have written papers and have
23 been an expert witness and given talks on this
24 subject throughout that time.

25 And so I'd like to go through with you some

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1 of the medical consequences from this treatment.
2 Being in endocrinology, we study glands and
3 hormones. When hormone levels are very high, they
4 can cause problems. We try to bring them back into
5 balance. If hormone levels are very low, that
6 causes various problems, and we try to bring those
7 into balance. And what you'll see here is what
8 they're doing with hormones is putting young people
9 way out of balance.

10 Just for some definitions, gender identity
11 is the internal feeling of being a boy or a girl or
12 some variation. Gender dysphoria is the discomfort
13 that results from having a perceived gender that
14 mismatched with the person's body. It leads to
15 significant distress and impairment lasting at least
16 six months. The majority of these children,
17 depending on what study you look at, but still the
18 majority will grow out of this by adulthood, some 50
19 percent to 98 percent, depends where you're looking.

20 So anytime we undergo any sort of treatment
21 for a condition, we want to have a definite
22 diagnosis. So if I want to treat diabetes, I want
23 to make sure someone has a really high blood sugar.
24 If we're going to treat cancer, we want a biopsy to
25 prove that there's a cancer there to treat.

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1 How can we prove the gender identity? Can
2 you find it on a scan, like a CT scan or a brain
3 biopsy or genetic testing? The answer is none of
4 the above. There is no definite physical evidence
5 of a gender identity, and, therefore, many kids will
6 grow out of this and will be harmed if they undergo
7 the treatments I'll describe.

8 A bit of basic biology, there's only two
9 human sexes. You can verify this by thinking of
10 your own fertilized ovum. When you developed, there
11 was a male sperm and a female egg that led to
12 development. This proceeds on in embryology, where
13 males and females initially have similar tubules,
14 but then there's a divergence, a split, with the
15 males developing male specific organs on one side
16 and the females on the other. This happens very
17 early in embryology, and the bridge cannot be
18 crossed thereafter.

19 There's four stages to gender affirmative
20 therapy: social transition or wearing clothes
21 stereotypical of the opposite sex or adopting
22 mannerisms, perhaps; puberty blockers, which
23 Dr. Biggs described very well; cross-sex hormones or
24 opposite sex hormones; and surgical modifications.

25 Just to have a look at one good long-term

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1 study of Sweden, they looked at 30 years of data for
2 324 individuals who had hormones and completed
3 surgery for transition. And over time, you can see
4 here year 0 to 30 years, survival rates dropped
5 dramatically after ten years for those who had
6 transitioned. They also found that they had three
7 times the rate of all-cause mortality and three
8 times the rate of inpatient psychiatric care and 19
9 times the rate of completed suicide compared to the
10 population of Sweden.

11 This is just showing what Dr. Biggs had
12 described. Puberty blockers, this is the pituitary
13 here, and these are the testes. They stop the
14 normal communication between these organs, resulting
15 in low testosterone for males, low estrogen for
16 females. These are the normal what we call Tanner
17 stages of puberty from early development to final
18 adult development in males and females.

19 And what the Endocrine Society is proposing
20 is to block this very early on Tanner stage 2. Why
21 is this important? Because fertility is established
22 around Tanner stage 4. So if they're blocked with
23 puberty blockers and then take hormones and have
24 surgeries, they will have infertility. And if they
25 have surgical removal of their organs, they will be

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1 obviously sterilized.

2 To move on to sex hormones or opposite sex
3 hormones, to give you an idea, this is showing
4 female adult testosterone levels. It's in a fairly
5 narrow range, from 10 to 50. Females do have some
6 amount of testosterone, which we associate with
7 males, but there is some smaller amount in females.
8 In a common endocrine condition that I see,
9 polycystic ovarian syndrome, they will be higher,
10 say from the 40 to 150 range. With rare endocrine
11 tumors, this will be much higher, say from 150 to
12 1000. And these are dangerous tumors which
13 generally have to have surgery or other treatments.

14 What are they proposing for hormones -- for
15 this treatment is to bring levels to 300 to 1000
16 level, which is on the order of these dangerous
17 tumors that I described and is some 6 to 100 times
18 higher than endogenous female levels.

19 What are the consequences on the body for
20 that? To stay with females here, but females and
21 males both have an increased risk of myocardial
22 infarction and death due to cardiovascular disease,
23 they found. Females will develop very high red
24 blood cell counts, which is also a risk for heart
25 disease. They can develop liver dysfunction, high

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1 blood pressure, various cancer risks of the ovary
2 and breasts, hirsutism, which is hair growth all
3 over the body in different portions, particularly
4 the face and abdomen, a deepening of the voice --
5 and both of those are permanent changes -- sexual
6 dysfunction and infertility.

7 For males taking estrogen -- again, these
8 are very high doses of estrogen -- there's a five
9 times increased risk of thromboembolism or deadly
10 blood clots, gallstones, high triglycerides are
11 possibilities. Breast cancer risk has been
12 increased by 46 times and also sexual dysfunction
13 and infertility.

14 What about going back to testosterone?
15 High doses of testosterone have, in terms of
16 psychological effects, have mainly been studied with
17 anabolic steroid abuse. And what they found in
18 those studies that some 23 percent of subjects using
19 these high doses met criteria for major mood
20 syndrome such as mania or major depression, and even
21 8 percent or so develop psychotic symptoms. So it's
22 a problem for the body and a problem for the mind to
23 have these hormones so grossly out of the normal
24 range.

25 To move on to surgeries, referred to

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1 earlier as top surgery or mastectomy, this is a
2 person who's natal female, born female. You can see
3 the male growth pattern on the face we call
4 hirsutism and the abdomen, and a surgical procedure
5 has been done to remove the breasts. Complications
6 from that, of course, the person will lose the
7 ability to breastfeed. The woman will lose the
8 ability to breastfeed. There can be significant
9 scarring of 7 to 10 inches that can widen and cause
10 problems, can cause pain. Loss of normal nipple
11 sensation and difficulties with wound healing are
12 possible complications.

13 Just to emphasize, here's another study,
14 2018, I believe, showing how young patients around
15 the country are getting the surgery. There were two
16 13 year olds who had mastectomies, five 14 year
17 olds. You can see 15 and 16 year olds.

18 Professor Biggs had described the surgery.
19 I won't go too much into it, but again, the problem
20 with stopping a male at Tanner stage 2 is that
21 they'll have a very undeveloped penis and scrotum
22 area. Therefore, when the cavity is produced where
23 the penis is inverted inside, there's not enough
24 tissue. So a portion of colon needs to be attached
25 to it. There are other procedures, which increase

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1 your risk and risk for multiple surgeries.
2 Complications can include strictures of the urethra,
3 infection, prolapse, fistulas, injury to the sensory
4 nerves with partial or complete loss of erotic
5 sensation.

6 This is showing the phalloplasty or the
7 creation of a pseudo-penis. A swath of tissue is
8 taken from the forearm or thigh and rolled into the
9 pseudo-penis. This obviously can have very high
10 rates of complication, as you might imagine. One
11 study showed 76 percent had urethra fistulas or
12 urethral strictures. Other complications can
13 include infections like peritonitis. You'll
14 obviously have large scarring to the forearm or
15 thigh, possible injury to the sensory nerves.

16 So what is the basis for this type of
17 treatment? Who's making these rules or guidelines
18 and such? The Endocrine Society, which I belong to
19 and otherwise does very good work, except in this
20 area, produced clinical practice guidelines in 2017.
21 I think you should know that nine out of ten of the
22 persons who created these guidelines belong to the
23 organization called WPATH, which is an advocacy
24 group and is not a medical organization though it
25 has some medical doctors. So it's a very biased

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1 sample of physicians and others who created this
2 document.

3 They have in their disclaimer very clearly
4 that this does not establish a standard of care. So
5 if you hear it's a standard of care, they even said
6 it isn't the standard of care. If you look at the
7 grading of evidence, it's either low, very low
8 quality, or there's no evidence for what they're
9 doing.

10 Now, the WPATH, which I just talked about,
11 is an international organization. They create
12 standards of care which really exist within their
13 organization. It doesn't apply to anyone else and
14 shouldn't apply to anyone else. And with this
15 recent set, they actually lowered or removed the age
16 minimums for surgery. So any of the things that I
17 described and the other doctors described could be
18 done at any age, which is obviously extremely
19 dangerous, and children cannot consent to these
20 procedures. They also removed all guidelines for
21 minimum age of opposite sex hormones in
22 contradiction to the recommendation of their own
23 expert consensus. So this is an extreme document,
24 presents a grave danger to minors, and should not be
25 followed by any healthcare person in Florida or

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1 anywhere else in my opinion.

2 How can we help these kids? Well, they
3 have high rates -- Dr. Levine will, I'm sure, talk
4 about comorbid psychological illnesses. These need
5 to be treated and discovered. Perhaps they had
6 physical, sexual abuse or autism, problems in the
7 marriages, or family problems due to divorce. These
8 things need to be identified and properly treated by
9 qualified psychologists, psychiatrists, counselors,
10 and others who don't follow the WPATH model,
11 individual counseling, family counseling.

12 Just to emphasize, it's not a standard of
13 care. We don't have the technology to make a male
14 into a female or vice versa. Kids would not
15 understand this. We don't know long-term outcomes,
16 and what we do know for adults is not good.
17 Medications are being used off-label experimentally
18 and at high doses without proper FDA risk assessment
19 profiles. Evidence quality is very low, as we said,
20 and desisters and detransitioners have been ignored,
21 though there are some studies showing the problems
22 that they've had. Thank you very much for allowing
23 me to present.

24 CHAIRMAN FINE: Thank you. I very much
25 appreciate it and again look forward to the

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1 questions. That was an excellent presentation.

2 We're going to continue you with our
3 medical professionals. We're sort of hearing them
4 all up front. We're now going to hear from
5 Dr. Levine, who is the clinical professor of
6 psychiatry at Case Western Reserve University. So
7 he is not as far away. He's also joining us
8 remotely.

9 Dr. Levine, you are recognized.

10 DR. LAIDLAW: Thank you very much. I plan
11 to emphasize 13 ideas that I have found in the
12 literature written by those who affirm care for
13 children and adolescents and adults for transgender
14 phenomenon.

15 Each one of these 13 points, I believe, is
16 scientifically untrue. Nonetheless, they are firmly
17 believed, and when they are countered in meetings,
18 when they're confronted in meetings, it produces a
19 passionate outcry that it isn't true. But as far as
20 I can see, these 13 ideas are not scientifically
21 verifiable and are clinically, apparently,
22 incorrect.

23 Nonetheless, affirmative care doctors
24 assert them in their writings and in their speeches
25 repeatedly. And so having eavesdropped on this

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1 literature for all these years, I feel very strongly
2 that each of these points can be defended as
3 correct. That is, none of them are correct.

4 And before I give you these 13, I want to
5 raise that one way of considering this big question
6 of trans care for youth is whether this is an
7 example of therapeutic advance to help afflicted
8 human beings, or whether this is yet another medical
9 misadventure that in medicine we have a history of
10 many medical misadventures, most recently and most
11 damaging is the opioid epidemic, where we began
12 prescribing in medicine opioids liberally without
13 scientific demonstration as to its use and its
14 utility and its harms. And now every state in the
15 United States and elsewhere is suffering from
16 premature death due to opioid abuse.

17 So here are the 13 things that are not true
18 in my view. A trans identity, once established, is
19 immutable, unchangeable, unchanging. This is
20 clearly not true. Second, trans identities are
21 primarily caused by prenatal biologic forces. That
22 is, the justification of the treatment is we're just
23 correcting some biologic embryologic mistake.

24 And third, sexual orientation is entirely
25 independent of gender identity. Sexual orientation

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1 is a bias that all of us have towards for romantic
2 and sexual purposes for members of a class of males
3 or females. And in the standards of care from
4 WPATH, it's been asserted that they're entirely
5 separate.

6 But when you watch the child develop from a
7 childhood to puberty to middle adolescence, you
8 often see that the first manifestation of gender
9 dysphoria before gender dysphoria shows up, it is
10 that I am attracted to members of the same sex. And
11 you watch the evolution throughout adolescence of
12 orientation, and you quickly see that they are not
13 entirely separate phenomenon like the advocates say
14 they are.

15 And the fourth idea that is not true is
16 that no form of gender identity is an abnormality,
17 and no form of gender identity is a symptomatic
18 reflection of some other problem. This is not a
19 psychologically tenable concept, but it is asserted
20 all the time. And you can read it in the standards
21 of care.

22 Fifth, gender dysphoria is a serious
23 medical condition, and it requires medical
24 intervention only if the patient wants it. So there
25 is some inherent paradox in that idea, right? It's

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1 a serious medical condition. That implies that we
2 should treat it, but we should only treat it if the
3 patient wants it.

4 Six, the associated emotional problems are
5 primarily due to living in a discriminatory world,
6 even though many of the children who were diagnosed
7 with gender dysphoria eventually previously have
8 been diagnosed with other problems.

9 Seven, no effective alternative approaches
10 to affirmative care exist. This is the only thing
11 that will save your child, we tell parents, you see,
12 and many of the practitioners actually believe there
13 are no alternate approaches. But Dr. Laidlow just
14 told us about an alternate psychiatric approach.

15 Eight, attempts to provide psychotherapy
16 are unethical versions of conversion therapy and
17 should be outlawed. You see, any attempt to help
18 the child and the family is called conversion
19 therapy, and people are urging that to be outlawed
20 in various jurisdictions.

21 Nine, affirmative care lastingly improves
22 mental health and social function. This is the
23 justification for the treatment, even though we
24 don't have studies that demonstrate that. We don't
25 have long-term studies at all that demonstrate that,

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1 and we have many studies that indicate -- and you've
2 seen slides of the death rates and a recent study
3 has reaffirmed the elevated death rates of
4 transsexual adults. So the idea that this improves
5 mental health is uncertain at best.

6 Ten, affirmative care reduces the rates of
7 suicidal ideation and prevents suicide. This is the
8 most powerful coercive untruth that parents of
9 teenagers are told. Would you rather have your
10 child -- visit your child in the cemetery or have a
11 trans child? And many people, including one of our
12 panelists today, have demonstrated the lack of
13 veracity of that assumption.

14 When we look at the Swedish studies, the
15 females who underwent sex reassignment surgery had,
16 I think, 40 times the suicide rate, and the average
17 suicide rate that was quoted was 19 times because
18 the male's suicide rate was a little less than 19.
19 So we realized that we are exposing people to great
20 risk of suicide in the long run. And when we don't
21 have follow-up studies of the youth, you see, we
22 need to be informing parents about what we do know
23 about the long-term outcomes, which is not happening
24 at all.

25 And the 11th idea is that teens, young

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1 teens know best what will make them happy in the
2 future. I hear that all the time because this is
3 their genuine true self. Not true. They don't know
4 what's best for them necessarily.

5 And, 12, meeting diagnostic criteria for
6 gender dysphoria predicts a good outcome to
7 affirmative care. That's not true either. And,
8 finally, regret and detransition are rare among
9 these patients. As the last two years have begun to
10 show, detransition is increasingly recognized.
11 Regret is -- when people assert that regret is rare,
12 it's because they're defining regret as telling
13 their original therapist that they wish they didn't
14 undergo this or asking to have their body rechanged
15 back to their original form, which is a very limited
16 concept of what regret represents.

17 So these 13 ideas, I think, stand as a
18 monument to the assertions that affirmative care,
19 the science of affirmative care, has already
20 established its superiority and its benefit. If
21 ideas that underpin intervention are not true, are
22 not correct, how can we trust the intervention
23 itself? I think that's all I wanted to say to you
24 today, and I'm happy to answer any questions in the
25 future.

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1 CHAIRMAN FINE: Thank you. And like I
2 said, I appreciate all of you, and we will get to
3 questions at the end.

4 Before we move to our two non-
5 professor/doctors, she is not here, but I did want
6 folks to know that we had invited sort of one of the
7 most publicly public advocates, medical
8 professionals who's done this. Her name's
9 Dr. Sidhbh Gallagher. She has 280,000 TikTok
10 followers where she promotes this. She dubs herself
11 Dr. Teetus Deletus. That is her name, not mine.
12 And she proudly has done 400 to 500 gender -- what
13 she calls gender affirmation surgeries a year,
14 including 13 on minors.

15 And we did invite her to come. I mean,
16 she's willing to talk about it on TikTok. We
17 figured she might be willing to talk about it to the
18 Florida Legislature, but I guess platforms that
19 reach more than children just aren't that
20 interesting.

21 So we will move on to our nonmedical
22 professions. And next, we're going to now hear from
23 Ms. Chloe Cole, who's here to tell us about her
24 personal experience with this type of supposed
25 medical care. Ms. Cole, you are recognized.

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1 CHLOE COLE: Excuse me. I'm an 18-year-old
2 de-transitioned woman from the Central Valley of
3 California, and I commend California -- I commend
4 Florida for stepping up for the rights and safety of
5 our children and preventing what happened to me as a
6 child to happening -- from happening to other
7 children.

8 I transitioned and de-transitioned all
9 while I was a minor when I was in middle and high
10 school. And at roughly the age of 12, I started
11 feeling that after years of being a tomboy, being a
12 more masculine girl, and a misfit amongst all the
13 other girls, I was, in fact, a boy this whole time.
14 And I began cutting my hair and wearing boys
15 clothing to reflect this belief.

16 And I experimented with new names, and
17 eventually, I wrote a letter to my mom and dad
18 telling them that I wanted to be their son. And
19 they were concerned because they knew very little
20 about the subject, and they certainly didn't expect
21 to hear such a thing from their own daughter. And I
22 don't think any parent really does.

23 So they decided to send me to a therapist.
24 And their expectation was that they would get to the
25 bottom of my distress and where it was stemming

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1 from, and that in therapy, my feelings would be
2 resolved. But this did not happen. This is far
3 from what happened.

4 When they voiced their concerns to my
5 doctors, they were immediately shot down, and
6 immediately the therapist, and eventually the gender
7 specialist, their approach was only to affirm my
8 identity, and there was no questioning. There was
9 not a proper psychological evaluation done.

10 But my mom and dad were told that children
11 are already confident in their gender identities
12 from early childhood, that I knew exactly what I
13 wanted, and if I were not affirmed, it was very
14 likely that I would kill myself. The doctors, it
15 was life or death, and Mom and Dad were not given
16 any other option but to allow me to transition. And
17 so I was put onto the path of medical transition,
18 starting with puberty blockers and testosterone at
19 13.

20 A few months after starting testosterone, I
21 was sexually assaulted by a classmate of mine. And
22 out of fear of the assault happening a second time
23 and of being recognized as my biological sex ever
24 again, I started to use a compression device called
25 a chest binder. And by the time that I entered my

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1 freshman year, my voice was already considerably
2 deeper, and I looked just like pretty much any other
3 boy my age.

4 I passed considerably well as the opposite
5 sex throughout high school, but I still lived with
6 great anxiety of being discovered as a biological
7 female, especially because I was still using male
8 restrooms and locker facilities. One day after
9 coming home from school, I started feeling a dull
10 sensation that started turning into stabbing pains
11 in my lower abdomen. And I realized that these were
12 uterine cramps. And they were worse than any period
13 cramps I had ever had in my life, and I figured that
14 it was because I was experiencing atrophy of my
15 reproductive organs. And so this atrophy was
16 treated with topical estrogen, and for the most
17 part, these cramps disappeared. They lessened.

18 But in the middle of my sophomore year,
19 after years of using the binder and wearing this
20 thing for anywhere from around 8 to 12 hours on
21 weekdays and whenever I went out to work out or swim
22 or whenever I had guests over at home, I was sick of
23 it. And I thought of myself to be like any other
24 boy my age, and I wanted my body to reflect that.

25 And so I spoke to my therapist about my

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1 desire to get my breast removed, and then I was
2 referred to a gender specialist, who then gave me a
3 letter of recommendation to a surgeon. And several
4 appointments with a surgeon later, about a month
5 before my 16th birthday, I went under the knife.

6 And initially, when I woke up from the
7 surgery, I was happy. I was very happy. I mean, it
8 was a big -- to me, it was a major milestone in my
9 transition and a big step in the right direction.
10 And it was an outpatient surgery. So I was
11 immediately sent home pretty much as soon as the
12 medication wore off, and I was conscious.

13 And my mom had to take a few weeks off from
14 work to take care of me while I was recovering
15 because it was a major surgery in the upper area of
16 my body, and I had very little range of motion. I
17 couldn't even lift my arms up until about two or
18 three months afterward.

19 But after about a week or so, I had to get
20 my stitches taken out, and it was the most
21 disgusting feeling I had ever had in my life. The
22 sensation was there, but it was very numb and very
23 dull. And it made me nauseous, and I nearly threw
24 up a few times. And once I was sent home, I started
25 having to regularly change my dressings after every

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1 shower. And during every shower, I had to look down
2 at this wounded area of my body.

3 And it wasn't really the scars that
4 bothered me so much. But the type of incision that
5 I was given was called a double mastectomy with
6 nipple grafts, meaning that they excised into the
7 breast and took out the tissue. But they also cut
8 around my areolas, and they did a deep scrape on an
9 area of my chest and then put the areolas onto that
10 area of scraped skin to simulate a more masculine
11 positioning of the nipples.

12 And because during this process the blood
13 supply was cut off, the top layer of skin was now
14 completely dead, and it was black. And I was told
15 that this would be part of the process, but nothing
16 really would have prepared me for it until I
17 actually went through it. And with every shower, I
18 watched this dead skin slowly fall off, and it was
19 hard to watch that happening to my own body.

20 After a while, I started to actually
21 realize that I missed being feminine. I miss things
22 like wearing makeup and having my hair long and
23 wearing skirts and dresses. And there are other
24 things that I missed about being a woman as well.

25 Socially, as a male, it's not easy. I

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1 mean, there's a lot less room for expressing
2 yourself either in the way you present yourself or
3 even just talking about your feelings and emotions.
4 And I found that a lot of my relationships with my
5 peers, with my friends, with both boys and girls,
6 and even within my family were a lot less
7 emotionally fulfilling, and I felt very alone.

8 And I started to go down an emotional
9 downward spiral into my junior and senior years, and
10 my grades dropped. I had a very low GPA by this
11 point in time. I was hardly even attending my
12 classes sometimes.

13 But in my junior year in an online class, I
14 was taking a psychology class, and part of the
15 psychology -- towards the end of the class, there
16 were lessons on things like parenting and childhood
17 development.

18 And, I mean, during my consultations with
19 the endocrinologist and the surgeon, I was told
20 things like I may not be able to have children as an
21 adult if I were to go on blockers or hormones, and
22 that if I were to get my breast removed, I would
23 never be able to breastfeed. And, I mean, at the
24 time, none of this really meant anything to me
25 because I was still a kid. I was still being taken

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1 care of by my parents, and I didn't know what it
2 meant. I didn't know the importance of eventually
3 deciding to have a family of my own.

4 And it was only when I was in that class,
5 when I was learning about this, that I realized that
6 I had a maternal instinct, and I wanted to have
7 children down the line. And I knew that because of
8 the decision I made to medically transition as a
9 kid, that may never be possible, and I really
10 couldn't take it anymore. I couldn't keep lying to
11 myself that I was something that I wasn't, and I
12 stopped transitioning cold turkey.

13 I'm only 18. My life is just beginning.
14 I'm far too young to feel like I am a broken woman,
15 but it's hard to look in the mirror. It's hard to
16 look at what has become of my body, and I have to
17 live my entire adulthood knowing I'll never have
18 breasts. I'll never be able to breastfeed my
19 children, and it's possible I might not ever be able
20 to carry a child. And sometimes, I have episodes
21 where I still see a boy in the mirror, and it makes
22 me panic.

23 But the emotional turmoil and regret are
24 far from the worst parts about my story. All of
25 this was a huge failure on the part of my medical

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1 practitioners. My mom and dad and I were lied to.
2 We weren't given any other option or informed fully
3 of the potential consequences of medical transition.
4 And my parents did sign off, but it was under the
5 false pretense that my life depended on it. And I,
6 a 13 year old, was expected to know exactly what I
7 needed and to know the consequences.

8 I had several comorbidities that the
9 doctors failed to rule out or address. I was
10 previously diagnosed with ADHD, but it actually
11 turned out later that I'm actually on the spectrum.
12 And it was actually the gender specialist, the same
13 one who referred me to surgery, who about a year
14 afterward told me that I had some pretty key
15 symptoms of autism, that I should be screened for
16 it. And even if I was diagnosed with autism, my
17 doctors still would have transitioned me.

18 To this day and throughout the process of
19 medically transitioning, I've faced several
20 complications. From the blockers, while I was on
21 them, because I was already about three to four
22 years into puberty, it essentially put me into a
23 state of artificial menopause. And while I was on
24 them, I started experiencing some hot flashes and
25 itching all over my body, not too unlike what women

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1 in their 40s to 50s, 60s tend to experience. But
2 after going off of them years later, I've started
3 getting some joint pains, namely in my limbs and my
4 hands and my finger, but I also get shooting pains
5 up my back, and these are pretty sporadic. They
6 don't happen very often, but they've been starting
7 to become more frequent and more painful and more
8 disruptive.

9 And from the testosterone, I mean, some of
10 the most visible changes would be to my bone
11 structure. Like I have larger shoulders and smaller
12 hips than most women, and I have more defined
13 features in my face. But I also have some issues
14 with my urinary tract. Like I have to use the
15 restroom rather frequently. I'm often dehydrated
16 because of that, and I'm prone to infections.

17 For a while, it actually got to the point
18 that I would get blood clots in my urine and
19 sometimes little bits of tissue even. But I'm also
20 experiencing sexual dysfunction, and my fertility is
21 questionable. I am getting periods, and they are on
22 -- I do have a fairly regular cycle. But I don't
23 know if I'm ovulating, or even if I am able to
24 conceive, if I'll be able to safely carry.

25 But the worst complications might be from

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1 the surgery. I mean, I'll never be able to
2 breastfeed my kids, as I said, and I have some
3 issues with the sensation. I have no -- I have very
4 little erogenous sensation, and sometimes I get the
5 feeling of phantom breasts. Sometimes when I'm
6 walking, like going up a flight of stairs, I'll feel
7 them move, even if they're not there, even though
8 they're not there.

9 And the graphs, at first, they seem to be
10 healing fairly well, other than the fact that on
11 top, the area of skin was very dehydrated. But
12 about two years post-op, they've started to fail.
13 The top area of skin is almost not there, but it's
14 just -- it's leaking fluid. I have no idea why. I
15 don't know what the fluid is, but I have to bandage
16 my chest daily. I've tried to reach out to my
17 surgeon for help with this, and all I got was just
18 put some Vaseline on it. That was his response,
19 which actually gave me a temporary skin infection.

20 So I can't trust my doctors who helped me
21 get into the situation in the first place to help me
22 now. But it's worth noting that most of the serious
23 complications that I'm facing now, I was not
24 informed of, and it's very likely that my young age
25 played a part in the onset of many of them.

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1 With all that being said, what is it that
2 we can do to help gender dysphoric children? The
3 best and the most obvious solution is to prevent
4 minors from going on these treatments, from taking
5 hormones and blockers and going under the knife in
6 the first place.

7 And conservatives are constantly reacting
8 to the most obvious and immediate dangers, but we
9 fall short when establishing a vision. And right
10 now, the conservative movement is largely just about
11 combating the vision of the left. But my question
12 for the DeSantis administration, and more broadly,
13 the conservative movement, is what is your vision
14 for the future? What is your vision for helping
15 people suffering with gender dysphoria, for helping
16 the children, parents, and families in need?

17 I've traveled to many states to testify on
18 these bills, and I've noticed a glaring problem.
19 These bills are trying to take away something
20 without replacing it with anything else. And we
21 have thousands of individuals who regret their
22 transitions, who want to go off these treatments and
23 detransition, but they have no idea how.

24 There's an epidemic approaching of children
25 and young adults who regret or have been harmed by

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1 transition, and we are at the very beginning of the
2 exponential curve. And the Florida government is in
3 uniquely positioned to not only end the affirmative
4 care model in children, but also to provide a model
5 of care that actually helps gender dysphoric
6 patients of all ages.

7 Right now, de-transitioners are their own
8 doctors. We have not a clue about how the endocrine
9 system works, but somehow, we have to navigate it
10 without proper blood tests or treatment. The first
11 month after I stopped transitioning, I was tested
12 for my hormone levels. But my endocrinologist gave
13 me the guidelines for the average hormone levels of
14 teenage males.

15 Questions that I've asked my doctors but
16 never have gotten a proper answer for are: how do
17 you taper off testosterone? Are my hormones stable?
18 Am I fertile? Why are my skin grafts failing and
19 leaking fluid two years after surgery? I've had --
20 I'm still trying to figure all this out on my own.
21 I can't trust my doctors to help me. I've reached
22 out, and I've gotten absolutely nothing. I almost
23 committed suicide several times while trying to
24 detransition.

25 So how do you provide mental health

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1 services for a child who's lost her breasts to a
2 political ideology? We need answers now. No doctor
3 knows how to provide care for de-transitioners, but
4 the WPATH has standards of care for dysphoric
5 patients that every major medical institution in
6 North America follows like it's the Bible. But we
7 need standards of care for de-transitioners now.

8 There is no science supporting gender-
9 affirming care for minors, and we need to replace it
10 with something else. Florida needs to step up and
11 do the right thing. Thank you.

12 CHAIRMAN FINE: Thank you. And I'm sorry
13 for what you've gone through.

14 Finally, we're going to hear from
15 Mr. Leatherwood, who represents the Florida chapter
16 of Gays Against Groomers.

17 Mr. Leatherwood, you are recognized.

18 MR. LEATHERWOOD: Thank you.

19 The modern trans movement is using the LGBT
20 community as a shield to push their radical agenda
21 of mutilation, sterilization, and indoctrination of
22 minors, and as a gay man who represents the
23 organization Gays Against Groomers, I'm here to make
24 it loud and clear. The LGBT community is sick of
25 being used as a scapegoat for these destructive

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1 practices that are ruining kids' lives before they
2 ever even had a fighting chance.

3 For years, the LGBT community has fought
4 valiantly for tolerance and acceptance in American
5 society, and in the year 2023, we have achieved
6 that. Now, all our progress is being erased because
7 our community has been hijacked by trans terrorists.

8 The LGBT community is being used like a
9 Trojan horse by extremists in a death cult to ruin
10 the future generation of our country by destroying
11 their bodies, creating irreversible damage, and
12 lifelong medical patients before these kids ever
13 reach puberty.

14 And make no mistake, the radical trans
15 movement has become a death cult. Their most recent
16 mantra is death before detransition. They're
17 possessed by a sick obsession with bodily
18 mutilation, self-harm, identity destruction, and
19 pure hatred for anyone who dares to question this
20 dangerous ideology.

21 America is a free society, and as a
22 patriot, I stand for the freedom of all individuals
23 to make their own decisions about their own lives.
24 But where we draw the line is children, minors who
25 cannot consent. Yet that is exactly the demographic

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1 that these terrorists are targeting with their
2 culture war. It's your kids.

3 They say, if you don't bend the knee and
4 submit to their demands of gender-affirming care,
5 which is the nice way of saying mutilation and
6 sterilization, you are a bigot or a transphobe, and
7 now LGBT acceptance in America is down for the first
8 time in years.

9 It's because people know that something is
10 wrong, and they're not on board with what's
11 happening. It only takes a caring parent with a
12 little common sense and gut instincts to know that
13 permanently mutilating their child's body is much
14 worse than being labeled anti-LGBT. Many now wear
15 that label proudly. They say, if being against the
16 medicalization of minors means I'm anti-LGBT, then
17 fine. Call me anti-LGBT because good parents care
18 more about the lives and safety of their children
19 than catering to these rainbow terrorists.

20 I'm here to tell you now, standing up
21 against these bullies and wanting to protect your
22 children is not anti-LGBT. In fact, the majority of
23 LGBT individual are against it too, like me and like
24 our entire organization, Gays Against Groomers. And
25 we are fighting for visibility to reclaim our

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1 community from the trans extremists, to stand up
2 against this evil and destructive ideology, to stand
3 in solidarity with parents, and to give a voice to
4 everyone who knows on a gut level that this is not
5 right but is too afraid to speak out in fear of
6 being smeared or labeled a bigot. It is not bigoted
7 to want to protect children from elective
8 experimental medicalization. It is common sense, it
9 is compassionate, and it is scientific.

10 The gay left, in collusion with gay media
11 and gay advocacy groups like GLAAD and HRC, are
12 promoting a narrative that the LGBT community
13 supports the medicalization of children, but that is
14 a lie. The LGBT community at large does not support
15 this. It's only fringe radicals. This lie is
16 funded by donor dollars brought to you by Big
17 Pharma.

18 That's right. These organizations are
19 sponsored by corporations like Pfizer, Johnson &
20 Johnson, UnitedHealth Group, and other medical
21 corporations who have a vested interest in turning
22 your kids into lifelong medical patients because
23 they don't see an innocent child with a bright
24 future. They see dollar signs.

25 It's funny. They call a group like Gays

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1 Against Groomers an anti-LGBT hate group, but the
2 ideology of gender-affirming care is actually very
3 homophobic. The truth is the majority of gender
4 nonconforming kids grow up to be gay. So in effect,
5 they are erasing gays.

6 Telling a masculine girl she's trans and
7 needs to start puberty blockers deprives that girl
8 of the right to explore her identity. What if she's
9 a lesbian? What if she's just a tomboy? And
10 telling a feminine boy he's meant to transition to
11 female simply because he prefers playing with
12 Barbies over trucks is outright sexist.

13 At GAG, see ourselves in these kids. Stop
14 trans and gay youth. Stop gay eraser. Save the
15 tomboys. Stop the sexism. Stop using the LGBT
16 community as a scapegoat for hurting children. This
17 is a nonpartisan issue. Protect our kids. We are
18 Gays against Groomers, and we stand firmly against
19 the elective medicalization of minors.

20 CHAIRMAN FINE: Okay. Members, that was a
21 lot, and that concludes all of our panelists. We
22 will now entertain questions from our members. I
23 know since he is a doctor and a Representative, I'm
24 going to let Representative Massullo go first. And
25 if you would like to ask questions, just sort of

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1 look down towards me, and I will put your name on a
2 list.

3 REPRESENTATIVE MASSULLO: Thank you,
4 Mr. Chair. And I want to thank you and your staff
5 for putting together such a fine panel of experts on
6 this subject who were very thorough in going over --
7 and I won't say side effects -- but I will say
8 consequences of this type of -- and I hate to use
9 the word, but I will because it's associated with it
10 -- affirming care.

11 I have two real quick questions. One, I'll
12 actually answer myself. There is a thing that all
13 physicians take called the Hippocratic oath, and one
14 of the chief tenets of that oath is to do no harm.
15 In any procedure in medicine, we are required to
16 give informed consent. It is impossible to give
17 informed consent to someone that is not of the age
18 to give consent.

19 My question is for you, Dr. Ackerman. How
20 do we, in this state of Florida, allow healthcare
21 providers to continue having a license that provide
22 this type of care? And ignorance is not an excuse.
23 Ignorance of what they're doing to these individuals
24 is not an excuse. How do we continue to allow them
25 to practice medicine? And it is almost like, do we

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1 allow -- and we do -- frontal lobotomies for people
2 that are depressed or anxious. No one does it, but
3 it's still legal in some states.

4 CHAIRMAN FINE: You are recognized.

5 DR. ACKERMAN: Thank you. Well, that's
6 exactly the rule we put forth, and the rule we put
7 forth says that the following therapies and
8 procedures performed for the treatment of gender
9 dysphoria minors are prohibited. So any physician
10 that does sex reassignment surgery or other surgical
11 procedures that alter the primary or sexual
12 characteristics will potentially lose her license.
13 Any physician that provides puberty-blocking hormone
14 treatment or hormone agonist therapies could
15 potentially lose their license.

16 And so that's what we've put forth in our
17 rule, and that's what is being put through the
18 system and should be into place within the next
19 month, both the Board of medicine and the Board of
20 osteopathic medicine.

21 REPRESENTATIVE MASSULLO: Thank you.

22 CHAIRMAN FINE: Representative Anderson,
23 you recognize for a question.

24 REPRESENTATIVE ANDERSON: Thank you,
25 Mr. Chair.

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1 And thank you, everyone, for your
2 presentations today. It was very informative, very
3 eye opening. I especially need to commend Ms. Cole
4 for your courage. I can't imagine how difficult
5 this is for you and appreciate your advocacy.

6 CHLOE COLE: Thank you.

7 REPRESENTATIVE ANDERSON: My question, I
8 believe, is likely for maybe more than one member of
9 the panel, but I'm interested to know what kind of
10 numbers are we talking about for minors versus
11 adults that are currently being treated or have
12 previously been treated for gender dysphoria? And
13 how does that compare in our state versus nationwide
14 and perhaps in Europe as well?

15 CHAIRMAN FINE: Anybody like to answer --
16 did you have that question for anyone in particular,
17 or are you just opening it up to the panel?

18 REPRESENTATIVE ANDERSON: Whoever can
19 handle that one.

20 CHAIRMAN FINE: Okay. Does anybody want to
21 take a crack at it, either here or -- how many was
22 the question.

23 DR. LEVINE: Well --

24 CHAIRMAN FINE: You are recognized. Go
25 ahead.

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1 DR. LEVINE: I think I can answer that
2 definitively as we don't know the answer to your
3 question. However, in the last 25 years, the
4 movement has been and the activity in clinical
5 centers has not been with well-established adults as
6 it was before the turn of the century. It has been
7 with youth, and by youth, I mean teenagers.

8 And by teenagers, what we mean is that the
9 number of -- say, in 1995, throughout the world,
10 there were about three boys who wanted to be girls
11 for every girl who wanted to be a boy. And more
12 recently, since the turn of the century, in
13 particular, in the last 10 years, I would say 15
14 years, the ratio has reversed. And in some centers,
15 there are seven girls presenting for every boy who
16 presents now.

17 So we really think this is like an -- I
18 don't know -- epidemic is not the right word, but
19 there is a tsunami of teenage girls who are
20 responding to early puberty changes in their bodies
21 by going on the internet and then declaring
22 themselves to be lesbian, bisexual, eating
23 disordered, and then trans.

24 Now, I don't want to emphasize that there
25 is a paucity of boys who want to be girls. I think

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1 there's been an increase in all youth who want to
2 transition, but the sex ratio has changed. I've
3 been running a gender clinic for -- it's hard to
4 believe -- but since 1974, and in the first 25, 30
5 years, we saw an occasional teenager, a rare child,
6 and most people were in their 30s and 40s.

7 And I recently had a 60-year-old man come
8 to see me, and that was the first adult who's come
9 to see me in year. But I've seen a lot of
10 teenagers. So when you ask state by state, I have
11 no idea. When I look at what is published in the
12 literature, I've just summarized what is published
13 in the literature, and I think really what's
14 happened in the trans movement, it's about trans
15 youth, not about trans adults.

16 I think when we approach the adult, say the
17 25 year old or the 50 year old or the 43 year old,
18 we don't have the controversies because, in part,
19 they're cognitively mature enough to make their own
20 bad decisions. And so we don't have as much
21 internal angst about the treatment, and there is not
22 that much controversy. And it would be interesting
23 to see if, in fact, adults, having seen the
24 controversies that are being discussed in the media
25 today, they are perhaps not willing to undergo this

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1 as often as they did in the past. But that's a wild
2 speculation.

3 PROFESSOR BIGGS: I just got information
4 from the Tavistock, which was the largest pediatric
5 gender clinic in the world and has just been sort of
6 closed down. So it was started in 1989, and in the
7 first decade, from all over England, it had 14
8 individuals a year. The last year, we have data for
9 over 6000, and that's even with a massively long
10 waiting list. So the numbers have increased
11 massively all over the world, and obviously, the
12 United States will be the same, all over the
13 English-speaking world and Western Europe.

14 And, indeed, there was a survey that came
15 out from pediatrics of schools in Pittsburgh, which
16 suggested that 9 percent of school students were
17 identified as trans, and that said it was important
18 that they would all be given, if they wanted it,
19 gender-affirming care.

20 Now, I think their numbers were
21 exaggerated. I would estimate it at 7 percent from
22 that survey, and probably some of those students
23 were just, you know, weren't really trans. They
24 were just ticking the box because they thought it
25 would be fun. But even so, the very fact that in

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1 Pediatrics, a leading medical journal, they can
2 entertain that 1 in 10, as they say it in the sort
3 of editorial, 1 in 10 kids need to go through the
4 same process that Chloe Cole had gone through,
5 that's really extraordinary. It gives you an idea
6 of the magnitude.

7 DR. ACKERMAN: Can I address it as well?

8 CHAIRMAN FINE: Absolutely.

9 DR. ACKERMAN: Unless someone else wants
10 to go ahead.

11 CHAIRMAN FINE: No.

12 DR. ACKERMAN: So what we found out from
13 the Florida Board of Medicine when we asked the
14 different providers of care from around the state to
15 come speak to us, and specifically we had the team
16 from the University of Florida in Gainesville, the
17 pediatric endocrinologists come, they're very cagey
18 about their numbers. They weren't very -- they
19 didn't disclose their numbers to us. When pressed,
20 we had a very hard time getting answers about those
21 numbers.

22 And specifically, we were asking questions
23 about the ages of the patients, et cetera, et
24 cetera. And we weren't getting straight -- we
25 weren't getting answers. I'm not saying we weren't

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1 getting straight answers. We had a hard time
2 getting any answers.

3 If you read in the back of tab -- of the
4 last tab, the article that was published a few weeks
5 ago by Jamie Reed, she quotes in here that according
6 to Reuters, the number of pediatric gender clinics
7 in America have gone from 0 15 years ago to more
8 than 100 today. So that may give you a perspective
9 as well.

10 And we also heard from physicians who spoke
11 to us -- and, remember, we had three meetings about
12 this -- different physicians speak to us. We heard
13 that the demand and the inquiries to the clinics and
14 the volume of the clinics had been going up over the
15 past few years.

16 CHAIRMAN FINE: Just a follow-up from me on
17 that.

18 DR. ACKERMAN: Yes.

19 CHAIRMAN FINE: If this is a great thing
20 and all scientifically valid and good, good, good, I
21 mean, why would someone be cagey about the numbers?
22 Why wouldn't they cheer from the rafters about how
23 many of these they're doing? What's your belief as
24 to why they were cagey?

25 DR. ACKERMAN: Well, frankly, you know, I

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1 called them out on this, that we weren't getting
2 straight answers. And we had a woman who spoke to
3 us from Yale about it, and when I personally
4 questioned her about the numbers that she was seeing
5 -- because, remember, we've gone through this very,
6 very thoroughly, and we looked at hormone blocking
7 agents. We looked at hormone affirming agents,
8 right? So you block the hormones first, then you
9 give a woman -- a girl testosterone or a guy
10 estrogen, and then you do surgery. And that's a
11 continuum.

12 And I asked the woman from Yale -- I can't
13 remember her name right now, but I mentioned it
14 before -- how many patients go in each of those
15 stages. Because as I said to her, I'm an
16 oncologist. I do radiation, but my patients
17 sometimes need chemo or surgery. And those are all
18 part of doing appropriate cancer care.

19 And so when pushing and asking her how many
20 go on to have surgery, because I think that's the
21 most -- I personally think that's the most
22 aggressive of the three -- she said that none of her
23 patients has she recommended surgery for, but it
24 wasn't easy to get that answer out of her. It was
25 question, question, question.

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1 So they were cagey about it, and the
2 reason, Representative Fine, I think they're
3 disingenuous. That's my personal opinion. That's
4 not the Board of Medicine's official word, but
5 that's my personal opinion. I think they're
6 disingenuous.

7 CHAIRMAN FINE: And just for the record --

8 DR. ACKERMAN: And I think that they want
9 to treat these kind of patients because that's --
10 because in academia, you get promoted, and you get
11 recognized better when you have a greater amount of
12 work like that.

13 CHAIRMAN FINE: And just, for one data
14 point, Dr. Gallagher says that she did 13 top
15 surgeries on minors last year. That's one provider.

16 CHLOE COLE: Excuse me.

17 CHAIRMAN FINE: Yes, Chloe. Go ahead.

18 CHLOE COLE: I'd like to add to that.

19 Kaiser, which is my healthcare provider, they
20 actually released a study recently on minors who
21 underwent a double mastectomy and the regret rate.
22 And in the study, there were about 200 or so minors,
23 and it's likely that -- the study was conducted
24 between, I think, 2013 to 2021. And I actually
25 wasn't included in this.

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1 It said that out of 200 or so of these
2 girls, only 2 of them regretted it. And the 2
3 patients were 15 and 16 at the time, I think. And I
4 reported -- even though I reported to my healthcare
5 providers, my endocrinologist and the surgeon, that
6 I regretted it, I was not included in the study.

7 And I know at least three other people who
8 went through the same provider, through the same
9 hospital, and got the same surgery and were not
10 included in the study. So it's likely that, even in
11 these studies, that the numbers are being stifled.

12 And other than that, the figures are about
13 -- it's 2000 percent to 4000 percent increase in
14 minors, mostly young girls, who have been referred
15 to gender clinics in the past decade.

16 And this is just a little anecdote, but I
17 didn't know anybody else who was transgender until I
18 was in -- in person until I was in my sophomore year
19 of high school, when I noticed that other biological
20 girls my age were also starting to identify as boys.
21 And it was only girls.

22 UNIDENTIFIED FEMALE: Thank you.

23 CHAIRMAN FINE: And members, we've got
24 about 35 minutes, and we've got 8 more members with
25 questions, just so people know.

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1 Whip Salzman, you're recognized for a
2 question.

3 REPRESENTATIVE SALZMAN: Thank you,
4 Mr. Chair. And thank you to each of you for
5 presenting to us today. I appreciate hearing your
6 insight on this.

7 I just have a question, and if more than
8 one of you want to answer it, that's great. I'm
9 interested in knowing how much it costs per year to
10 take these medications, these testosterone and hormone --
11 these hormone drugs per year. And then I also would
12 like to know, is the state covering any of the costs
13 of this treatment?

14 CHLOE COLE: Yeah. So in the state of
15 California, actually, gender-affirming care is
16 actually required by law to be covered by insurance.
17 So everything other than copays for like visits to
18 doctors was covered by insurance.

19 CHAIRMAN FINE: Okay. Any, you know,
20 again, I think there were two questions there. How
21 much did the drugs cost per year? And does anybody,
22 you know, whoever's paying for them, whether it's
23 the government or the insurance company or the
24 person? And then again, the second point would be
25 in Florida. Do any of you know, you know, what's

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1 paid for today?

2 DR. LAIDLAW: I can give you a rough idea
3 of the general cost of something like Lupron, a
4 puberty blocker. I sent something to our state a
5 few years back, but it's something like \$1000 a
6 month. It could be more, less for something like
7 that, and they may take it for one year or two years
8 or four or five years.

9 Testosterone is going to be cheaper because
10 it's generic. If it's given in liquid form, maybe
11 you could get it, a cash price, \$100 a month,
12 something like that. And estrogen or estradiol
13 tablets or patches are probably -- I don't know
14 exactly -- but maybe \$50, \$60 a month.

15 So the most expensive cost would be puberty
16 blockers, and, of course, surgeries are on the
17 orders of, you know, thousands or tens of thousands
18 of dollars.

19 CHAIRMAN FINE: But so, to be clear, the
20 puberty blockers could be, you know, whoever's
21 paying for them, more than \$10,000 a year. So good
22 business, I guess.

23 DR. LAIDLAW: Yeah.

24 CHAIRMAN FINE: Yeah. Rep. Salzman, you're
25 recognized.

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1 REPRESENTATIVE SALZMAN: Thank you,
2 Mr. Chair. I just have a follow-up. Earlier in one
3 of the presentations, I believe it was the first or
4 second presentation, you said 96 percent of the
5 children who are on these hormone blockers in the
6 beginning continue to permanent treatment. How much
7 does it cost to stay on the treatment lifelong
8 usually, right.

9 CHAIRMAN FINE: Is it -- do you have to
10 take the \$12,000 drug for the rest of your life, or,
11 you know, or do you get to stop after a certain
12 amount of time?

13 PROFESSOR BIGGS: So --

14 CHAIRMAN FINE: You know, if you stop
15 puberty, you know, maybe it starts again. But, I
16 mean, how long do you have to stay on these?

17 PROFESSOR BIGGS: So for girls, girls, once
18 they start taking testosterone, they can stop
19 puberty blockers. For boys, they need to -- because
20 testosterone is so powerful, you don't need anything
21 to block the estrogen. For boys, they will need to
22 stay on puberty blockers or something like that
23 until they have their testicles removed in order to
24 suppress testosterone. It's not simply enough to
25 take estrogen.

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1 CHAIRMAN FINE: Okay. So a long time.

2 Representative Woodson, you're recognized
3 for a question.

4 REPRESENTATIVE WOODSON: Thank you, Chair
5 Fine, for the recognition.

6 Chloe, I'm sorry for what you went through.
7 As legislators, we are tasked to look at all angles
8 because we have parents from different sides calling
9 out to us as well because they have their children
10 that they feel need this type of therapy.

11 Before I even came, I did some research,
12 and I looked to the National Institute of Health,
13 the NIH. And basically, they did research in 2022,
14 actually, that was one, and there were some that was
15 done before that. And they say research proves that
16 gender-affirming care improves the mental health and
17 overall well-being of gender diverse children and
18 adolescents.

19 My question to you: are you suggesting that
20 the state provide mental health services in place of
21 gender-affirming care? And what should the state do
22 in order to mitigate the increase in mental health
23 if we have a ban on this type of therapy?

24 CHLOE COLE: Yeah. I absolutely think that
25 in place of gender-affirming care in children, there

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1 should be psychotherapy instead because most of
2 these children actually have some sort of
3 comorbidity. Like I was on the spectrum. I was --
4 and part of that was, I think, I mean, due to my
5 autism. I believe that it was one of -- that
6 because I'm autistic, I naturally tend to have some
7 more masculine tendencies, like being more objective
8 oriented than people oriented, for example.

9 But a lot of these kids have like either
10 like a learning disorder, personality disorder,
11 depression, anxiety, or a severe like familial
12 trauma or sexual trauma. And that needs to be
13 sorted out before the dysphoria is treated because
14 oftentimes that is what causes the onset of the
15 dysphoria.

16 DR. LEVINE: May I respond to your
17 question?

18 CHAIRMAN FINE: Absolutely. Yes, sir. Go
19 ahead.

20 REPRESENTATIVE WOODSON: You're referring
21 to a study that was just published in the New
22 England Journal of Medicine last month, which was a
23 two-year prospective study of 315 teenagers, average
24 age 16. And what they found is that the vast
25 majority of those children were very happy with

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1 their aesthetic appearances by age 18.

2 They also looked at the depression and the
3 anxiety scores of those kids, and they found that
4 that was all over the place. The mean was slightly
5 significant, but there was enormous variability in
6 whether the hormones increased or decreased
7 depression, increased or decreased anxiety. They
8 had a number of suicides in the -- I think 2
9 suicides in the 315 kids, and they didn't talk
10 anything about the medical problems like obesity or
11 the development of diabetes or bone troubles. They
12 didn't provide anything like that.

13 So I think we didn't need a study that
14 teenagers are happy who want to transition in the
15 short term, that they're happy with their
16 appearance, you see, but the issue has always been,
17 what is the long-term outcome of these kids in terms
18 of the parameters that we've made reference to
19 already in the presentations today?

20 And the answers are unknown, but we have a
21 lot of indications it's not very good. And so I
22 just say that in answer, the real question you're
23 asking is: what is Florida to do or what is the
24 state and what is the medical profession to do?

25 And I just want to pick up on what

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1 Ms. Cole said, and that is these children deserve a
2 thorough psychiatric evaluation, which cannot be
3 accomplished in 1 hour and cannot be accomplished by
4 just talking to the kid because the kid doesn't know
5 what happened to that child in the first four years
6 of life.

7 And so the evaluation bleeds into a
8 psychotherapeutic relationship between the parents,
9 the child, and the mental health professional. And
10 that requires time, you see, and that will
11 inevitably lead to what can we do to help this
12 child's source of distress other than changing their
13 gender presentation?

14 And that requires a commitment and the
15 training of mental health professionals who believe
16 that treating a gender child is just like treating
17 any other psychiatric problem with a child. They
18 need a thorough evaluation. They need a trusting
19 relationship with one person who's knowledgeable and
20 who can address the underlying problems, whether
21 it's autism or bedwetting or learning disabilities,
22 whatever it may be, you see.

23 So there is an alternative. It is the
24 traditional alternative. It is the traditional
25 approach to psychiatric problems in children. We've

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1 made a special exception of the gender child, and as
2 the 6th speaker spoke about, if you leave these kids
3 alone, most of them are going to grow up to be gay.
4 And we're not trying to remove gayness from the
5 world by creating trans, or if we are trying to do
6 that, that's a terrible thing.

7 CHLOE COLE: I'd like to add to that.

8 CHAIRMAN FINE: Yeah. Go ahead. Sure.

9 CHLOE COLE: There is not a single other
10 psychiatric issue that we treat with cosmetic
11 interventions. We don't give -- we don't refer
12 patients with anorexia to liposuction. And if a
13 cosmetic surgeon has a patient who presents to them
14 with body dysmorphia, they turn them away because
15 they know it's not right.

16 CHAIRMAN FINE: Yes, sir.

17 MR. LEATHERWOOD: I think Chloe's case is a
18 perfect example and a response to your question.
19 When she was taken to the doctor's office, they
20 jumped straight to gender-affirming care, you know.
21 It's like do not like collect \$200. Do not pass GO.
22 Just go all the way. Jump to the end game. You're
23 being medicalized.

24 At Gays against Groomers, we actually have
25 a lot of transgender members that are part of our

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1 organization, and gender dysphoria is obviously a
2 real condition. And a lot of them have chosen to
3 transition just after they are grown adults, and
4 they're capable of consenting to make that decision.

5 Treating these cases psychologically, I
6 think, is a smart idea and should be promoted by the
7 state as a first course of action, you know. The
8 answer should not just be jumping to medicalizing
9 children, and the problem right now that we're
10 seeing is the societal and cultural pressures that
11 is being put on these kids in school, you know.

12 There's a colloquial term. We call them
13 trans-trenders. But a lot of people, these young
14 kids that are just experiencing the normal growing
15 pains of life and growing up, they're uncomfortable
16 with their bodies because that's normal going
17 through puberty. They are confused, and it's, you
18 know, not cool to be normal. It's trendy to
19 explore, you know, changing their gender or being
20 gender nonconformist.

21 The solution should not be jumping straight
22 to medicalization, and if there are serious issues,
23 it should be psychologically evaluated first. And
24 if a person does have gender dysphoria and they
25 believe that medically transitioning is the best

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1 option for them, they should be able to make that
2 decision after they are a grown adult able to
3 consent to that decision and not while they're a
4 young, impressionable child.

5 CHAIRMAN FINE: Thank you.

6 Representative Snyder --

7 DR. LEVINE: I think we have to --

8 CHAIRMAN FINE: Sorry?

9 DR. LEVINE: I'm sorry. I think we have to
10 face --

11 CHAIRMAN FINE: Oh, okay.

12 DR. LEVINE: -- the very fact that it's
13 very hard to find mental health professionals who
14 have not been indoctrinated that the best way to
15 treat trans people is to affirm them and to get them
16 what they want.

17 We have to take our hats off to WPATH
18 because they have convinced the American mental
19 health professionals, including their organizations,
20 that science has already delivered the verdict that
21 this is the best treatment, and young mental health
22 professionals are coming out of graduate schools
23 being taught that the only thing to do for these
24 kids is to transition them and to affirm them.

25 And I think they don't understand what the

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1 13 points that I made and the other speakers made.

2 They just don't understand. Our medical -- our

3 psychiatric professions have been brainwashed.

4 CHAIRMAN FINE: Thank you. So we've got

5 five members left who wish to ask questions.

6 So Representative Snyder, you're recognized

7 for a question.

8 REPRESENTATIVE SNYDER: Thank you,

9 Mr. Chairman, and thank you again to the presenters,
10 you know.

11 Last week in this Committee, we talked
12 about just some of the harmful impacts of social
13 media and just some of the disturbing trends we're
14 seeing with just again the mental health crisis in
15 our country.

16 Mr. Leatherwood, you kind of touched on
17 just some of the societal pressures on this. I was
18 curious, you know, kind of from the nonmedical
19 perspective and then also the medical perspective,
20 you know, if you can talk about just the
21 intersection that social media plays in this uptick,
22 you know. I'm curious if the opinion is, you know,
23 is this a great awakening in today's youth that
24 they're now realizing they have these issues, or are
25 they're getting drawn into this and steered

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1 potentially in that direction?

2 CHAIRMAN FINE: And again we've got about
3 20 minutes left. So if you've got something to say,
4 please say it. But if not, I want to try to get to
5 every member's questions.

6 MR. LEATHERWOOD: Well, it's definitely
7 become trendy. It's definitely become what's cool.
8 I'm not a kid today going through school.
9 Obviously, Chloe did it more recently, but people
10 like Dr. Gallagher, who was mentioned earlier, who
11 is targeting her propaganda directly to the younger
12 generation through social media platforms like
13 TikTok, is incredibly dangerous.

14 And I find it shocking to this day that she
15 is able to just get away with what she's doing on
16 platforms like TikTok, you know. She's making these
17 trendy videos. She's bragging about the joys and
18 wonders of gender reassignment surgery and double
19 mastectomies and posing with children after they've
20 had these surgeries. And to me, it's horrifying.

21 But that type of content is targeted
22 towards that demographic, and I think, you know,
23 there's a lot going on in today's society. This
24 idea that it's not cool to be straight, that that's
25 normie, and that that's boring. And, you know, I

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1 know, like I said, I'm obviously not a kid going
2 through school now, but when I was a kid -- and I'm
3 sure we all experienced this, you know -- you don't
4 want to just be normal, you know. You want to be
5 cool. You want to -- you want to fit in.

6 And this is -- I mean, the percentage of
7 the younger generation who now identify as part of
8 the LGBT -- I call it the rainbow spectrum -- has
9 exponentially increased from the time I was in
10 school or the, you know, generation beyond me.

11 I mean, and I think now we're seeing what
12 Chloe was talking about, the uptick in de-
13 transitioners, it's going to be horrifying. And she
14 just warned us all. This is just the beginning.
15 All these kids, they think that they're trans now.
16 They're jumping all in on this. In five, ten years,
17 oh my gosh, and it's already happening in England.
18 All these gender clinics are shutting down because
19 they're being hit with these lawsuits. It's
20 horrifying.

21 CHAIRMAN FINE: Okay. If anybody wants to
22 add anything. Or --

23 DR. ACKERMAN: I'll just say something very
24 quick. So from the Board of Medicine, I'm not a
25 social scientist. I really can't speak to that.

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1 But I can tell you that the past two issues we've
2 had the past couple of years, this is a current
3 issue that we've been dealing with, and recently
4 we've been dealing with the Brazilian butt lift
5 issues we've had with that with safety associated
6 with Brazilian butt lift surgery.

7 And both of these, we've seen an increase
8 in number of procedures, transgender procedures and
9 Brazilian butt lift procedures, because -- what
10 we've heard is a lot of this is through social
11 media. But again I'm not a social scientist, and
12 the word of medicine isn't in that business.

13 CHAIRMAN FINE: Ranking Member Skidmore,
14 you're recognized for a question.

15 REPRESENTATIVE SKIDMORE: Mr. Chair, my
16 question is for Dr. Levine, who doesn't seem to be
17 there.

18 CHAIRMAN FINE: Do you want me -- that
19 wasn't planned. Do you want me to come back to you?

20 REPRESENTATIVE SKIDMORE: That would be
21 great.

22 CHAIRMAN FINE: Okay. We have a couple
23 other members. And I was going to do a Democrat
24 next.

25 Representative Cross, you're next.

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1 REPRESENTATIVE CROSS: Thank you for
2 recognizing me, Mr. Chair.

3 My question is for Dr. Laidlaw. In your
4 slides, you used a definition that states that
5 gender dysphoria is a discomfort with one's sex and
6 perceived gender leading to significant distress or
7 impairment of functioning lasting at least six
8 months. My question is: can you discuss some of the
9 potential effects of banning gender-affirming
10 therapies that are being sought specifically to
11 ameliorate significant distress or impairment in
12 trans patients?

13 CHAIRMAN FINE: You are recognized.

14 DR. LAIDLAW: So just to clarify, so you're
15 saying if this medical treatment and surgical
16 treatments aren't available, what will happen to the
17 kids with gender dysphoria? Is that --

18 REPRESENTATIVE CROSS: Yes.

19 DR. LAIDLAW: Can you hear me? Okay.
20 Well, one thing to recognize, that I'm an
21 endocrinologist. Gender dysphoria is not an
22 endocrinologic condition. It has nothing to do
23 actually with hormones or problems with hormones or
24 glands in most of the cases. It only becomes an
25 endocrine condition once you start providing these

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1 hormones of very high doses or blocking normal
2 puberty.

3 So really, this originated in the realm of
4 psychological disorders. So I've listed the harms
5 that can happen from this treatment. The
6 alternative is going back, like Dr. Levine said, to
7 traditional psychological treatments to help these
8 kids. It's really not an endocrine condition until
9 people like Chloe have been harmed by these
10 treatments.

11 CHAIRMAN FINE: I promise. But we are --
12 some of the folks who've put their hands up late,
13 we may not have time. But I will take you next,
14 Representative Skidmore.

15 But, first, Representative Rizo, you are
16 recognized.

17 REPRESENTATIVE RIZO: Thank you very much,
18 Chair. Thank you to everyone that presented, and
19 especially the final two speakers. Thank you so
20 much for coming here today and just showing, you
21 know, your intelligence and also just your
22 willingness to speak your mind.

23 My first question, Chair, I have two.
24 First of all, speaking about puberty suppression,
25 how reversible is this? How permanent is this?

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1 When are we undergoing this treatment, does it
2 become irreversible? And if so what are the long-
3 term effects?

4 CHAIRMAN FINE: Anybody who wants -- yeah.
5 Go ahead.

6 DR. ACKERMAN: We've heard at the Board of
7 Medicine that from the physicians involved in this
8 sort of care, that these treatments are reversible,
9 that these are a way to put puberty on hold. But we
10 also heard from other experts that, no, it's not --
11 there are side effects of these treatments that are
12 not reversible. When you put someone on Lupron --
13 this is a testosterone blocking drug -- it
14 demineralizes the bones. There's calcium lost in
15 the bones, and that may never come back.

16 As I mentioned before, I'm an oncologist.
17 I actually prescribe Lupron, this hormone blocking
18 drug. I treat men who have metastatic prostate
19 cancer with that drug. It blocks testosterone, and
20 we do it all the time. And there are side effects
21 with that. And I try to minimize the dose of
22 testosterone I give men because it causes
23 osteoporosis, which is irreversible. It also causes
24 early onset of dementia, Alzheimer's. And so I try
25 not to have men on that more than a few months

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1 unless I really have to.

2 And so those same -- we heard from other
3 experts that in the adolescence, that there are the
4 similar irreversible side effects of those hormone-
5 blocking drugs. They're not to be taken lightly.
6 That's not the sort of thing you just put a little
7 pause on and then take off, and that there are long-
8 term effects of those drugs.

9 CHAIRMAN FINE: Okay. I'm not -- maybe.
10 But I want to make sure that Ranking Member Skidmore
11 has time. So and she may, depending on how long it
12 takes, be the last question.

13 So Ranking Member Skidmore, you are
14 recognized for a question.

15 REPRESENTATIVE SKIDMORE: Mr. Chair, thank
16 you.

17 My question is to Dr. Levine. In your
18 comments earlier, you said that it made more sense
19 to let adults make any bad decision that they
20 wanted. Is it your opinion that it is always a bad
21 decision to receive transgender care at any age?

22 DR. LEVINE: No. That is not my opinion.
23 I just think adults are able to weigh the pros and
24 the cons of the decision. They're able to recognize
25 their own internal ambivalence, that is, they feel

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1 both attracted to and worried about it, whereas
2 teenagers can't tolerate the concept that they have
3 ambivalence. They present themselves as absolutely
4 certain.

5 And you and I, as adults, know that human
6 beings are not absolutely certain about anything,
7 and we don't trust certainty in medicine at all. So
8 there are people who have the right to make this
9 decision, and for them, because they're an expert in
10 their suffering and in their developmental history
11 and when they convince me that this is a prudent
12 thing, I certainly open the gate for them to make
13 this decision or give them my blessing, so to speak.

14 But I'm very hesitant to give my blessing
15 to hormones to anyone who's not of the age of
16 majority and who is certain. Certainty is not to be
17 trusted in any field.

18 So the simple answer to your question is
19 absolutely no. I'm not opposed to everyone under
20 these circumstances forever having these kind of
21 treatments. I am very much in favor of the
22 scientific approach to this. That is a controlled
23 study, as Dr. Biggs talked about.

24 CHAIRMAN FINE: Ranking Member Skidmore,
25 you can ask a follow-up, but just so you know, there

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1 are two Democrats and one Republican that haven't
2 asked a question yet.

3 REPRESENTATIVE SKIDMORE: Mr. Chair, my
4 question is also to Dr. Levine or Dr. Ackerman. Is
5 there any regimen or procedure that has no risks or
6 side effects in your profession, in your specialty?

7 DR. LEVINE: No.

8 DR. ACKERMAN: No.

9 CHAIRMAN FINE: All right. Okay. In the
10 order they asked, Representative Koster, you are
11 recognized. You've been waiting a while.

12 REPRESENTATIVE KOSTER: Thank you, Chair.
13 And I guess I just want to try to break this down to
14 its simplest form, in my understanding, and if I've
15 got it wrong, somebody will correct me.

16 We've got a DSM-recognized mental health
17 disorder, mental health condition, but we don't have
18 a recognized standard of care or standard of
19 treatment or something. And I sort of see some
20 nodding. So I'm going to assume that, at its
21 simplest form, that's what we're dealing with here.

22 And I guess my question is sort of for
23 Chloe or for Dr. Ackerman. Chloe, like you talked
24 about wanting to see regulation in terms of de-
25 transitioning and more standards there, but what

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1 would you have wanted to see on the front end as
2 somebody struggling with gender dysphoria as a
3 teenager? What would you have wanted to see in
4 hindsight then now?

5 And then, you know, for Dr. Ackerman, sort
6 of should the standard of care just be what the
7 standard of care is for other mental health
8 conditions? I know with like schizophrenia, we used
9 to incarcerate people. Obviously, the more we've
10 learned about schizophrenia, we clearly know that
11 that's not the solution. So, I mean, as we're
12 studying this, how do we come up with a nationalized
13 standard of care? So whoever wants to take that
14 very compound question.

15 CHLOE COLE: I really wish that during my
16 screening for gender dysphoria, they went more into
17 my background and treated the underlying conditions
18 that led to the onset of it. But I also really wish
19 that it wasn't pushed as the only option, that I
20 was, I guess you could say, gatekept more and not
21 allowed to undergo these treatments while I was
22 still a minor, especially because, I mean, it was --
23 they directly interfered with my physical and
24 psychiatric and cognitive development in doing so.

25 CHAIRMAN FINE: Okay. Go ahead.

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1 DR. ACKERMAN: So you're correct. There is
2 a DSM diagnosis of gender dysphoria, and I think in
3 medicine, there's a number of things where there's
4 no consistent or no generally accepted standard of
5 care. We have standards of care for lots of things,
6 diabetes, and most cancers that I deal with, we have
7 standards of care. But just again looking at what I
8 do in cancer, there's a lot of unusual cancers that
9 aren't very frequent where there's really no
10 standard of care developed yet.

11 One standard of care in gender dysphoria,
12 psychological support, is certainly a well-accepted
13 standard of care. People are trying different
14 things, hormones and surgery. People are trying
15 that, but we felt, from the perspective of the Board
16 of Medicine, that there wasn't a generally widely
17 accepted, agreed upon standard of care. And so
18 that's why we felt uncomfortable allowing that sort
19 of care to be given to minors in the state of
20 Florida.

21 Representative Gantt, you are recognized
22 for a question. This may be the last one.

23 REPRESENTATIVE GANTT: Thank you for your
24 recognition, Mr. Chair.

25 Dr. Biggs, excuse me, you talked

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1 extensively about the physical effects of hormone
2 therapy. Just for clarification, you are a doctor
3 in sociology and not a medical doctor, correct?

4 CHAIRMAN FINE: You are recognized.

5 PROFESSOR BIGGS: Yes. That's correct.

6 But I've also published now, over the last couple of
7 years, my own research in medical and psychological
8 journals.

9 CHAIRMAN FINE: Okay. All right.

10 Representative Edmonds -- that was quick.

11 Representative Edmonds, you are recognized.

12 REPRESENTATIVE EDMONDS: Thank you.

13 CHAIRMAN FINE: You might put your name tag
14 down so people can see you.

15 REPRESENTATIVE EDMONDS: Dr. Ackerman, in
16 the Board of Medicine last meeting, when discussing
17 these rules, were they in support or against these
18 rules, and how many people were in support versus
19 against?

20 DR. ACKERMAN: Who are you referring to,
21 the Board members?

22 REPRESENTATIVE EDMONDS: Yes.

23 DR. ACKERMAN: In the last meeting the
24 Board of Medicine had --

25 REPRESENTATIVE EDMONDS: And related to

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1 this topic.

2 DR. ACKERMAN: -- related to this topic,
3 we had a -- it was a petition to the Board to look
4 at the rules, and so the Board did not make any
5 change to the rule.

6 REPRESENTATIVE EDMONDS: So were they in
7 support or against? Do you have a number or a
8 count?

9 DR. ACKERMAN: Yes. They were all --
10 because we didn't have a vote at the last meeting.
11 So let me just get this -- my notes. Give me a
12 second to get my notes together here for a second.

13 CHAIRMAN FINE: I think he's asking what
14 the vote was when you adopted the proposed rule,
15 what your vote was.

16 DR. ACKERMAN: It was unanimous.

17 CHAIRMAN FINE: Thank you.

18 REPRESENTATIVE EDMONDS: Thank you.

19 CHAIRMAN FINE: All right. Well, Rep.
20 Trabulsy, I think if you're quick, you can ask your
21 question. And everyone who wanted to ask one will
22 have been able to.

23 REPRESENTATIVE TRABULSY: Thank you,
24 Mr. Chair.

25 My question is for Chloe. I would like to

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1 think when a child has a dysphoria or something of
2 your nature, that it the whole family would be
3 treated, right, because it's something that you're
4 all going through. And you did all go through this,
5 and you had, although it be negative treatment,
6 how's your family doing? What is the collateral
7 damage there with your family?

8 CHAIRMAN FINE: And I ask you to keep the
9 answer relatively brief --

10 CHLOE COLE: Okay.

11 CHAIRMAN FINE: -- because we have to end
12 on time.

13 CHLOE COLE: I mean, it was really hard on
14 my family. I had a lot of family who disagreed, but
15 they felt like they couldn't really speak up. And
16 the ones who did, I mean, my relationship with them
17 suffered, obviously, because I thought they were
18 wrong. I thought they were being ignorant.

19 And now that I'm speaking out, not all my
20 family necessarily agrees with what I'm doing now.
21 But for the most part, after I've stopped, my
22 relationship with the majority of my family, and
23 especially my parents, has been much better.

24 CHAIRMAN FINE: Well, thank you.

25 I have a couple -- I'm not going to ask a

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1 question, but I have a couple of closing comments.

2 First, I want to say I'm incredibly
3 grateful, both to the panel -- all of you both came
4 from far and near to participate. It's a very, very
5 emotional subject for people, and I appreciate it.
6 I will tell you. I think in my seven years in the
7 legislature, this has been the least looking at cell
8 phones among legislators maybe that I have seen. I
9 think people were mesmerized by what all of you had
10 to say. I also want to thank the members for how
11 you comported yourself today, and I want to thank
12 the audience. We were very concerned about not
13 being able to get through this in a professional
14 way, and I could not hear anyone breathe. And so I
15 thank you for that.

16 When I hear these comments -- so you all
17 know I'm Jewish, and I study the Holocaust. And
18 it's been an impactful part of my life, and I will
19 tell you that when I hear this discussion, when I
20 hear this discussion, when I hear these medicine,
21 when I hear this, I think of Dr. Mengele, who was
22 another doctor.

23 And so I will tell you this. I say these
24 panels are oftentimes a predicate for what's to
25 come. That's exactly what today was. And I promise

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1 you, you will like the bill that is coming. I'm
2 sorry.

3 With that, Representative Amnesty moves we
4 rise.

5 (END OF VIDEO RECORDING)

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Julie Thompson, CET-1036

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TRANSCRIPTION OF AUDIO RECORDING

JOINT SESSION - FLORIDA CHANNEL
Excerpt from Speech of Governor DeSantis

MARCH 7, 2023

Stenographically Transcribed Audio Recording By:
Terri L. Martin, Certified Shorthand Reporter

Med Def_002232

1 Whereupon, the following proceedings were
2 transcribed from an audio recording:

3 GOVERNOR DESANTIS: And it's sad that we
4 have to say this, but our children are not guinea
5 pigs for science experimentation, and we cannot
6 allow people to make money off mutilating them.

7 Chloe Cole is now a young adult, but she
8 was receiving puberty blockers at age 13, and she
9 underwent a double mastectomy at age 16. She's now
10 an advocate against allowing these procedures for
11 our children.

12 Chloe, thank you for your bravery. And the
13 people of Florida and the legislature should heed
14 your advice and provide protections against these
15 procedures.

16 * * *

CERTIFICATE OF REPORTER

STATE OF IOWA)

COUNTY OF WARREN)

I, Terri L. Martin, Certified Shorthand Reporter, certify that I was authorized to and did stenographically transcribe the foregoing audio recording to the best of my ability and that the transcript is a complete record of my stenographic notes.

Dated this 25th of August, 2023.

/s/ Terri L. Martin
Terri L. Martin, CS

Jane Doe

vs.

Joseph Ladapo

March 13, 2023



Med Def_000087

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAP0,

6 Defendant.

7

8 CASE NO. 423CV114RHMAF

9

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TRANSCRIPTION OF VIDEO RECORDING

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COMMITTEE ON HEALTH POLICY

14

MARCH 13, 2023

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TRANSCRIBED AUDIO RECORDING BY:

22

Julie Thompson, CET

23

24 Job No.: 323393

25

1 Thereupon,

2 The following proceeding was transcribed from a
3 video recording:

4 * * * *

5 (START OF REQUESTED PORTION)

6 CHAIRWOMAN BURTON: Do we have additional
7 questions?

8 Senator Brodeur, you're recognized.

9 SENATOR BRODEUR: Thank you, Madam Chair.

10 And as a fellow public health practitioner,
11 I find a great deal of value in research.

12 Recently your office released opinions --
13 or I'm sorry -- research on the treatment of gender
14 dysphoria in youth and adults, and I wondered if you
15 might be able to summarize the depth of that
16 research and what the conclusions were.

17 CHAIRWOMAN BURTON: You're recognized.

18 SURGEON GENERAL: Sure, sure. And I think,
19 just to be sensitive to the individuals who are here
20 today, I want to make it clear that for -- you know,
21 for me, none of the language is about hate and none
22 of the language is about anyone being any less
23 worthy than any other human being on this Earth.
24 We're all -- we're all reflections of God.

25 So scientifically, this report reviewed

1 published studies about gender dysphoria treatment,
2 particularly with a focus on children, on minors.
3 And I didn't do the study. The study was performed
4 by researchers who have expertise in systematic
5 reviews.

6 So this research -- the research that they
7 performed demonstrated that there is no high quality
8 data indicating a benefit from treatments like
9 hormone blockers or from surgical interventions --
10 pardon me -- among people diagnosed with gender
11 dysphoria.

12 And it also highlighted the fact that some
13 of these treatments are actually very risky, and in
14 fact, squarely experimental. For example, with
15 hormone blockers, some -- many people may not know
16 that receptors for your hormones during puberty are
17 in literally every organ in your body, including
18 your brain. And the effect of interfering with the
19 process, the normal natural process of hormone
20 production and development and maturation for young
21 people by giving them hormone blockers is unknown.
22 Like literally that is a fact. It is uncertain what
23 the effect is.

24 There are other harms that have been
25 identified including harms related to bone

1 development and bone density, sometimes with very
2 serious complications, including fractures.

3 And my assessment, based on the evidence
4 that they shared, is that these types of
5 experimental therapies are just -- they're not
6 appropriate for children. They're not appropriate.
7 They are unable to consent or assent for procedures
8 that are highly experimental.

9 And my own personal sense is that it's
10 actually completely unethical to be providing those
11 kinds of treatments, treatments that affect the
12 ability of an individual to procreate later in their
13 life. It's unethical to provide those types of
14 therapies to minors, to people who are unable to
15 consent or assent to them, particularly considering
16 that we can't even provide accurate information
17 about the benefits and risks of those therapies.

18 (END OF REQUESTED PORTION)

19 (START OF REQUEST PORTION)

20 CHAIRWOMAN BURTON: We shall reconvene.
21 I'll give everybody a minute to grab your seats.
22 Thank you very much.

23 Senators, if you will take up Tab 4, which
24 is Senate Bill 254 on treatments for sex
25 reassignment by Senator Yarborough.

1 Senator Yarborough, the Committee has a
2 proposed committee substitute pending. And we'll
3 move directly to the PCS, which is barcode 112830.
4 You're recognized to explain the PCS.

5 SENATOR YARBOROUGH: Thank you, Madam
6 Chair, and good afternoon to you and the Committee.

7 As introduction, parents have the right and
8 a responsibility to raise their children as they see
9 fit, and government intervention should be a last
10 resort.

11 I filed this legislation because I believe,
12 as lawmakers, we do have to draw the line when
13 drastic life-altering gender dysphoria therapies and
14 surgeries are being prescribed for our children.

15 Our laws should set appropriate boundaries
16 that respect the rights and responsibilities of
17 parents while protecting children from serious
18 health, safety, and welfare risks. I also believe
19 our law should firmly respect that both parents have
20 a right to be involved in the upbringing of a child.
21 One parent should not be able to unilaterally
22 attempt to change the sex of their child.

23 With the exception of extreme
24 circumstances, custody arrangements typically honor
25 the rights of both parents to be involved in major

1 decisions and events in a child's life. If one
2 parent is attempting to authorize life-altering sex
3 reassignment therapies and surgeries, then by all
4 means, the other parent should have the ability to
5 have a court review the custody agreement.

6 Over the last week, I've listened to
7 feedback and answered important questions from those
8 who oppose the bill, as well as those who support
9 it. In order to clear up any misconceptions about
10 the child custody provisions of the bill, I
11 submitted a proposed committee substitute with
12 clarifying language for consideration by this
13 Committee today.

14 The proposed committee substitute or PCS
15 has three goals. First, to protect Florida's
16 children from being subjected to irreversible and
17 life-altering sex reassignment prescriptions and
18 procedures.

19 Number two, to require that when adults
20 seek these prescriptions or procedures, the
21 treatments can be legally provided only after the
22 patient has been informed of the nature and risks of
23 the treatment in order to make a prudent decision.

24 And number three, to protect against the
25 expenditures of state funds for sex reassignment

1 treatments.

2 So first, with regard to protection of
3 children, Madam Chair, members of the Committee, the
4 PCS has a number of provisions to protect children
5 from being subjected to the treatments.

6 The PCS amends Florida's child custody
7 statutes to give courts in this state jurisdiction
8 to enter, modify, or stay a child custody
9 determination relating to a child in this state to
10 protect the child from being subjected to sex
11 reassignment prescriptions or procedures.

12 Next, the provision gives courts broad
13 discretion to determine whether and how to protect a
14 child, but the provision does not require a court to
15 take any specific action or require a court to
16 ignore a child custody determination made by a court
17 of another state.

18 The PCS prohibits Florida healthcare
19 practitioners from providing these treatments for
20 children, but it makes an exception for children who
21 were already receiving prescription treatments at
22 the time this bill would become law. The PCS
23 requires that the continuation of prescription
24 treatment for such children must be administered by
25 a medical doctor or osteopathic physician, and must

1 be consistent with emergency rules adopted by the
2 Board of Medicine and the Board of Osteopathic
3 Medicine.

4 These boards have spent the past eight
5 months extensively reviewing research, hearing from
6 medical experts, and listening to the public on this
7 very issue, and are the appropriate bodies to
8 determine standards of care for these children who
9 are already receiving these prescriptions.

10 The PCS creates a third-degree felony for
11 healthcare practitioners who willfully or actively
12 participate in violating the prohibition against
13 providing these treatments to a child. The PCS
14 amends existing law relating to the authority for
15 the Department of Health to issue an emergency order
16 suspending the license of a practitioner who is
17 arrested for violating certain crimes, and the PCS
18 adds the crime of providing these prescriptions or
19 procedures to a child to that list.

20 Lastly, with regard to protecting children,
21 the PCS provides at any hospital, ambulatory
22 surgical center, or physician's office registered
23 for the provision of office surgery must provide
24 assigned attestation to OCA or DOH as applicable,
25 that they do not offer or provide sex reassignment

1 treatments for children, except for those who are
2 already being treated before this PCS would become
3 law, and also do not refer such patients to other
4 providers for the treatments.

5 A facility's failure to provide this
6 attestation will lead to revocation of the
7 facility's license or registration.

8 Second, with regard to protecting adults,
9 if an adult decides to seek treatment with sex
10 reassignment prescriptions or procedures, the PCS
11 ensures that only licensed medical doctors and
12 osteopathic physicians can lawfully provide such
13 treatment.

14 The physician providing the treatment must
15 take certain measures to inform the patient of the
16 nature and risks of the treatment while physically
17 in the same room as the patient using forms approved
18 by the Department of Health, the patient must
19 provide voluntary written informed consent before
20 treatment can commence.

21 And the PCS provides that a healthcare
22 practitioner other than a physician who provides
23 these treatments or a physician who provides the
24 treatments without obtaining voluntary informed
25 consent commits a first-degree misdemeanor.

1 Lastly, with regard to protecting state
2 funds, the PCS creates a prohibition against the
3 expenditure of state funds for these treatments by a
4 governmental entity or organizations contracted by
5 the state to manage the provision of Medicaid
6 services or to manage the state's mental health and
7 substance abuse providers.

8 Madam Chair and the Committee, that is the
9 PCS for Senate Bill 254.

10 CHAIRWOMAN BURTON: Thank you. Are there
11 questions on the PCS? Any questions? We have --
12 excuse me.

13 Senator, which -- who has questions? Thank
14 you.

15 Senator Davis, you're recognized.

16 SENATOR DAVIS: Thank you, Madam Chair.
17 Thank you.

18 Senator Yarborough, could you talk to us
19 about the purpose or the intent of your bill? We
20 heard all that it does but talk to us about the
21 intent or the purpose of this bill.

22 CHAIRWOMAN BURTON: Senator Yarborough,
23 you're recognized.

24 SENATOR YARBOROUGH: Thank you, Madam
25 Chair.

1 The purpose for this bill is to protect
2 children in Florida, Senator Davis. We have other
3 components in this bill that relate to adults and
4 relates -- and relate to the expenditure of state
5 funds, but we want to let kids be kids in Florida.
6 The overall goal of the bill is to protect the
7 children of our state.

8 CHAIRWOMAN BURTON: Additional questions?

9 SENATOR DAVIS: Yes.

10 CHAIRWOMAN BURTON: Senator Davis, you're
11 recognized.

12 SENATOR DAVIS: What is the current
13 standard for gender-affirming care in the state of
14 Florida? Could you talk to us about that?

15 CHAIRWOMAN BURTON: You're recognized.

16 SENATOR YARBOROUGH: Thank you, Madam
17 Chair. Senator and members of the Committee, we do
18 not have any current law on the books for sex
19 reassignment surgeries or prescriptions in Florida
20 for children or adults.

21 CHAIRWOMAN BURTON: So question is --
22 Senator Davis, yes.

23 SENATOR DAVIS: According to your bill, and
24 it's a lot that's defined in here, could you talk to
25 us about what are the protections that are provided

1 at the federal level to protect people against
2 discrimination?

3 CHAIRWOMAN BURTON: Senator Yarborough,
4 you're recognized.

5 SENATOR YARBOROUGH: Thank you, Madam
6 Chair. Through the Chair to Senator Davis, the bill
7 contemplates what we would do as a state, and we do
8 not speak specific to federal provisions in the
9 bill.

10 CHAIRWOMAN BURTON: Additional questions on
11 the bill? Any additional questions?

12 SENATOR DAVIS: Yeah.

13 CHAIRWOMAN BURTON: Senator Davis, you're
14 recognized.

15 SENATOR DAVIS: Thank you, Madam Chair.

16 CHAIRWOMAN BURTON: Uh-huh (affirmative).

17 SENATOR DAVIS: Thank you. Just trying to
18 get some answers out.

19 Have you spoken to any parent or -- of a
20 gender-diverse youth?

21 CHAIRWOMAN BURTON: Senator Yarborough,
22 you're recognized.

23 SENATOR YARBOROUGH: Could -- through the
24 Chair to the Senator, Senator, could you -- to any
25 parent is the question, just so I can make sure I

1 answer to the best ability.

2 CHAIRWOMAN BURTON: Senator Davis, you're
3 recognized.

4 SENATOR DAVIS: Thank you, Madam Chair.
5 Have you spoken to a parent that has a
6 transgender child?

7 CHAIRWOMAN BURTON: You're recognized?

8 SENATOR YARBOROUGH: Thank you, Madam
9 Chair. Through the Chair to the Senator, I have
10 spoken to a lot of parents about this and many other
11 issues.

12 Senator Davis, I don't ask when I'm talking
13 to parents. I mean, I haven't had any who have
14 volunteered that that may be the case with their
15 child. But in the course of a week or even in the
16 course of a few days, I know all of us engage with
17 parents of children out there. So I couldn't tell
18 you that specific, whether or not they have a child
19 who falls into that category.

20 SENATOR DAVIS: Okay. Madam Chair?

21 CHAIRWOMAN BURTON: You're recognized.

22 SENATOR DAVIS: Thank you. Thank you for
23 that answer.

24 Were any medical experts consulted while
25 you were drafting this bill?

1 CHAIRWOMAN BURTON: Senator Yarborough,
2 you're recognized.

3 SENATOR YARBOROUGH: Thank you. Through
4 the Chair to Senator Davis. So there's a lot of
5 different information that I've reviewed and I know
6 staff has reviewed as we've worked through the
7 process with this bill, Senator Davis. And that
8 includes not only reports and research that has been
9 done in our country but also that of other countries
10 related to this.

11 And so I can't speak for every review that
12 our staff might have done, but for me, I have gone
13 through a long list of different research and tried
14 to get as educated as possible to present this bill
15 to you today.

16 CHAIRWOMAN BURTON: Additional questions?

17 SENATOR DAVIS: Madam Chair, just a few
18 more, I promise.

19 CHAIRWOMAN BURTON: You're recognized.

20 SENATOR DAVIS: Thank you, Madam Chair.

21 Thank you, Senator for that. Your bill
22 talks about puberty blockers, and so I'm curious.
23 Are you aware that puberty blockers are used for
24 medical procedures in children rather -- for things
25 rather than what we're talking about here in your

1 bill, puberty blockers are often used for things
2 like precocious puberty?

3 CHAIRWOMAN BURTON: You're recognized,
4 Senator Yarborough.

5 SENATOR YARBOROUGH: Thank you, Madam
6 Chair.

7 To the first part of your question, Senator
8 Davis, I'll say I'm aware that they're used for more
9 than just these types of purposes that we would seek
10 to prohibit today, and we do have some exceptions in
11 the bill.

12 If there is a legitimate need in the eyes
13 of a healthcare practitioner to continue to
14 administer those because of certain developmental
15 disorders or certain other conditions that may be
16 present in a minor, that that can continue to be
17 used.

18 CHAIRWOMAN BURTON: Senator Davis, you're
19 recognized.

20 SENATOR DAVIS: Thank you, Madam Chair.

21 Could you talk to us a little bit about
22 those exceptions and just, kind of, identify those
23 exceptions and then talk to us about the fact that,
24 is it anything in your bill that would make dealing
25 with those exceptions criminal or what would -- what

1 is criminal under your bill?

2 CHAIRWOMAN BURTON: You're recognized,
3 Senator Yarborough.

4 SENATOR YARBOROUGH: Okay. Thank you,
5 Senator Davis. Thank you, Madam Chair.

6 I may have to ask you to repeat the second
7 part, Senator Davis, but on the first part, you're
8 asking about some of the exceptions.

9 So if you pick up on page 6 of the bill
10 starting at lines -- starting at line 151, we
11 mentioned that the term does not include treatment
12 provided by a physician who in his or her good faith
13 clinical judgment performs procedures upon or
14 provides therapies to a minor born with a medically
15 verifiable genetic disorder of sexual development,
16 including any of the following.

17 And then it lays out external biological
18 sex characteristics that are unresolvable, ambiguous
19 disorder of sexual development, as I mentioned a
20 moment ago. And it lists some other descriptors
21 related to that. So those are the main exceptions.

22 CHAIRWOMAN BURTON: Have questions,
23 Senator?

24 SENATOR YARBOROUGH: And then can you -- if
25 you could clarify this. Sorry, Madam Chair. Just

1 if you could clarify the other part.

2 CHAIRWOMAN BURTON: Did you have another
3 comment, Senator? Go ahead.

4 SENATOR YARBOROUGH: Thank you, Madam
5 Chair. And I apologize. I -- Senator Davis asked a
6 second part and I just -- I wasn't clear about the
7 second part of her question. I want to make sure I
8 could answer it.

9 CHAIRWOMAN BURTON: Senator Davis, you're
10 recognized.

11 SENATOR DAVIS: Thank you, Madam Chair.

12 Senator, I asked, could you talk about what
13 is criminal under your bill. Right now, you have
14 criminal penalties for healthcare practitioners and
15 others. Could you talk to us about the criminal
16 penalties under your bill.

17 SENATOR YARBOROUGH: Yes, ma'am.

18 CHAIRWOMAN BURTON: Senator Yarborough,
19 you're recognized.

20 SENATOR YARBOROUGH: Thank you very much.
21 So there are a couple of portions related to that,
22 Senator Davis, related to a healthcare practitioner
23 that might pursue performing treatments or giving
24 prescriptions to minors.

25 That would be a third-degree felony under

1 the bill. And then we also have the requirement
2 that if you do not obtain the informed consent for
3 an adult prior to giving them the prescriptions or
4 doing the treatments, then there could be
5 disciplinary action by the Board of Medicine that
6 oversees that.

7 And then also, if a facility -- a licensed
8 facility does not provide the annual attestation
9 that they are not performing the procedures, then
10 they can risk revocation of their licensure.

11 CHAIRWOMAN BURTON: Additional questions?

12 SENATOR DAVIS: One last question.

13 CHAIRWOMAN BURTON: You're recognized,
14 Senator Davis.

15 SENATOR DAVIS: Thank you, Madam Chair. In
16 lines 59 through 58 -- 59 through 68, it talks about
17 a court of this state having jurisdiction to enter,
18 modify, or stay a child custody determination
19 relating to a child who is present in this state to
20 the extent necessary to protect the child from being
21 subject to sex reassignment prescriptions and
22 procedures. I read that because I'm having an issue
23 understanding it.

24 So the question with that is, with that,
25 what I just read, Senator Yarborough, does your bill

1 permit the judge in a custody ruling or custody
2 order to be -- to challenge a court in another
3 state? From those lines.

4 CHAIRWOMAN BURTON: You're recognized,
5 Senator Yarborough.

6 SENATOR YARBOROUGH: Thank you, Madam
7 Chair, and I appreciate the question.

8 Through the Chair to Senator Davis and the
9 Committee, so on the custody piece, which is spelled
10 out in Section 1, as you've identified, Senator, we
11 speak about the Uniform Child Custody Jurisdiction
12 and Enforcement Act that has been enacted by 49
13 other states in our country and we're one of the 49.

14 But consistent with federal law, grants
15 court's authority to protect a child from
16 mistreatment or abuse.

17 The provision of the PCS gives courts in
18 Florida the jurisdiction to enter, modify, or stay a
19 child custody determination relating to a child in
20 the state to protect the child from being subjected
21 to sex reassignment prescriptions and procedures.

22 So more plainly, the courts in our state
23 could evaluate what a concerned parent, for example,
24 may bring to them if they disagree with what might
25 be taking place by that child's other parent in a

1 different state, but it does not require that a
2 state in Florida has to automatically grant or act a
3 certain way.

4 It's not a mandate. It gives the court the
5 opportunity to weigh it, but it is providing that
6 specific avenue so that the parent can pursue or
7 petition the court rather for the relief that they
8 may be seeking.

9 CHAIRWOMAN BURTON: Thank you.

10 Additional questions?

11 Senator Book, you're recognized.

12 SENATOR BOOK: Thank you, Chair. And thank
13 you Senator Yarborough for some of the time that we
14 spoke on the phone kind of talking through the bill.
15 And I want to make sure that we're really clear
16 about a few things.

17 Currently, because of the Department of
18 Health's rule, can minors in the state of Florida
19 receive gender-affirming care and medication?

20 CHAIRWOMAN BURTON: You're recognized,
21 Senator Yarborough.

22 SENATOR YARBOROUGH: Thank you. So the
23 rule -- thank you Leader Book for the question.

24 So the rule that was published by the Board
25 of Medicine back in November of 2022 becomes

1 effective this Thursday, March the 16th, I believe
2 it's Thursday. And so we are more or less codifying
3 what that rule from the Board of Medicine
4 establishes moving forward in our bill that we have
5 before you today.

6 There is also a Medicaid rule that already
7 said that state funds could not be used for these
8 purposes. And I -- the date of which -- I would
9 have to get that for you, but that's also in place.

10 CHAIRWOMAN BURTON: Senator Book, you're
11 recognized.

12 SENATOR BOOK: Thank you. So starting
13 Thursday, new children year 18, you know, as
14 defined, could not receive any more gender-affirming
15 medication or care, but the children who are
16 currently receiving care in the state can continue
17 their care?

18 CHAIRWOMAN BURTON: Senator Yarborough,
19 you're recognized.

20 SENATOR YARBOROUGH: Thank you. And just
21 to be clear, Leader Book, were you saying under our
22 bill or under the rule?

23 CHAIRWOMAN BURTON: You're recognized.

24 SENATOR BOOK: Well, are we grandfathering
25 these minors in who are currently on medication?

1 CHAIRWOMAN BURTON: Senator Yarborough,
2 you're recognized.

3 SENATOR YARBOROUGH: Thank you. Under the
4 bill, we do, Senator Book.

5 CHAIRWOMAN BURTON: Additional question?

6 SENATOR BOOK: Yes, follow-up.

7 SENATOR YARBOROUGH: You're recognized.

8 SENATOR BOOK: So under the current --
9 because there are -- because I have spoken to the
10 several of the gender clinics, particularly the UF
11 clinic for minors under the age of 18, 23 patients,
12 and this is all information that they've sent to the
13 Department of Health, 23 patients received puberty
14 blockers, 42 have received hormones, and 2 received
15 hormone blockers.

16 That's a total of 67 children receiving
17 care under the rule. Will they be able to continue
18 that care on Thursday?

19 CHAIRWOMAN BURTON: Excuse me. I turned it
20 off. You're recognized, Senator Yarborough.

21 SENATOR YARBOROUGH: Thank you, Chair
22 Burton. Through the Chair to Leader Book, not under
23 the rule. They will not, Leader Book.

24 CHAIRWOMAN BURTON: Follow-up, Senator
25 Book?

1 SENATOR BOOK: I do.

2 CHAIRWOMAN BURTON: You're recognized.

3 SENATOR BOOK: So under the rule, these
4 current patients will not be able to receive the
5 medications that they're currently on, however,
6 under the bill we've grandfathered them in?

7 CHAIRWOMAN BURTON: You're recognized.

8 SENATOR YARBOROUGH: Thank you, Madam
9 Chair. Let me give you some clarification, Leader
10 Book, and I apologize.

11 Under the rule, and I have it in front of
12 me now, we do, and I'll read directly from it. It
13 says, "Minors being treated with puberty-blocking
14 hormone or hormone antagonist therapies prior to the
15 effective date of the rule may continue with such
16 therapies." That is what is effective this
17 Thursday, March 16th. I apologize for the
18 confusion.

19 SENATOR BOOK: That's --

20 CHAIRWOMAN BURTON: Additional questions?

21 SENATOR BOOK: Yes, I do.

22 CHAIRWOMAN BURTON: You're recognized.

23 SENATOR BOOK: One of the other things I
24 simply want to point out as a question.

25 When you were doing some of your research

1 for the bill, Senator Yarborough, you talked a
2 little bit about, you know, the -- I don't want to
3 mischaracterize it because I don't know -- I don't
4 remember your direct quote.

5 But you are aware that the puberty blockers
6 are -- it's not a permanent -- it's not anything
7 permanent that puberty blockers, once they stop,
8 revert back to where a child would be naturally,
9 correct? That that is not something that you have
10 to take medication for to reverse?

11 CHAIRWOMAN BURTON: Senator Yarborough,
12 you're recognized.

13 SENATOR YARBOROUGH: Thank you. Through
14 the Chair to Leader Book and the Committee, I have
15 heard the same statement that you just said, Leader
16 Book.

17 I'm not a medical professional to be able
18 to say I could fully attest the efficacy of that,
19 but I have heard the same statement mentioned
20 several times that you have just mentioned.

21 CHAIRWOMAN BURTON: Additional questions?

22 SENATOR BOOK: Yes, ma'am.

23 CHAIRWOMAN BURTON: Senator Book, you're
24 recognized.

25 SENATOR BOOK: Thank you. For the adult

1 portion of this bill, and I believe it's in the PCB;
2 but with the different lines, I want to make sure.
3 "For adults that are receiving gender-affirming care
4 we are banning the use of anyone other than a doctor
5 to prescribe medication; is that correct or
6 incorrect?

7 CHAIRWOMAN BURTON: You're recognized,
8 Senator Yarborough.

9 SENATOR YARBOROUGH: Leader Book, that's
10 correct.

11 Thank you, Madam Chair.

12 CHAIRWOMAN BURTON: Additional questions?

13 SENATOR BOOK: Madam Chair?

14 CHAIRWOMAN BURTON: You're recognized.

15 SENATOR BOOK: Would there be a possibility
16 that you would look at -- for adults, okay, because
17 it's not happening for minors in the state -- the
18 possibility of allowing for nurses or telehealth to
19 provide some of those blockers or medications that
20 those seeking gender-affirming care may need?

21 CHAIRWOMAN BURTON: You're recognized,
22 Senator Yarborough.

23 SENATOR YARBOROUGH: Thank you, Madam
24 Chair. Through the Chair to Leader Book, and
25 Leader, I know that's a topic of one of the

1 amendments that is forthcoming.

2 I will certainly be open to considering
3 that. However, with the serious nature of the duty,
4 we have to protect the public and ensure patient
5 safety when treatments are authorized, I think we
6 need to be very careful for that. And I don't
7 believe that's too high of a standard for physicians
8 to be held to and for patients in their pursuit of
9 that if they wish, if they're adults, to go through
10 that process. And I will point out too, we have it
11 in place for new prescriptions that would be coming
12 forward.

13 So if someone is prescribed a certain
14 medication, they have to give the informed consent
15 on the front end under this PCS, but they don't have
16 to continually come back every time there is a
17 refill. If they get a refill of the -- of that same
18 prescription, it's only then if they go to a new
19 medication. So that to me is a more balanced
20 approach.

21 CHAIRWOMAN BURTON: I apologize for
22 interrupting questions. But just briefly, given the
23 limited time, we have remaining for the number of
24 people who still wish to speak and for committee
25 deliberation, I'm requesting that the president

1 authorize the extension of this meeting until the
2 completion of the agenda.

3 Thank you for that indulgence, and Senator
4 Book, you're recognized.

5 SENATOR BOOK: Thank you. I just have one
6 more follow-up question to Senator Davis's point and
7 something that I just want to make sure that I'm
8 clear on.

9 So let's say I have -- I do have two
10 children, a boy and a girl. And let's -- for
11 purposes of this discussion, my husband and I get
12 divorced and he lives in another state. Perhaps
13 it's a state that does not, you know, look at
14 gender-affirming care in the same way that -- or if
15 this bill is to move forward, would and be in the
16 state of Florida.

17 If I -- if he came to me and -- or either
18 one of my children came to me and said, "Mom, I feel
19 like not comfortable in my body." Take him to a
20 pediatrician, wanted to receive some sort of gender-
21 affirming care, this bill would allow, possibly, my
22 spouse to come in -- or no -- my ex-spouse to come
23 in and take custody of my child?

24 CHAIRWOMAN BURTON: Senator Yarborough,
25 you're recognized.

1 SENATOR YARBOROUGH: Thank you, Madam
2 Chair. Through the Chair to Leader Book, just so I
3 understand because the -- there are a few different
4 factors that would affect it.

5 Are you in Florida or the other state, is
6 your ex in a different state? And then also --
7 that, I mean, that's the main question. So I can
8 give you the right answer because that matters.

9 In Florida, it would be prohibited, but it
10 -- if you could clarify, I'd be happy to try to
11 answer it.

12 SENATOR BOOK: Let's just --

13 CHAIRWOMAN BURTON: Senator Book, would you
14 like to clarify?

15 SENATOR BOOK: Let's just say it this way.
16 If my son needed a blood transfusion and my ex-
17 spouse was of the religious belief or opinion that
18 that was not something that we should be doing for
19 my child. That is something that a court -- that
20 they could go -- that -- trying to -- these are
21 disputes that happen when raising a child together,
22 right?

23 And what -- this decision to receive
24 gender-affirming care is no different than any other
25 medical medication or decision for a family to

1 decide, right.

2 And so, I guess, my question is: talk us
3 through -- and you address it a little bit in
4 Senator Davis's question. What does this mean for
5 families? Because I get a -- we have a lot of
6 people here. I've gotten a lot of emails, a lot of
7 phone calls, and there's a lot of fear, a lot of
8 fear. And we've talked about that fear of families
9 that think that the State of Florida is taking their
10 children, that someone is going to lose access to
11 their kids, which is scary. It is scary.

12 And so I'm asking you to just very plainly
13 walk through the custody portion of what this is and
14 what this would mean for parents of young kids of
15 what -- who are very concerned about what this might
16 mean for them if they want to receive gender-
17 affirming care for their child.

18 CHAIRWOMAN BURTON: Senator Yarborough.

19 SENATOR YARBOROUGH: Thank you, Madam
20 Chair. Through the Chair to Leader Book and the
21 Committee, is very good question, Senator, and that
22 relates to a big portion of this bill. So I'm happy
23 to speak more about it.

24 So I believe the balance in this is, again,
25 we give the court in Florida -- the courts in

1 Florida, if they are petitioned by a parent in
2 Florida, just to take your example that I believe
3 you're trying to get to and that we spoke about
4 before.

5 If you were here in Florida and you did not
6 agree with the decision of the child's other parent,
7 who is in a different state, you could petition the
8 court here. Let me add in too, it doesn't mean that
9 you could harbor, someone suggested kidnap, all of
10 this other; that's not true.

11 You cannot violate a current custody
12 arrangement because then you're breaking the law.
13 So it doesn't mean it comes to the end of the
14 weekend, and then you're supposed to make sure the
15 child is back with the other parent, you know, by
16 that evening or 8 o'clock Monday morning or whenever
17 it might be, is determined in the custody
18 arrangement.

19 But what it does mean is you could approach
20 the Florida court and ask for this to be considered.
21 But again, the court is not mandated to have to give
22 you exactly what you're asking for.

23 So that's the crux of it, is you can't
24 harbor the child. You cannot violate the law. You
25 cannot do something outside of your custody

1 arrangement because then you have broken the law and
2 can be held liable for that. But you can go to the
3 court and ask for them to consider this very serious
4 concern that you have about the treatment the child
5 is receiving, and if the court chooses to weigh in,
6 they would be able to do so.

7 I hope that answered. I'm happy to try
8 more, but I hope that answered it for you.

9 CHAIRWOMAN BURTON: Are there additional
10 questions? See none.

11 We do have four amendments. So we'll take
12 up amendment barcode 788684 by Senator Davis.

13 And, Senator Davis, you're recognized to
14 explain the amendment.

15 SENATOR DAVIS: Did you -- Madam Chair,
16 could you repeat the number for me?

17 CHAIRWOMAN BURTON: Certainly, 788684.

18 SENATOR DAVIS: Okay. This amendment
19 simply is an amendment that deletes all of the bills
20 provision relating to the child custody orders. And
21 that is the amendment.

22 CHAIRWOMAN BURTON: Are there questions on
23 the amendment? Are there appearance cards on this
24 amendment? Okay.

25 Jon Harris Mauer is -- with Equality

1 Florida is waiving in support of the amendment, and
2 Nathan Bruemmer is also waiving in support of the
3 amendments.

4 Is there debate on the amendment?

5 SENATOR YARBOROUGH: Madam Chair?

6 CHAIRWOMAN BURTON: Senator Yarborough,
7 you're recognized.

8 SENATOR YARBOROUGH: Thank you, Madam
9 Chair. I appreciate Senator Davis's offering of
10 this amendment.

11 I would at this time term it as unfriendly.
12 The PCS clarifies any misconceptions about the child
13 custody provisions of the bill, and also the custody
14 provision provides courts with broad discretion to
15 determine whether and how to act to protect a child.
16 The provision does not require a court to take any
17 specific action or require a court to ignore a child
18 custody determination made by a court of another
19 state.

20 It is important to respect that both
21 parents have a right to be involved in the
22 upbringing of a child, and one parent should not be
23 able to unilaterally attempt to change the sex of
24 their child just because they live out of state. So
25 I would ask that you vote down the amendment.

1 CHAIRWOMAN BURTON: Senator Davis, you're
2 recognized to close on amendment barcode 788684.

3 SENATOR DAVIS: Thank you, Madam Chair.
4 Custody battles are tense and a complex issue, and
5 adding a court into the mix makes it even more
6 difficult.

7 A parent who could, otherwise, completely
8 deserve rightful custody could lose it simply
9 because of a private medical decision. We're
10 expanding the jurisdiction of the courts without a
11 clear -- without clear language to protect this
12 child.

13 Interstate child custody cases, as I said,
14 are difficult and usually the state only intervenes
15 if there is present danger for a child who has lived
16 here for more than six months.

17 To add to this, the course for something
18 that could occur in the future is vague and could
19 become an additional burden for parents.

20 And with that, Madam Chair, I close and ask
21 for your favorable -- the Committee's favorable
22 support on this amendment.

23 CHAIRWOMAN BURTON: All in favor of the
24 amendment say yea.

25 MEMBERS: Yea.

1 CHAIRWOMAN BURTON: All opposed say nay.

2 MEMBERS: Nay.

3 CHAIRWOMAN BURTON: The amendment fails.

4 We'll now take up amendment barcode 953930

5 by Senator Book.

6 And, Senator Book, you're recognized on the

7 amendment.

8 SENATOR BOOK: Thank you so much, Madam

9 Chair. This legislature should not be in the

10 business of picking and choosing sides in court

11 proceedings.

12 The preference should not be on what one

13 parent wants over the other parent and -- when

14 there's a real disagreement on healthcare options

15 for their children.

16 This amendment very simply requires the

17 court focus on the child and the best interest of

18 the child. That is the amendment, Madam Chair.

19 CHAIRWOMAN BURTON: Thank you. Are there

20 questions on the amendment?

21 Seeing no questions. Are there appearance

22 cards on this amendment? Thank you.

23 Jon Harris Mauer with Equality Florida

24 waives in support of the amendment. And Nathan --

25 excuse me -- Bruemmer with -- Nathan Bruemmer also

1 waives in support of the amendment.

2 Is there debate on the amendment?

3 SENATOR YARBOROUGH: Madam Chair?

4 CHAIRWOMAN BURTON: Senator Yarborough,
5 you're recognized.

6 SENATOR YARBOROUGH: Thank you, Madam
7 Chair. Through the Chair to the Committee, while,
8 again, I appreciate Leader Book the offering of the
9 amendment. I would say that whether or not a court
10 has jurisdiction as a key element of the Uniform
11 Child Custody Jurisdiction and Enforcement Act.

12 So by removing the PCS's granting of
13 jurisdiction to a Florida court, the amendment would
14 actually defeat the purpose of the PCS in that
15 regard, which is to clearly grant jurisdiction to
16 our state court.

17 So I would ask the Committee to vote down
18 the amendment.

19 CHAIRWOMAN BURTON: Senator Book, you're
20 recognized to close on amendment barcode 953930.

21 SENATOR BOOK: Thank you so much, Madam
22 Chair.

23 You know, members, if you're divorced and
24 are jointly raising a child, there are, of course,
25 disagreements that will come up when it comes to

1 making healthcare decisions for your children.

2 One parent may believe for religious
3 reasons or other reasons that a specific treatment
4 should not be taken or undertaken, and we have a way
5 of dealing with this, a way that works.

6 It goes through the court system, and a
7 court looks at both sides, and it should be what is
8 in the best interest of that child. And this type
9 of care should be no different.

10 The legislature should not be giving
11 preference to one parent's position, and we should
12 be ensuring that decisions are currently in the best
13 interest of children. And I ask for your favorable
14 support.

15 CHAIRWOMAN BURTON: All in favor of the
16 amendment say yea.

17 (Responses faint)

18 All opposed say nay.

19 MEMBERS: Nay.

20 CHAIRWOMAN BURTON: The amendment fails.

21 We'll next take up amendment barcode 309890
22 by Senator Book.

23 Senator Book, you're recognized on the
24 amendment.

25 SENATOR BOOK: Now, I know you're going to

1 love this one.

2 This legislature, Madam Chair, and
3 Committee, talks a lot about medical freedom and
4 expanding access to healthcare through telehealth
5 and qualified healthcare professionals, such as
6 advanced practice registered nurses. Yet this bill
7 specifically removes that option for transgender
8 adults -- we're not talking about children; we're
9 talking about adults here -- drastically reducing
10 healthcare for transgender adults.

11 This amendment simply removes the language
12 that bans telehealth and qualified healthcare
13 professionals from administering what is often life-
14 saving care.

15 CHAIRWOMAN BURTON: Thank you. Are there
16 questions on the amendment?

17 Seeing no questions. We do have a couple
18 of appearance cards. Nathan Bruemmer is -- would
19 like to speak. I'll say it now because I may have
20 mispronounced your last name. If you come to speak
21 to us today and I mispronounce your name, I'm going
22 to apologize in advance.

23 Everything is handwritten and there's no
24 phonetics on here, so I apologize. But you're
25 recognized, sir.

1 NATHAN BRUEMMER: Thank you. Senator Book,
2 I appreciate the amendment.

3 I'm a practicing lawyer here in the state
4 of Florida, a parent former educator. I'm also the
5 State's former LGBTQ Consumer Advocate with the
6 Florida Department of Agriculture and Consumer
7 Services. And I'm also a consumer of affirming
8 healthcare as a transgender man.

9 I'm born and raised in this state. This is
10 my home. And when we talk about access to
11 healthcare, I really want to get very specific about
12 what that means across all communities practically
13 speaking about the importance and the advantages of
14 telehealth.

15 We're talking about potentially emergency
16 circumstances. We're talking about better care
17 coordination and the efficiency of the care we're
18 providing. We're talking about protecting both
19 patients and medical personnel from risks of
20 infection, surging demands.

21 The world has just become increasingly
22 digitized, right? And the medical profession, the
23 healthcare sector has certainly kept up with that.

24 Our state is leading the way in a lot of
25 modernization of care. And telehealth is something

1 utilized by many Floridians, especially LGBTQ
2 Floridians and trans Floridians.

3 I'm a practicing attorney. I travel. I
4 have been a parent through most of my life, right,
5 including the early years of my transition. I'm
6 very informed about informed consent as an attorney,
7 as are all of the folks who are accessing this
8 healthcare for decades.

9 And the burden this will put on
10 practitioners and on patients is something
11 unnecessary. We are moving forward and continuing
12 to modernize in ways that this will take Florida
13 back. And this is a simple amendment, something
14 simple to move forward aside from minimizing the
15 role in busy practices of nurse practitioners.

16 I'm not sure that the medical associations
17 are aware of this and they should be, but they have
18 been advocating for the importance of nurse
19 practitioners quite passionately for many, many
20 years here in Committee.

21 So I'd urge you to accept this amendment.
22 It's a valuable one.

23 And again, thank you, Senator Book.

24 CHAIRWOMAN BURTON: Thank you. Jon Harris
25 Mauer is -- with Equality Florida is waiving in

1 supports.

2 Is there debate on the amendment?

3 SENATOR YARBOROUGH: Madam Chair?

4 CHAIRWOMAN BURTON: Senator Yarborough,
5 you're recognized.

6 SENATOR YARBOROUGH: Thank you, Madam
7 Chair. Through the Chair and -- through the Chair
8 to the Committee and Leader Book, we have a duty to
9 protect the public and ensure patient safety when
10 treatments are authorized that can be inherently
11 dangerous.

12 So similar to how we have addressed
13 treatment for medical marijuana and abortion, the
14 PCS conforms to those laws and only authorizes
15 allopathic and osteopathic physicians, which are MDs
16 and DOs, which include specialty physicians such as
17 psychiatrist and endocrinologists to treat patients
18 for sex reassignment medications and surgeries.

19 These treatments have the potential to have
20 life-altering effects and should be regulated in a
21 heightened manner and differently than other medical
22 treatments.

23 And for that reason, I would ask the
24 Committee to vote the amendment down.

25 CHAIRWOMAN BURTON: Additional debate?

1 Senator Book, you're recognized to close on
2 amendment barcode 309890.

3 SENATOR BOOK: Thank you, Madam Chair. The
4 transgender community already faces significant
5 barriers and disparities in accessing healthcare.
6 And the state should not be making that worse by
7 setting a really dangerous precedent about
8 government interference and personal decision-
9 making.

10 The American Medical Association, the
11 American Psychological Association, the Endocrine
12 Society, and other major medical organizations
13 oppose the restrictions on some of this gender-
14 affirming care. And I believe that we should be
15 making it as safe as possible for folks to access
16 this type of care.

17 We're talking about adults. We're not
18 talking about children. We talk a lot about access
19 to care for folks who live in rural parts of the
20 state, who may just be -- who may need a little bit
21 of a help in accessing care that they need and
22 deserve, quite frankly.

23 And I think we shouldn't be putting blocks
24 in the way for folks to receive care. That's not
25 medical freedom. So I ask for your favorable

1 support.

2 CHAIRWOMAN BURTON: All in favor of the
3 amendment say yea.

4 MEMBERS: Yea.

5 CHAIRWOMAN BURTON: All opposed say nay.

6 MEMBERS: Nay.

7 CHAIRWOMAN BURTON: The amendment fails.

8 Take up amendment barcode 448208 by Senator
9 Davis.

10 SENATOR DAVIS: Thank you, Madam --

11 CHAIRWOMAN BURTON: Senator Davis, you're
12 recognized on the amendment.

13 SENATOR DAVIS: Thank you, Madam Chair.
14 Spoke there before you gave me permission.

15 This amendment simply would eliminate,
16 delete lines 224 through lines 234, which refer to
17 the criminal punishment of external people involved
18 in providing care for the child.

19 The language is vague and could lead to
20 unequal enforcement of the law based on
21 interpretation. And that is the amendment.

22 CHAIRWOMAN BURTON: Thank you. Are there
23 questions on the amendment? I have a few appearance
24 cards.

25 But just briefly before we go to the

1 appearance cards. Under Rule 2.10(2), the president
2 has authorized a continuation of this meeting until
3 completion of the agenda.

4 Now we're on appearance cards for this
5 amendment.

6 Dr. Robinson -- Dr. D. Paul Robinson,
7 you're recognized.

8 DR. ROBINSON: Hello. I'm still Dr. Paul
9 Robinson. Thank you so much.

10 I'm afraid that the -- giving punishment
11 for people who give gender-affirming care could have
12 consequences much beyond what many of you think.
13 Right now, I'm on the Workforce Committee for the
14 Florida Chapter of the American Academy of
15 Pediatrics, and we are working hard to figure out
16 how to get more specialists into Florida.

17 And one of the specialties we have the
18 least numbers of are pediatric endocrinologists.
19 Pediatric endocrinologists take care of many things
20 besides transgender, including diabetes, which you
21 all know, we're about to have a huge increased
22 number of.

23 So if you criminalize this, there are going
24 to be people who are looking about whether they want
25 to come to Florida as pediatric endocrinologists.

1 Or they're going to be doing their fellowship here,
2 and they're going to be saying, "Hmm, do I want to
3 go to Florida where I might end up in jail if I do
4 something that they don't like, or do I want to go
5 somewhere else where I can practice as I was taught
6 to practice?"

7 So I really ask you guys, please think
8 about this because you're going to -- we are really
9 working on -- we're in trouble over the next 10
10 years with pediatric specialists, and if we
11 criminalized things, we're going to make that much
12 worse. Please try to find other consequences that
13 don't involve felonies, et cetera. Surely there's
14 something else you can come up with. Thank you.

15 CHAIRWOMAN BURTON: Thank you. Jon --
16 excuse me -- Jon Harris Mauer waiving in support
17 with Equality Florida, and Nathan Bruemmer is
18 waiving in support of the amendments.

19 Is there debate on the amendment? Debate
20 on the amendment? I'm sorry.

21 Senator Book, you're recognized.

22 SENATOR BOOK: Thank you, Madam Chair. I
23 just want to support Senator Davis's amendment.

24 At the end of the day, doctors, when they
25 become doctors, they take the Hippocratic Oath to

1 seek to do no harm for their patients. And they
2 want to ensure that they are doing everything in
3 their power to make sure that their patients are
4 getting the correct care, the right care, and doing
5 what is medically best for their patients.

6 And I think that doing anything to put a
7 medical professional in -- for criminal charges, for
8 doing what they believe is best for their patient is
9 not what we should be doing in our state.

10 We should be allowing doctors to go before
11 a Board of Medicine. We already have a shortage.
12 We know that it exists. And doing things like this,
13 I believe will create a chilling effect to bring
14 top-quality doctors to our state. And so I support
15 Senator Davis's amendment.

16 CHAIRWOMAN BURTON: Thank you. Is there
17 additional debate?

18 Senator Yarborough?

19 SENATOR YARBOROUGH: Madam Chair, thank
20 you. I appreciate the testimony and also the
21 comments from the leader.

22 I would say as we consider the risks
23 associated with hormone therapy for children, for
24 example, the reason that we need to be very clear
25 about what the penalties are is that, according to

1 AACE clinical practice guidelines, males seeking
2 transition to females with estrogen have a very high
3 risk of developing side effects involving dangerous
4 blood clots.

5 We also have found that males transitioning
6 to female also have a moderate risk of developing
7 other adverse outcomes like tumors, breast cancer,
8 coronary artery disease, cerebrovascular disease
9 gallstones, et cetera.

10 And then there are also risk from females
11 seeking to transition to males with testosterone.
12 Adverse reactions could include severe liver
13 dysfunction, coronary artery disease, hypertension,
14 breast or uterine cancer, and also cerebrovascular
15 disease.

16 We have got to do what we can to protect
17 the people of our state. And this would totally get
18 out that protection by letting folks know how
19 serious we are about protecting Floridian.

20 So again, similar to how we treat other
21 laws, violations under this bill should be treated
22 in a heightened manner to protect the public. And
23 these treatments are life-altering. They can have
24 permanent serious side effects, and we need to
25 protect children and ensure that healthcare

1 practitioners are held responsible if they violate
2 the law.

3 So I'd ask the Committee to vote down the
4 amendment.

5 CHAIRWOMAN BURTON: Senator Davis, you're
6 recognized to close on amendment barcode 448208.

7 SENATOR DAVIS: Thank you, Madam Chair. I
8 would like to thank the medical professional that
9 came to speak to us and give his medical insight on
10 this amendment.

11 Simply, this bill addresses -- this
12 amendment addresses people who knowingly contribute
13 to a child's -- a child receiving gender-affirming
14 care like someone at the front desk, like a nurse,
15 or an insurance agent, or a pharmacist who approves
16 a prescription.

17 Simply here today with the way this bill is
18 written, this language and this amendment simply is
19 too vague, and it addresses that. And it possibly
20 later on could be included in a catchall
21 investigation in the future.

22 So that's why I brought this amendment
23 forward. I would ask my colleagues to support this
24 amendment today.

25 And with that Madam Chair, I close.

1 CHAIRWOMAN BURTON: All in favor of the
2 amendment say yea.

3 MEMBERS: Yea.

4 CHAIRWOMAN BURTON: Opposed say nay.

5 MEMBERS: Nay.

6 CHAIRWOMAN BURTON: Show the amendment
7 fails.

8 Okay. Senators, to get us in proper
9 posture, Senator Brodeur moves at the PCS, which is
10 barcode 112830, be adopted in place of the bill as
11 filed.

12 Without objection, show that the motion is
13 adopted. By adopting the PCS, the amendments
14 pending on the original bill are disposed of.

15 Now we're back on the bill as amended by
16 adoption of the PCS.

17 We have a number of appearance cards, and I
18 want to thank you all for waiting patiently. It's
19 been a long meeting already. My intent is to give
20 everybody who has filled out a card an opportunity
21 to speak. There will be those in favor of the bill
22 and those opposed to the bill.

23 You have been amazingly quiet and patient,
24 and we're going to keep being amazingly quiet and
25 patient through the rest of this. We will not have

1 any clapping. We will not have any snapping -- no
2 snapping in your fingers. Don't wave any signs.
3 Just be like you've been, just paying attention to
4 the meeting because you're going to hear people from
5 both sides. So I appreciate that.

6 So moving forward, due to the number of
7 appearance cards that we have, you're going to be --
8 I'm going to limit everybody to 30 seconds.

9 Now, 30 seconds doesn't sound like a lot of
10 time, but I sat through many of these meetings
11 before. And when you have this many appearance
12 cards, 30 seconds with each person indeed gets
13 everybody's message across.

14 So please, what I ask you to do is continue
15 to pay attention as you have through the Committee
16 thus far. You'll hear somebody speak prior to your
17 opportunity to speak. If they say what you were
18 already going to say, you can waive either in an
19 opposition or support or make another point.

20 I mean, you probably, if you have multiple
21 points and your point has already been made, feel
22 free to make an additional point and feel free to
23 come forward.

24 I'm going to call somebody to begin
25 speaking, and then I'm going to call a second name

1 and that individual will be the on-deck individual.

2 And we're going to continue the entirety of the rest
3 of the meeting on appearance cards in that manner.

4 So when you hear your name called as first
5 person is going to be Jonathan Weber. So if
6 Jonathan Weber would like to begin to approach the
7 podium, and Madison Murphy is on deck.

8 So Madison, if you'll go directly -- if
9 Madison is still here, there's a clock directly
10 across from me. And does anybody know Madison
11 Murphy? Madison Murphy. Fabulous.

12 Madison, if you'll come back underneath the
13 clock there, and we'll continue. When Madison comes
14 forward, I'll say the next person on deck. And if
15 you'll go back there, that will keep us moving.

16 Jonathan Weber, you are recognized.

17 JONATHAN WEBER: Thank you so much.

18 Jonathan Weber. I'm the Florida Policy Director for
19 the SPLC Action Fund. I urge you to vote no on this
20 bill.

21 I'm the father of a 10-year-old, and like
22 all parents, my wife and I only want our child to go
23 to the doctor for his annual checkups. And I only
24 want to hear that he's healthy and happy.

25 I want nothing more than to keep my child

1 and all children safe. But I assure you that if any
2 medical issue prompted a doctor to recommend
3 treatment, I would listen intensely.

4 Then together with my child, we'd plot a
5 course of action based on medical advice given to us
6 by our doctors.

7 The State of Florida should not be a wall
8 between parents, medical providers, and trans youth.
9 This bill will -- thank you.

10 CHAIRWOMAN BURTON: Excuse me, Mr. Weber.
11 I'm sorry. Your time's up. Thank you for being
12 here today.

13 Madison Murphy -- excuse me -- followed by
14 Cielo -- and I'm so sorry, S-u-n-s-a-r-a-e, you'll
15 be on deck if you're here.

16 Madison Murphy, you're recognized.

17 MADISON MURPHY: Thank you, madam. It
18 doesn't take being transgender to be able to have
19 respect for other human beings.

20 Even if you don't understand someone, they
21 still have the right to give consent to live their
22 lives the way they see it.

23 Yes. There are some complications, there
24 are complications like that seen in almost any
25 choice you make in your life. But taking away the

1 ability for someone to consent to medical
2 procedures, to live their life, to have dignity, to
3 be treated with dignity by the law is not something
4 you can take lightly.

5 CHAIRWOMAN BURTON: Thank you.

6 MS. MURPHY: Just because you don't
7 understand doesn't mean you don't have to act well.
8 Thank you.

9 CHAIRWOMAN BURTON: Cielo, and I apologize
10 if I -- followed by Alexis Williams.

11 When you come to the podium to speak,
12 please state your name because I'm going to
13 mispronounce. I apologize in advance some, but go
14 ahead and state your name.

15 CIELO SUNSARAE: My name is Cielo Sunsarae.

16 CHAIRWOMAN BURTON: Thank you.

17 CIELO SUNSARAE: I'm a trans individual in
18 Florida. I just want to say, you guys who sponsor
19 this bill and vote for it, you fear our fabulous and
20 gay selves, our resilient trans lives. But more
21 importantly, you fear standing on the human right
22 side of history because your puppet strings will be
23 cut. And that fear empowers me and everyone here
24 today. But there's actually more than 200 people
25 here.

1 These are the names of over 1000 trans
2 people and allies here. And SB 254 impacts these
3 lives --

4 CHAIRWOMAN BURTON: I'm sorry. We ask that
5 you not display shirts, clothing with messages on
6 them as well. I should have been more specific in
7 my things we can't do. Thank you very much.

8 Alexis Williams?

9 It's just for everybody else coming up
10 forward. We we won't do that. Alexis Williams,
11 followed by Mauricio Marena.

12 And I hear -- and I apologize. You're
13 recognized.

14 ALEXIS WILLIAMS: Hi, everybody. It is
15 easier for my mother to receive addictive
16 painkillers that are killing her than a trans
17 individual to receive reversible gender-affirming
18 care.

19 I'm watching my mother with her way, and
20 we're here worried about -- we're worried about
21 people trying to feel at home in their bodies rather
22 than an opioid addiction in the United States.

23 So I ask that: what are you protecting?
24 What are you protecting children and adults from
25 rather than your personal opinions and biases?

1 CHAIRWOMAN BURTON: Thank you.

2 ALEXIS WILLIAMS: Thank you.

3 CHAIRWOMAN BURTON: Mauricio Marena and I
4 -- you all, please state your name, followed by
5 Ronnie Angelique. And Ms. Ronnie Angelique is here.
6 Go back -- if you'll go back here where the --

7 MAURICIO MARENA: My name is Mauricio --

8 CHAIRWOMAN BURTON: You're recognized.

9 MAURICIO MARENA: My name is Mauricio
10 Marena. And I just want to say that it is a
11 scapegoat to say that HRT is being -- or is
12 preventing, basically, dangers to other individuals
13 in terms of side effects, because anytime you go
14 ahead and see a medication that's introduced on TV,
15 they tell you the side effects.

16 These practitioners also tell you the side
17 effects, and you already, at any medication you
18 take, have to consent for this because you have to
19 acknowledge what you're taking.

20 CHAIRWOMAN BURTON: Thank you. Thank you
21 for coming.

22 Ronnie Angelique, followed by Mary Eakins-
23 Durand.

24 RONNIE ANGELIQUE: Hello, to everyone on
25 the Board. My name is Ronnie Angelique, and I'm a

1 black Latina trans woman. And I'm the success story
2 that you all miss.

3 I started my hormones here in Florida. I
4 got my life together. I became a master's degree of
5 psychology educated person. And I'm currently
6 pursuing my PhD in psychiatry.

7 I'm the thing that you are missing. So
8 look at me and understand. I have been living my
9 life as a woman for over 10 years, and I have a
10 successful life. And I teach children, and I change
11 the world day by day in my colloquial community in
12 Tampa, Florida. So look at me and remember this
13 face --

14 CHAIRWOMAN BURTON: Thank you.

15 RONNIE ANGELIQUE: -- because this is the
16 face that you're denying a future of your children.

17 CHAIRWOMAN BURTON: Mary Eakins-Durand,
18 followed by Robin Witt.

19 Ladies and gentlemen, no clapping, please.

20 Mary -- is there -- is Mary Eakins-Durand
21 here? Anybody know? I don't think so. No? Yes.

22 Robin Witt? Are you Robin Witt? Robin
23 Witt, followed by Jess Hunt.

24 Jess Hunt is here. If you'll go underneath
25 the clock in the back, that would be great.

1 You're recognized.

2 ROBIN WITT: Okay. My name is Robin Witt.
3 Good afternoon. So I'm an electrical engineer. I
4 work at Kennedy Space Center. I work as a
5 contractor for the Artemis program, and I'm also a
6 transgender woman.

7 Senate Bill 254 would severely restrict my
8 access to hormone replacement therapy as an adult
9 trans woman. If I can't find a doctor approved to
10 provide me care under this bill, I'll be forced to
11 look out of state for healthcare.

12 This bill tells me that Florida does not
13 appreciate me nor want me here.

14 I don't want to leave Florida, but I won't
15 live where I'm not wanted.

16 CHAIRWOMAN BURTON: Thank you for being
17 here.

18 ROBIN WITT: Yeah.

19 CHAIRWOMAN BURTON: Jess Hunt?

20 Excuse me, Robin Witt. Senator Book has a
21 question. Yes.

22 SENATOR BOOK: Thank you.

23 ROBIN WITT: Yes.

24 SENATOR BOOK: And certainly, we were
25 talking about making sure that people have access as

1 adults to healthcare --

2 ROBIN WITT: Yes.

3 SENATOR BOOK: -- and the use of
4 telehealth. How far, if you don't mind sharing, do
5 you have to drive to get your prescriptions filled
6 from your doctor?

7 CHAIRWOMAN BURTON: You're recognized.

8 ROBIN WITT: Okay. Out of state it would
9 likely be Virginia.

10 SENATOR BOOK: And currently, would you
11 just -- do you call your doc? Like how far away?

12 ROBIN WITT: Currently, I get it in
13 downtown Orlando.

14 SENATOR BOOK: Great. Thank you.

15 ROBIN WITT: Thank you.

16 CHAIRWOMAN BURTON: Thank you.

17 Jess Hunt, followed by Ted McCulligan
18 (phonetic). And Jess Hunt, you're recognized.

19 JESS HUNT: Thank you. I'm a librarian, a
20 Unitarian Universalist minister, a non-binary human.
21 And most importantly, I'm a parent of four children,
22 one of whom is transgender.

23 This bill denies me and my family our basic
24 humanity, our pursuit of happiness, and infringes
25 our religious liberty.

1 This bill comes between me, my child, her
2 pediatrician, her psychologist, and her
3 endocrinologist, an entire team of highly trained,
4 professionally certified medical professionals from
5 across the state that are helping me and my child
6 determine what the current, most advanced, best
7 practices are available to her.

8 This is my due diligence as a parent to
9 seek the advice, counsel, and expertise.

10 CHAIRWOMAN BURTON: Thank you.

11 Ted McCulligan and I apologize in advance.
12 Sam Sharf will be on deck. You're recognized.

13 TODD MCCULLIGAN: Yes, ma'am. My name is
14 Todd McCulligan. I'm a 56-year-old veteran. I
15 served from 1984 to 1988.

16 I just came out as trans and will be
17 getting gender-affirming care from the VA. But I
18 can't tell you what would have happened had I gotten
19 it when I was younger.

20 I would have not been an alcoholic. I
21 would have not had a drug addiction. I -- there are
22 a lot of things in my life wouldn't have happened.
23 High blood pressure at age 10 because of the stress.
24 Thank you. That's all I have to say.

25 CHAIRWOMAN BURTON: Thank you for coming.

1 Sam Sharf, followed by Kaitlynn Danehy-Samitz. You
2 are recognized.

3 SAM SHARF: Hi. I was once a trans youth,
4 and now I'm a happy 22-year-old trans adult student
5 at New College of Florida. This is my healthcare.

6 CHAIRWOMAN BURTON: Ma'am -- okay.

7 SAM SHARF: Don't tread on it.

8 CHAIRWOMAN BURTON: Kaitlynn Danehy-Samitz,
9 followed by -- I don't have a complete name. It
10 says Lisa and then initial O. So you're recognized.

11 KAITLYNN DANEHY-SAMITZ: Okay. Kaitlynn
12 Danehy-Samitz, vice president founder of Women's
13 Voices of Southwest Florida. I hope my time starts
14 after I say my name.

15 In Ron DeSantis' oasis of freedom and
16 parental rights, your freedom and parental rights
17 are dependent on whether or not Ron DeSantis
18 approves of your genitals.

19 Senator Yarborough has militarized the
20 Florida GOP into the genital gestapo. Ron DeSantis
21 wants trans people dead, trans kids, and trans
22 adults.

23 You have put targets on the backs of
24 Florida's queer community and state legislators are
25 putting guns into the hands of people who want us

1 dead.

2 From every angle and opportunity, you are
3 committing genocide. You've betrayed your oath to
4 office. You've betrayed your most vulnerable
5 constituents for the sake of --

6 CHAIRWOMAN BURTON: Thank you.

7 KAITLYNN DANEHY-SAMITZ: -- 2024 campaign,
8 and you're the fourth --

9 CHAIRWOMAN BURTON: Lisa, you're next,
10 followed by Jake with the initial L. So Lisa O.
11 Can you spell that for me, please?

12 LISA ODENA: O-d-e-n-a.

13 CHAIRWOMAN BURTON: O-d-e-n-a. You're
14 recognized.

15 LISA ODENA: Okay. Thank you. I just
16 wanted to go over something that Senator Yarborough
17 said, which is he said something about the AACE.
18 I'm reading their website right now, and it says,
19 "We strongly oppose legislation that criminalizes
20 physician and other health professionals who provide
21 medically appropriate endocrine care as recommended
22 by established medical guidelines.

23 The Endocrine Society of AACE have
24 published peer-reviewed evidence-based guidelines
25 and support endocrine care for transgender and

1 gender-diverse patients. Criminalizing provision of
2 endocrine care will further increase the health
3 disparities of very vulnerable population." Again,
4 this is what Senator --

5 CHAIRWOMAN BURTON: Thank you.

6 LISA ODENA: -- Yarborough said.

7 CHAIRWOMAN BURTON: Jake L. and if you
8 could tell me your last name, please?

9 JAKE L.: I don't feel comfortable or safe
10 doing that.

11 CHAIRWOMAN BURTON: Spell it.

12 JAKE L.: Oh, I'm not going to say my last
13 name.

14 CHAIRWOMAN BURTON: Okay. You're
15 recognized.

16 JAKE L.: Yeah.

17 CHAIRWOMAN BURTON: Excuse me, followed by
18 Linda Roberts.

19 JAKE L.: Okay.

20 CHAIRWOMAN BURTON: Now you're recognized.

21 JAKE L.: I'm a transgender and recent
22 astrophysics graduate from Florida Tech. As a
23 child, I was unable to receive gender-affirming
24 healthcare and was on the edge of committing
25 suicide. My dad fought for joint custody of me so I

1 could receive this life-saving gender healthcare.

2 Hadn't he done this, I wouldn't be here today.

3 Gender-affirming care is life-saving. If
4 you vote yes -- vote yes, and if you vote no, you're
5 ignoring the large consensus of the medical
6 community.

7 If people who are trans have access to
8 hormone blockers, then they will not have to go
9 through unnecessary trauma and surgeries --

10 CHAIRWOMAN BURTON: Thank you.

11 JAKE L.: -- such as top surgery. You will
12 be held accountable.

13 CHAIRWOMAN BURTON: Linda Roberts, followed
14 by James Harper -- James W. Harper.

15 LINDA ROBERTS: Thank you. Linda Roberts
16 --

17 CHAIRWOMAN BURTON: You're recognized. Uh-
18 huh (affirmative).

19 LINDA ROBERTS: -- transgender woman. I
20 challenged the characterization of this treatment as
21 experimental, the leading healthcare organization,
22 several that endorse it. The World Pathological
23 Association for Transgender Health has been putting
24 out standards of care for 45 years dealing with
25 this.

1 When you talk about the risks of treatment,
2 don't forget the risks of depression, higher rates
3 of suicide and anxiety for those who were denied
4 treatment, and the issue of procreation, which there
5 are --

6 CHAIRWOMAN BURTON: Thank you.

7 LINDA ROBERTS: -- alternatives.

8 CHAIRWOMAN BURTON: Thank you. James
9 Harper, followed by Scott Mena. You're recognized.

10 JAMES HARPER: Thank you. I'm James
11 Harper, and I just want to say what the world needs
12 now is love, sweet love. And I want you to keep
13 singing that song in your heads until you get it
14 straight. That this is based on hate, and it's
15 causing suffering for innocent people who did
16 nothing except be born the way they were born.

17 CHAIRWOMAN BURTON: Scott Mena, followed by
18 Trey-Shawn Perez. Is Trey-Shawn Perez here? I
19 really need people to be lining up if you're here.

20 You're recognized.

21 SCOTT MENA: Hello, I'm Scott Mena. I have
22 seen family. I have also seen friends that have
23 been affected by this, and the fear that's coming
24 through them because of these things that are
25 happening.

1 I'm in a community that this is very
2 important to them, and I know that with us standing
3 together and not pushing this into families and
4 lives, it will definitely bless a lot of people if
5 you don't push this into their lives. Please help
6 them.

7 CHAIRWOMAN BURTON: Trey-Shawn? Thank you.
8 Trey-Shawn Perez, followed by Fiona Rawls.

9 Fiona Rawls is here. If you could come
10 underneath the clock, that would be great. You're
11 recognized.

12 TREY-SHAWN PEREZ: Hi, my name is Trey-
13 Shawn Perez, and I'm a U.S. Army veteran. I'm also
14 an Iraq veteran and I'm also trans.

15 You take away my healthcare, you will also
16 take away the healthcare during the veteran system
17 because the veteran system is not up to date. So if
18 you take away that, you're going to take away my
19 life. And I attempted that at seven.

20 So you're going to have a lot of lives
21 that's going to be on the line with mental health
22 issues because I've already dealt with it for 30
23 years. I don't want to deal with it anymore, so
24 please help.

25 CHAIRWOMAN BURTON: Thank you. Fiona

1 Rawls, followed by Nathan Bruemmer.

2 You're recognized.

3 FIONA RAWLS: Thank you very much. I'm
4 Staff Sergeant Rawls from West Palm Beach, Florida.
5 The Pope says it is a sin to criminalize
6 homosexuality.

7 Matthew 19:12 guarantees my right to be
8 transgender. And being transgender is the highest
9 form of religious freedom.

10 Don't tell me you care about children when
11 you hire back the coward cop from the Parkland
12 shooting with back pay. Don't tell me you care
13 about children when Sheriff Ric Bradshaw, Palm Beach
14 County had a child's circumcised against his
15 mother's wishes. And don't tell me you care about
16 children when Joel Greenberg gave the world the
17 receipts with Venmo on our Governor's --

18 CHAIRWOMAN BURTON: Thank you --

19 FIONA RAWLS: -- best friend Matt Gaetz.

20 CHAIRWOMAN BURTON: Thank you, Fiona.

21 Nathan Bruemmer?

22 Ladies and gentlemen, I'm going to ask you
23 to keep your comments respectful to everybody.

24 Nathan Bruemmer, followed by Colin (phonetic), last
25 initial is B. You're recognized.

1 NATHAN BRUEMMER: Thank you. Senators, you
2 clearly hear the passion and the hearts of the folks
3 in front of you. I would like to appeal to the
4 spirit of compromise that is what this country was
5 founded on, especially as a former public official.

6 I'd like to revisit the conversation on
7 telehealth. If open to that, Senator, I'd like to
8 be able to be available to discuss some of those
9 things, please.

10 There are things here that are hard, but
11 there's some things that I think with a little bit
12 of conversation and education, we can move some of
13 the things and make this a little bit easier because
14 this is going to be remarkably hard --

15 CHAIRWOMAN BURTON: Thank you.

16 NATHAN BRUEMMER: -- for Floridians. Thank
17 you.

18 CHAIRWOMAN BURTON: Colin? And again, I
19 apologize of mispronouncing your name, last initial
20 B. J. Marie Bailey on deck. You're recognized.

21 COLIN B.: Thank you, Madam Chair. I'm
22 actually here to share a testimony for Allie M. who
23 couldn't make it though.

24 I will say I'm glad that she didn't drive
25 here five hours through a storm to pour her heart

1 out for -- so that she could be cut off at 30
2 seconds.

3 If you expect trans people to extend you
4 politeness in the attempt of our extermination, you
5 won't get it. We will not shrink ourselves for you.
6 We will not change to make you comfortable, and we
7 will not apologize for living authentically, not
8 now, not ever.

9 We will not exist in a system that attempts
10 to define us for who we are for us. We will live as
11 --

12 CHAIRWOMAN BURTON: Thank you.

13 COLIN B.: -- we are for ourselves.

14 CHAIRWOMAN BURTON: J. Marie Bailey,
15 followed by Jessica Wilson. You're recognized.

16 J. MARIE BAILEY: Thank you. Good
17 afternoon, senators.

18 Good afternoon, Senator Yarborough. Hi.
19 I'm a trans parent, nice to meet you, so you can
20 finally meet one of us. My son has said even now --

21 CHAIRWOMAN BURTON: Excuse me ladies and
22 gentlemen -- would you stop the timer for a second.
23 I don't want you to use up your time.

24 Ladies and gentlemen, we are not going to
25 respond with noise to comments made by anybody. You

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1 -- we've been great so far. Let's keep it up. And
2 also when you come up to speak, I would prefer if
3 you not send comments directly to members of the
4 Committee --

5 J. MARIE BAILEY: Oh, I apologize.

6 CHAIRWOMAN BURTON: -- address the entire
7 Committee.

8 J. MARIE BAILEY: Okay. It's very nice to
9 meet all of you.

10 CHAIRWOMAN BURTON: You're recognized.

11 J. MARIE BAILEY: Oh, I apologize. It's
12 very nice to meet all of you. I have heard in the
13 past two hours amazing testimony and people saying
14 how much they care about the healthcare of
15 Floridians. That everyone needs access to
16 healthcare with the diabetes. And even Dr. Ladipose
17 (phonetic) said, "I believe in taking care of your
18 mind and soul." This doesn't add up to everything
19 that you all are working so hard for. Please work
20 for us like you say you are. Thank you.

21 CHAIRWOMAN BURTON: Thank you.

22 Jessica Wilson, followed by Judy Schmidt.

23 Judy Schmidt is here. Please come
24 underneath the clock. Good afternoon or evening.
25 You're recognized.

1 JESSICA WILSON: My name is Jessica Wilson.
2 I'm a mother of trans son who committed -- attempted
3 suicide, was diagnosed gender dysphoria in the
4 hospital and was given mind altering medication
5 against his consent as well as mine. This happens
6 all the time.

7 Mental health medication is given that
8 gives lifelong permanent changes to the brain, and
9 nobody's restricting that. This is transphobic,
10 plain, and simple. It's the same. You want to
11 compare apples to apples?

12 CHAIRWOMAN BURTON: Judy Schmidt. On deck
13 with Trey-Shawn Perez. Did we already hear from
14 Trey-Shawn or is that on the amendment?

15 Trey-Shawn Perez, you're up again. Unless
16 you already spoke.

17 I'm sorry. You're recognized. Just trying
18 to make sure everybody gets their chance. You're
19 recognized.

20 JUDY SCHMIDT: Thank you. I'm Judy Schmidt
21 and thank you for the opportunity to speak.

22 Everybody has really said things that I
23 would want to say, but I do want to say I'm the
24 parent of a transgender child who is almost eight
25 years old. And we are at the beginning of our

1 journey. And what you're doing is taking away life-
2 saving potential opportunity for me and my family.

3 A decision that should be made between me
4 and my healthcare professionals and my therapist
5 that work with my child and criminalizing gender-
6 affirming care is going to hurt my son more than a
7 puberty blocker will.

8 CHAIRWOMAN BURTON: Thank you. Trey-Shawn
9 Perez. I think Trey-Shawn Perez spoke on the
10 amendment. If you're still here -- I don't see
11 them. He is -- Trey-Shawn Perez is against the
12 bill.

13 Sophia Amber James (phonetic), followed by
14 Kerry Burner. Sophia Amber James? And if Kerry
15 could please get her at the clock to start. That'd
16 be great. You're recognized.

17 SOPHIA AMBER JAMES: Good afternoon, Chair
18 and panel members. I'm a retired master sergeant
19 Sophia A. James, son, daughter, father, mother,
20 husband, wife, peacekeeper, peace seeker, human
21 being.

22 To this stage of life, I've been in and
23 perform many roles as many of us have. Do you
24 agree? My most recent stage of life, I'm 53-year-
25 old transgender woman. I'm speaking in an

1 opposition to SB 254 because I was also once a
2 transgender child. What you're doing will not help
3 the child.

4 CHAIRWOMAN BURTON: Thank you. Kerry
5 Burner or Burner, followed by Rehn, R-e-h-n. I'm
6 sorry. I think the last name --

7 KERRY BURNER: It's Burner-Reeves.

8 CHAIRWOMAN BURTON: Thank you, ma'am. Rhen
9 Burner-Reeves. So Kerry? Yes.

10 KERRY BURNER: My name is Kerry Burner.

11 CHAIRWOMAN BURTON: You're recognized.

12 KERRY BURNER: I find this bill to be an
13 extreme overreach. I grew up in Germany in the
14 aftermath of Nazis, and what you people are doing is
15 no different. It is transphobic. It is cruel, and
16 you really should be ashamed.

17 CHAIRWOMAN BURTON: Rehn Burner-Reeves,
18 followed by Ann Burner-Reeves. You're recognized.

19 REHN BURNER-REEVES: I waive against the
20 bill.

21 CHAIRWOMAN BURTON: You're against the
22 bill.

23 Ann Burner-Reeves, followed by D. Paul
24 Robinson.

25 ANN BURNER-REEVES: My name is Ann Burner-

1 Reeves, and I waive against the bill.

2 CHAIRWOMAN BURTON: Against the bill.

3 D. Paul Robinson, followed by Vance Arons
4 (phonetic). You're recognized.

5 D. PAUL ROBINSON: I just wanted to make a
6 quick point that, again, these therapies are not
7 experimental. They've been around for a long time.
8 The puberty blockers are not permanent. And please
9 remember that one side effect of not doing this care
10 is suicide.

11 Suicide rates or suicide attempts are twice
12 as much in children who are transgender and not
13 treated as those who are -- do not have that
14 condition. Please don't pass this bill.

15 CHAIRWOMAN BURTON: Vance Arons, followed
16 by Mason Manion. You're recognized.

17 VANCE ARONS: Thank you, Chair. I'm Vance
18 Arons. I'm in opposition to this. Those that have
19 put it forward have stated that there's no research
20 on this. There is -- just this year in the Journal
21 of American Medicine, there was a two-year study
22 showing how this is beneficial and improves the
23 lives of transgender people.

24 I guarantee none of you on the GOP, though,
25 is going to actually listen to this. You're all

1 going to continue with the genocide that DeSantis
2 wants to put on this.

3 CHAIRWOMAN BURTON: Thank you.

4 Mason Manion, followed by Paula Pifer.
5 You're recognized.

6 MASON MANION: Good evening. My name is
7 Mason Manion, and my best friend is here with me
8 today. And I've seen what gender-affirming care has
9 done in their life. This allows them to be the
10 person they always were inside.

11 They're happy and successful. Why would we
12 deprive human beings from care that allows them to
13 live authentic, happy lives? It's cruel.

14 Passing this harmful legislation is taking
15 us backwards and harming real human beings.

16 Please remember that when you are writing
17 these bills and voting on these bills, you are
18 affecting real human beings. This is an attempt to
19 erase a community, and you will not succeed. Thank
20 you.

21 CHAIRWOMAN BURTON: Thank you.

22 Paula Pifer, followed by -- Dr. Robinson
23 already spoken -- followed by Regina -- I want to
24 say Longs or Lovings. I -- sorry. I can't read
25 Regina's last name.

1 Paula? Yes. You're recognized.

2 PAULA PIFER: Thank you. My daughter,
3 Hunter Pifer is a model pictured in this month's
4 March 2023 Vogue magazine dressed in Valentino. She
5 is as beautiful on the inside as she is on the
6 outside. You would never know that this young woman
7 was born in the wrong body.

8 Hunter at age 15 was able to be part of the
9 first generation of transgender kids here in the
10 United -- in Florida to receive life-saving medical
11 care.

12 She completed her transition from male to
13 female at the age of 18. She's now 23. She just
14 walked for Prada.

15 CHAIRWOMAN BURTON: Thank you.

16 PAULA PIFER: Thank you.

17 CHAIRWOMAN BURTON: Regina Longs or Lovings
18 or Loweis in opposition, waiving opposition.

19 Ginger Maso -- Major (phonetic), followed
20 by the Reverend Bromleigh McCleneghan.

21 You are Ginger? Ginger is waiving
22 opposition.

23 Is the Reverend McCleneghan here? Followed
24 by Meg Titcomb. You're recognized.

25 REVEREND MCCLENEGHAN: Thank you. I'm the

1 Reverend Bromleigh McCleneghan. I serve as the
2 coordinating minister at the United Church of
3 Gainesville. And I have always had great faith in
4 my elected leaders, despite the fact that I grew up
5 in Chicago where we, you know, vote early and often.

6 But nevertheless, I am dismayed as a
7 religious leader by this bill and the way that it so
8 refutes the great and, I think, universal truth,
9 that Jesus speaks, that the truth will set you free.
10 There is so much mischaracterization --

11 CHAIRWOMAN BURTON: Thank you.

12 REVEREND MCCLENAGHAN: -- in this bill.

13 CHAIRWOMAN BURTON: Meg Titcomb followed by
14 Javier Gomez. You're recognized.

15 MEG TITCOMB: Thank you. Good evening.
16 I'm the proud parent of the non-binary teen. I'm
17 here today along with my child in Equality Florida
18 to stand up and support for all transgender
19 Floridians, their parents, and their healthcare
20 providers. Without gender-affirming healthcare, I'm
21 quite certain I'd be visiting my child in a cemetery
22 today rather than visiting you all here at the
23 Capitol.

24 As a mother and as a concerned citizen, I'm
25 begging you to oppose SB 254, which criminalizes

1 gender-affirming care. Thank you.

2 CHAIRWOMAN BURTON: Thank you.

3 Javier Gomez followed by Alastor Vergalh.

4 JAVIER GOMEZ: I had a whole testimony
5 planned, but I would just say this and let it be
6 known.

7 As a cisgender person, which I believe all
8 of you are, don't ever tell a trans person, "Be
9 respectful with your testimony," when you're all
10 attempting trans genocide. Treat others how you
11 want to be treated. It's that simple. Thank you.

12 CHAIRWOMAN BURTON: Alastor. Is there
13 somebody -- it looks like A-l-a-s-t-o-r, V-e-r-g-a-
14 l-h is what this last name looks like. Does that
15 sound familiar to anybody? I'll hold it in case
16 they come back.

17 Vince Cuadra, followed by Jared, last name
18 first initial R. Anybody named Vince? First name
19 Vince? No. I'm sorry. Is there Vince?

20 Are you Jared? Okay. Jared, followed by
21 -- we'll let Jared proceed up, followed by Kelly
22 Everling.

23 You're recognized.

24 JARED REYNOLDS: Hi, there. My name is
25 Jared Reynolds. Sorry. I'm not a public speaker.

1 I'm not accustomed to this, but I will say this. I
2 have many stories, and I wish I had more than 30
3 seconds to explain them. But what you are doing by
4 signing this bill is an act of war. You are trying
5 to kill my people, and it will not go lightly.

6 The way it is as it is now, my people will
7 die, and that blood, if you support this bill, will
8 be on your hands. Thank you.

9 CHAIRWOMAN BURTON: Kelly Everling --
10 excuse me -- followed by Lilith Black.

11 REVEREND KELLY EVERLING: Good evening,
12 Reverend Kelly Everling.

13 CHAIRWOMAN BURTON: Sorry. You're
14 recognized.

15 REVEREND EVERLING: Thank you. It was said
16 earlier in this meeting that healthcare needs to be
17 accessible to all. I believe that is the case for
18 our children, and I believe that is the case for our
19 LGBTQ plus community.

20 I have two trans members that I serve in my
21 context as a pastor. And I have seen the real
22 change in self-actualization when care is received
23 as well as the harm that is caused when gender-
24 affirming care, both healthcare and personal care,
25 is denied.

1 I would urge you to vote no on this bill
2 today. Thank you.

3 CHAIRWOMAN BURTON: Thank you.

4 Lilith Black, followed by Aaron DiPietro.
5 You're recognized.

6 LILITH BLACK: Every --

7 CHAIRWOMAN BURTON: One moment please,
8 Lilith. Let's make sure he's okay. Well, make sure
9 he's okay.

10 Somebody please assist him, please.

11 LILITH BLACK: Every 45 seconds --

12 CHAIRWOMAN BURTON: You're recognized.
13 We'll start now.

14 LILITH BLACK: Thank you. Every 45
15 seconds, a trans person makes an attempt on their
16 life, meaning that one happened every two speakers
17 that you saw this very moment.

18 Ten years ago, that was me and one year ago
19 that was one of my siblings. And tomorrow it will
20 be the children of people in this room.

21 Your vote on this bill determines if that
22 45 seconds becomes 30. Thank you.

23 CHAIRWOMAN BURTON: We'll wait to see if
24 Aaron is able to come back.

25 Rain Johnson, I believe, followed by

1 Aurelie Colon.

2 I'm sorry. Aaron DiPietro. I hope you're
3 okay. You're recognized.

4 AARON DIPIETRO: Thank you, Chair. My name
5 is Aaron DiPietro. I'm the Legislative Affairs
6 Director for the Florida Family Policy Council. And
7 we rise in support of this legislation.

8 Every child deserves a natural childhood,
9 one that allows them to experience puberty and other
10 natural changes that will shape what they become.

11 Children should not be pushed to receive
12 experimental treatments that can leave them
13 permanently sterile and physically marred for life.

14 Children are unable to comprehend and fully
15 appreciate the risks in life implications, including
16 permanent sterility that result from these puberty
17 blockers, cross-sex hormones, and drastic surgical
18 procedures.

19 We encourage you to support this bill in
20 order to protect the children of the state of
21 Florida.

22 CHAIRWOMAN BURTON: Thank you.

23 AARON DIPIETRO: Thank you.

24 CHAIRWOMAN BURTON: Rain Johnson, followed
25 by Aurelie Colon Larrauri. And you are Rain

1 Johnson?

2 RAIN JOHNSON: Uh-huh (affirmative).

3 CHAIRWOMAN BURTON: You're recognized.

4 RAIN JOHNSON: Today I represent more than

5 one trans person. I represent my uncle. I

6 represent my friends. I represent every single of

7 friend that I've had that was ever trans.

8 Every time that I look at you guys in this

9 Committee, I realize more and more that you guys

10 want to commit trans genocide, and that our blood is

11 on your hands. Thank you.

12 CHAIRWOMAN BURTON: Aurelie Colon, and I'm

13 going to let you pronounce your whole name, please.

14 Amil Fox (phonetic) supposed to be on deck.

15 You're recognized.

16 AURELIE COLON LARRAURI: Hi. My name is

17 Aurelie Colon Larrauri. My pronouns are she and

18 they, and I'm the Florida State Policy Advocate for

19 the Latina Institute for Reproductive Justice

20 Florida. I'm also a genderqueer gay person here in

21 solidarity with my trans and gender-diverse

22 siblings.

23 The reproductive justice framework is

24 rooted in the belief that all individuals and

25 communities should have the resources and power they

1 need to make their own decisions about their bodies,
2 gender, sexualities, families, and lives. LGBTQ
3 justice is reproductive justice. Trans people are
4 humans, and they don't owe you your trauma to be
5 seen as humans. Thank you, and I oppose this bill.

6 CHAIRWOMAN BURTON: Amil Fox, followed by
7 Kim Moore.

8 And you're recognized.

9 AMIL FOX: Ignorance can develop into hate
10 because it's frustrating not to understand people.
11 I'm going to assume the best; that it's not
12 genocide. History tells us that it could be.

13 You're legislators, not doctors. You've
14 never been to med school. How many doctors have you
15 individually spoke to about this? Do you think
16 we're all psychotic? I've been psychotic actually.
17 I've been Baker Acted for a separate disease. It's
18 circular thinking you guys. Maybe bullying causes
19 mental illness.

20 CHAIRWOMAN BURTON: Thank you. Kim Moore,
21 followed by Kimberly Cox.

22 You're recognized.

23 KIM MOORE: Aren't you glad I have an easy
24 name? I'm here as the parent of a transgender
25 child, and one of the things that we dealt with in

1 school was bullying. It happens a lot to
2 transgender children.

3 My child was hospitalized twice for
4 suicidal ideation. And I know that not getting the
5 proper care causes problems.

6 As a parent, I have to make sure that my
7 kid gets medical care. Every time we see a new
8 doctor, there's always a concern, even if it's the
9 dentist, or the pediatrician, or the psychiatrist or
10 the psychologist. You don't know if they're going
11 to support you, and to put this law through is going
12 to make it even --

13 CHAIRWOMAN BURTON: Thank you.

14 KIM MOORE: -- harder.

15 CHAIRWOMAN BURTON: Kim Cox -- Kimberly Cox
16 -- excuse me -- followed by -- I want to say is
17 Zayv, but maybe --

18 KIMBERLY COX: It's Zayd.

19 CHAIRWOMAN BURTON: Zayd.

20 KIMBERLY COX: Is my child.

21 CHAIRWOMAN BURTON: Okay. Kimberly Cox,
22 you're recognized.

23 KIMBERLY COX: I'm Kimberly Cox, and I'm
24 with Women's Voices. And I'm proud mom of that 17-
25 year-old non-binary child that's going to speak

1 next.

2 I'm not an ally. I'm an accomplice. I'd
3 also like to implore you all to remember that less
4 than a week ago, gun laws -- gun law restrictions
5 were loosened. And anyone who thinks it's a good
6 idea to come and take my child, I dare you.

7 CHAIRWOMAN BURTON: Zayd Cox, followed by
8 Amanda Langworthy.

9 You're recognized.

10 ZAYD COX: My name is Zayd Cox. I'm 17
11 years old, and I'm openly and proudly a part of the
12 LGBTQ plus community.

13 I'm fortunate enough to live in a home with
14 parents that love and accept me, but I'm now at risk
15 of being forcibly taken away from them because they
16 accept me.

17 Signing this bill into law is nothing less
18 than a death sentence for trans people like me and
19 the ones I love.

20 CHAIRWOMAN BURTON: Amanda Langworthy, is
21 Amanda here? Followed by Harrison, I want to say,
22 Lundy. It may be Lindy. Hold on one second,
23 please? Thank you. You're recognized.

24 AMANDA LANGWORTHY: My name is Amanda
25 Langworthy. I'm pansexual and non-binary.

1 Being gay and being trans is not an
2 aberration. It's a natural form of existence. Even
3 God in the Bible that so many use against us is
4 trans, non-binary, and gender fluid.

5 I was diagnosed with PTSD at five years
6 old. And why? Because I was forced to feel ashamed
7 of who I am.

8 You say that gender-affirming care is child
9 abuse, even though so many studies prove it's not.
10 Forcing a child to hide who they are, forcing them
11 to feel alone and so distraught from merely
12 existing, that is the child abuse. What you're
13 proposing is child abuse. And I'm living proof of
14 that.

15 CHAIRWOMAN BURTON: Harrison Lundy,
16 followed by Corey Bleakley.

17 You're recognized.

18 MR. LUNDY: Thank you, Madam Chair. I want
19 to use my time to focus on the permission that you
20 are giving disgusting people to do disgusting
21 things. It was disgusting people that have already
22 passed legislation or approved legislation that will
23 arm dangerous transphobic people with the weapons to
24 erase us.

25 You are giving disgusting people permission

1 in this room to come after trans kids and adults,
2 and somehow you are scared to be called transphobic.

3 Also, what kind of surgeon general can't
4 deny the existence of demon sperm? Kind of weird.

5 CHAIRWOMAN BURTON: Corey Bleakley,
6 followed by Lola Smith.

7 I'm going to ask you all to be respectful
8 when you speak please.

9 And you are recognized.

10 COREY BLEAKLEY: My name is Corey Bleakley,
11 and I represent Women's Voices of Southwest Florida.
12 And I'm also the vice president of Social Unity
13 Network.

14 I stand in opposition of Senate Bill 254.
15 This bill is state-sponsored genocide. This bill is
16 going to kill trans kids, and the blood will be on
17 your hands.

18 You told our youth chapter vice president
19 to respect your authority, but I cannot respect the
20 hand that strikes us or the pen that signs our death
21 warrants.

22 And we'll not be silent. Stonewall was a
23 riot, and if this bill passes, you'll be declaring
24 --

25 CHAIRWOMAN BURTON: Thank you.

1 COREY BLEAKLEY: -- war on our trans
2 community.

3 CHAIRWOMAN BURTON: Lola Smith, followed by
4 Seneca Bristol, I believe this is what it is.

5 Lola Smith, you're recognized.

6 LOLA SMITH: I'm Lola Smith. I'm 12 years
7 old. I'm a non-binary. If you pass this bill, many
8 of us will die. I deserve to live as long as all of
9 you. We are humans too.

10 Why are you so afraid of me,
11 Mr. Yarborough?

12 CHAIRWOMAN BURTON: Excuse me. Lola, I
13 asked people not to -- speak to the whole committee.
14 You can continue. Speak to the whole committee.

15 Seneca Bristol, followed by Zaide
16 (phonetic) Smith.

17 You're recognized.

18 SENECA BRISTOL: Can I ask a quick question
19 first?

20 CHAIRWOMAN BURTON: No, ma'am. You may
21 make --

22 SENECA BRISTOL: Oh, okay.

23 CHAIRWOMAN BURTON: -- a statement for 30
24 seconds.

25 SENECA BRISTOL: Sorry. I'm Seneca

1 Bristol, the vice president of the Youth Chapter
2 Women's Voices of Southwest Florida. And I'm here
3 to oppose this bill.

4 Let me make this very clear. Gender-
5 affirming care is not self-harm. It is life-saving.
6 You all makers have shown time and time again they
7 do not care about discrimination. That you only
8 support constitutional rights when suits your
9 agenda.

10 You are afraid of the new generation, plain
11 and simple. But let me remind you that this is land
12 of the free. Advocating for freedom means
13 advocating for the freedom of all individuals,
14 including us young people.

15 Don't hide behind the facade of freedom
16 until we are all truly free. Do not pass this bill.

17 CHAIRWOMAN BURTON: Zaide -- and I'm sure
18 I'm mispronouncing your name, but I think it says
19 Zaide Smith, followed by Theresa Jones.

20 You're recognized. If you would pronounce
21 your name, we do -- I --

22 ZAIDE SMITH: My name is Zaide Smith. I'm
23 here with Women's Voices of Southwest Florida. I
24 would like you to know that we brought children here
25 that came 6 hours and you gave them 30 seconds to

1 speak. That's embarrassing.

2 If our child is being strangled by
3 society's expectations, should we not remove the
4 noose. Calling supportive parents abusive is like
5 watching a person doubt a fire and then complaining
6 about the puddles. We're saving lives, and you are
7 taking lives.

8 You should all be ashamed that we are even
9 having this conversation, nonetheless that you're
10 letting children advocate for their own lives for 30
11 seconds. They're worth more than 30 seconds of your
12 time. I'm ashamed of you. Everyone in this room is
13 ashamed of you, and you should be ashamed of
14 yourself.

15 CHAIRWOMAN BURTON: Thank you. Let's --
16 all right.

17 Ladies and gentlemen, if you clap, I'm
18 going to have to ask you to clap outside this room.

19 Theresa Jones, you're recognized.

20 THERESA JONES: I'm Theresa Jones, and I
21 came from Ocala at three hours, just like everybody
22 else. But this-- let me tell you. God put babies
23 in our bodies. Nobody has the right to play God.

24 I support this bill. And by the way, I
25 heard you, guys, earlier. I'm a fourth-generation

1 black American, and I'm a Republican. We fight for
2 rights, ma'am.

3 This bill is a good bill to protect our
4 children. The government needs to keep their hands
5 off and when they turn 18, they do what they want.
6 Go to college and switch curriculums three times.

7 CHAIRWOMAN BURTON: Thank you, ma'am.

8 THERESA JONES: Thank you.

9 CHAIRWOMAN BURTON: Sarah Parker, followed
10 by George (Indiscernible). Is Sarah Parker here?

11 Sarah Parker, you're up. Yeah. I know you
12 -- I missed you on deck opportunity. I apologize.

13 SARAH PARKER: I was trying to follow rules
14 because we got threatened to be banned forever.

15 CHAIRWOMAN BURTON: Thank you. You're
16 recognized.

17 SARAH PARKER: My name is Sarah Parker.
18 I'm with Women's Voices of Southwest Florida.

19 I know that you don't -- you guys don't
20 like the way that we do things, but I want to remind
21 you, we take notes from the Boston Tea Party. We
22 take notes from the civil rights movement, we take
23 notes from the women's suffrage movement.

24 With that being said, if Dark Brandon and
25 the blue states decided that they were going to get

1 involved in your custody battles because you guys
2 don't want to vaccinate your children or your
3 custody battles because you teach your children vile
4 hate problems, what would you do? And whatever
5 you're thinking you would do times up by 10.

6 You call Women's Voices Southwest Florida
7 daddy now because every child in this room, I am now
8 the parent of. Thank you.

9 CHAIRWOMAN BURTON: Sarah Parker -- you
10 were Sarah Parker. Sorry, Sarah.

11 SARAH PARKER: Always do that --

12 CHAIRWOMAN BURTON: Sorry, Sarah. George
13 (Indiscernible). I don't -- he is not -- he is
14 waiving in support of the bill. Oh, I'm waiving
15 now.

16 Ryan Kennedy, Florida Citizens Alliance is
17 waiving in support of the bill.

18 Jamie Merchant is waiving in support of the
19 bill.

20 Karen Woodall, Florida Center for Fiscal
21 and Economic Policy is waiving against the bill.

22 Barbara DeVane with Florida now is waiving
23 against the bill.

24 Gabe, initial I think it's either an I or
25 L, I'm going to think it's a I, is here. Is Gabe

1 here? Well, Gabe is waiving opposition of the bill.

2 Dalton Vanderford, followed by Leanne

3 Klumb, K-l-u-m-b.

4 And you are recognized.

5 DALTON VANDERFORD: My name is Dalton

6 Vanderford. Choices have consequences. Every

7 single choice you make does not affect your life

8 when you leave this building, but it affects every

9 single person that you are looking out at today and

10 thousands upon thousands upon thousands upon

11 millions in the world just like us. And we are not

12 going anywhere.

13 CHAIRWOMAN BURTON: Leanne Klumb. Here,

14 again, I apologize. So please state your name when

15 you get to the podium. Followed by Kelly Podracky

16 (phonetic).

17 You're recognized.

18 LEANNE KLUMB: Leanne Klumb.

19 CHAIRWOMAN BURTON: Klumb.

20 LEANNE KLUMB: My daughter, Annie, began

21 expressing a desire to dress like a boy from the

22 time she could put words together. The age of one

23 and a half.

24 My now son, Andy, once told me that before

25 he transitioned, he never thought he'd live to see

1 21 because he planned to kill himself.

2 My child did transition and receives --
3 currently receives this affirming care that's life-
4 saving. He's now 25 and finishing graduate school.

5 CHAIRWOMAN BURTON: Kelly Podracky,
6 followed by Alex Stanwood.

7 You're recognized.

8 KELLY PODRACKY: My name is Kelly Podracky.
9 I'm a lifelong resident of Florida, a taxpayer, and
10 a registered voter.

11 My husband and I have four children. Our
12 oldest child is transgender.

13 In his ninth grade year, we found the razor
14 he was using on himself because of gender
15 dysmorphia. He began his transition his ninth grade
16 year of high school. He is now in college on a full
17 academic ride. He is thriving. He is successful.
18 He is happy, and he is whole. I, please, appeal to
19 each of you to think of my child, to think of that
20 razor blade when you are talking about this bill.

21 CHAIRWOMAN BURTON: Thank you.

22 KELLY PODRACKY: It literally saved his
23 life.

24 CHAIRWOMAN BURTON: Alex Stanwood, followed
25 by Lisa, last -- I mean, first initial last name, O.

1 So Alex Stanwood, you're recognized.

2 ALEX STANWOOD: My mother and father had a
3 custody battle when I was a kid. Before he won
4 custody, I stood on a bridge and told the police if
5 I had to go back with my abusive and unaccepting
6 mother, I would jump off the bridge.

7 If this bill had been in place the time I
8 transitioned, my mother got custody of me, I would
9 be dead right now.

10 When we say that our blood is going to be
11 on your hands, this is what we mean. This is
12 genocide, and this is the scars of someone that
13 cannot transition. Don't let this happen to another
14 kid.

15 CHAIRWOMAN BURTON: Lisa, opposed -- waives
16 in opposition. Van Harms, followed by Denise
17 Barber. Is Van here?

18 You're recognized.

19 VAN HARMS: My name is Van Harms. I'm 24.
20 I would not be a 24 if it were not for gender-
21 affirming care. I'd be dead.

22 When I was two, I wanted to kill myself.
23 By the time I was 15, I attempted to slice my own
24 breasts off.

25 I went to the ER because I was bleeding

1 out. How do you conjure that up? How do you
2 explain that? This is a picture of my friend Dakota
3 Ren. Look at it.

4 CHAIRWOMAN BURTON: Van, you need to turn
5 your phone around. We don't bring -- we don't allow
6 pictures.

7 VAN HARMS: She killed herself because of
8 shit like this.

9 CHAIRWOMAN BURTON: Okay. You're excused.
10 Thank you.

11 Denise Barber. Jon Harris Mauer, you'll be
12 on deck.

13 You're recognized.

14 DENISE BARBER: Hi. My name is Denise
15 Barber, and I just wanted to say that I've lived in
16 Northwest Florida 67 years. It's about to be 68,
17 born and raised in Northwest Florida. And the
18 language in this bill is scary. It is horrific.

19 I have a 43-year-old trans son who lives
20 here in Tallahassee. Happy, married, got a kid. I
21 have a 15-year-old trans granddaughter who lives
22 here.

23 I am scared to death for them, scared to
24 death, and wondering if it is time that I leave my
25 home state where I've been --

1 CHAIRWOMAN BURTON: Thank you.

2 DENISE BARBER: -- born and lived all my
3 life.

4 CHAIRWOMAN BURTON: Thank you.

5 Jon Harris Mauer, followed by Melinda
6 Stanwood. You're recognized.

7 JON HARRIS MAUER: Equality Florida
8 fundamentally opposes Senate Bill 254.

9 You cannot pretend this is about parents'
10 rights when it overrides the decisions of affirming
11 parents. You cannot pretend there's a lack of data
12 when there's extensive scientific evidence.

13 You can't pretend this is about protecting
14 people who can't consent when it blocks care for
15 adults.

16 Each of you know a transgender person or
17 her parent. I hope that you will listen to those
18 people, those parents, and the parents you're
19 hearing today before you take this vote.

20 CHAIRWOMAN BURTON: Melinda Stanwood,
21 followed by Claudia Thomas. Claudia Thomas is here.
22 If you'll come underneath the clock, I'd appreciate
23 it. You're recognized.

24 MELINDA STANWOOD: Thank you. My name is
25 Melinda Stanwood. My husband and I are raising six

1 beautiful children together. Two of them are
2 transgender, including my wonderful stepson, Alex.

3 This bill is both vague and hostile to
4 families like ours. Could someone see my child
5 perhaps wearing new clothes or using an unexpected
6 pronoun and decide that my husband and I need to be
7 investigated?

8 It's painfully ironic that parental rights
9 are supposed to be protected in our state for
10 parents while those rights are explicitly denied for
11 parents like myself. At the core of conservative
12 value should be the resistance of this type of
13 government overreach.

14 Why are our conservative leaders in Florida
15 silent --

16 CHAIRWOMAN BURTON: Thank you --

17 MELINDA STANWOOD: -- on this?

18 CHAIRWOMAN BURTON: -- ma'am. Thank you.

19 Claudia Thomas, followed by Ivy Lynch (phonetic).

20 Ivy Lynch is here. Please meet underneath the
21 clock. You're recognized.

22 CLAUDIA THOMAS: Thirty seconds. I'm going
23 to cut to the chase.

24 This bill and many others is not
25 specifically about -- well, it is about what it's

1 about, but the reality is, and you all know it.

2 I'm old enough to remember when parties
3 would submit legislation for good reasons, for
4 things their constituents care about that make
5 sense; taxes, lowering their rent.

6 These are culture awards and you all know
7 it. And I would love to think that there might be
8 one person on this panel who would have the guts to
9 stand up for your party, take it back to --

10 CHAIRWOMAN BURTON: Thank you.

11 CLAUDIA THOMAS: -- the good conservative
12 party used to be and stop with this --

13 CHAIRWOMAN BURTON: Renee Davis will be
14 following Ivy Lynch.

15 And you're recognized.

16 IVY LYNCH: Senators, I urge you to look at
17 all the trans youth in this room and dare you to
18 tell them that they do not deserve healthcare. That
19 they do not deserve to live.

20 Every single one of them in here has
21 considered, is going to attempt, or has attempted
22 suicide, and that blood is on your hands.

23 My name is Ivy. This is my healthcare.
24 Fuck you and trans rights.

25 CHAIRWOMAN BURTON: You're excused.

1 Ladies and gentlemen, we are not going to
2 use what is highly inappropriate language in a
3 professional setting. If it happens, then you will
4 not be invited back to speak at another committee.

5 You're recognized. So Renee Davis,
6 followed by Madison Hilt.

7 RENEE DAVIS: Thank you, Madam Chair. My
8 name is Renee Davis, and I'm a woman who happens to
9 be transgender.

10 And at 2:00 in the morning last night, I
11 drove here in about six and a half hours, and I
12 prepared a large speech. I'm a research scientist,
13 an entrepreneur, a homeowner, a taxpayer here in
14 Florida.

15 Unfortunately, I'm not going to get that
16 time to discuss those things. So instead I want you
17 to just sit here and look at me and realize that
18 we're here. We're trans, and we're not going
19 anywhere.

20 CHAIRWOMAN BURTON: Thank you.

21 RENEE DAVIS: Thank you.

22 CHAIRWOMAN BURTON: Madison Hilt followed
23 by Paul Arons.

24 You're recognized.

25 MADISON HILT: Hello, members. My name is

1 Madison Hilt. I come to speak in opposition of this
2 bill. I would like to read you a section out of the
3 Bible, actually. "Blessed are you, when people hate
4 you and when they exclude you, revile you and defame
5 you on account of the son of man. Rejoice on that
6 day and leap for joy. For surely your reward is
7 great in heaven. For that is how the ancestors
8 treated at their prophets."

9 I'm a deacon in a Baptist church, and I am
10 transgender. You're taking away my choices for
11 healthcare, not just the children's, mine as an
12 adult. Just process that and talk to your trans
13 friends for a minute --

14 CHAIRWOMAN BURTON: Thank you.

15 MADISON HILT: -- okay? Thank you.

16 CHAIRWOMAN BURTON: Paul Arons, followed by
17 Shane Mahoney or -- Shane, last name begins with an
18 M.

19 Paul Aarons, you're recognized.

20 PAUL ARONS: Thank you. Good afternoon.
21 My name is Paul Arons. I've been an MD for 42
22 years, 25 of which were with the Florida Department
23 of Health.

24 This anti-science bill intrudes government
25 controls into private relationships between gender-

1 diverse Floridians and their families and their
2 healthcare providers, many in specialized university
3 environments who have spent whole careers developing
4 sensitive and nuanced expertise.

5 It also violates medical ethics and human
6 rights as is tested by members of the Florida
7 Bioethics Network and the human rights campaign.
8 Please withdraw this ill-advised, life-threatening
9 bill.

10 CHAIRWOMAN BURTON: Shane?

11 PAUL ARONS: Thank you for the opportunity
12 to testify.

13 CHAIRWOMAN BURTON: Could you please
14 pronounce your name?

15 SHANE MAHONEY: Okay, here.

16 CHAIRWOMAN BURTON: Thank you. You're
17 recognized.

18 SHANE MAHONEY: I would really appreciate
19 it if you could say what treatments are happening
20 rather than just sex reassignment treatments.

21 Also, the child exists. They aren't just
22 the parents' plaything. And it is absurd for the
23 state to automatically side with one of the parents
24 over the other because of their opinion on their
25 child receiving gender-affirming care. Also, look

1 at the goddamn photos of the --

2 CHAIRWOMAN BURTON: All right. You're
3 excused.

4 Wendell Bader -- Badey (phonetic), followed
5 by -- I'm sorry. You're welcome to come to the
6 podium, followed by Caroline Pryor.

7 You're recognized.

8 WENDELL BADEY: Chair committee, thank you
9 for having us. Gender dysphoria is real. And WPATH
10 works as mentioned earlier.

11 I would ask that you reject this bill in
12 that why would a parent put their child through what
13 I spent 45 years self-medicating and, you know, some
14 don't make it.

15 I'm a parent. I'm a grandparent. I'd
16 whatever it meant to keep them alive. Thank you.

17 CHAIRWOMAN BURTON: Thank you. Caroline
18 Pryor, followed by Melia Orrell.

19 You're recognized.

20 CAROLINE PRYOR: Good afternoon. As a
21 foster parent, I have seen firsthand the stress of
22 the system on our children, our most vulnerable
23 being those LGBT youth in the foster system.

24 I'm a parent. I am also a queer parent.
25 And attacking trans youth and trans families is

1 wrong, and that is what this bill does.

2 I urge you to oppose this bill, voice
3 support for families that don't look like your own,
4 and to protect trans children and families. Thank
5 you.

6 CHAIRWOMAN BURTON: Thank you. Melia
7 Orrell, followed by Shayani Quinn Cutliffe
8 (phonetic), I believe.

9 You're recognized.

10 MELIA ORRELL: Hi, my name is Melia Orrell.
11 I'm a mother and a foster parent. My daughter is
12 behind me in the stroller.

13 I've seen firsthand the harm done to
14 Florida children when their parents reject them
15 based on their identity, they end up dead, or they
16 end up in the foster care system. At the same time,
17 I've witnessed the life-saving power of accepting
18 children as they are.

19 Gender-affirming care is life-saving care.
20 Affirmative parents and medical professionals save
21 the lives of children. Gender-affirming care should
22 not be criminalized. Affirming and supportive
23 parents should not --

24 CHAIRWOMAN BURTON: Thank you.

25 MELIA ORRELL: -- be penalized.

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1 CHAIRWOMAN BURTON: Thank you. And I'm

2 going to ask you if you would be so kind as to

3 pronounce your name because --

4 SHAYANI QUINN CUTLIFFE: No worries.

5 CHAIRWOMAN BURTON: -- I mispronounced it.

6 SHAYANI QUINN CUTLIFFE: My name is Shayani

7 Quinn Cutliffe.

8 CHAIRWOMAN BURTON: Shayani. Okay.

9 SHAYANI QUINN CUTLIFFE: And I'm a
10 homeowner.

11 CHAIRWOMAN BURTON: (Indiscernible) the
12 time, please.

13 SHAYANI QUINN CUTLIFFE: No worries.

14 CHAIRWOMAN BURTON: On deck -- I'm going to
15 put my on-deck person is Emma Roy.

16 Now, I apologize. You're recognized.

17 SHAYANI QUINN CUTLIFFE: Thank you. I'm
18 not going to spend my time pleading with you guys.
19 I'm just going to say this: if you support this
20 bill, you clearly didn't do your research, and you
21 didn't look at the science behind it; and you didn't
22 talk to the people.

23 I commend you, sister, but that man never
24 answered your questions. Real talk. And the fact
25 that you all can't answer people's real questions,

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1 and the fact that you just sit here and stare at us
2 weirdly tell us all we need to know. You don't want
3 to know us.

4 CHAIRWOMAN BURTON: Thank you.

5 SHAYANI QUINN CUTLIFFE: You just want to
6 be bigots.

7 CHAIRWOMAN BURTON: Emma Roy is followed by
8 Heather Wilkie.

9 You're recognized.

10 EMMA ROY: Emma Roy.

11 CHAIRWOMAN BURTON: You're recognized.

12 EMMA ROY: I'm a trans parent. This law
13 ensures deaths near death and uncertain death from
14 cherry picked data. It violates my parental rights,
15 also human and children's rights.

16 Shame on you for a complete lack of empathy
17 and no conscience. Vote no.

18 Every trans youth, this monstrous law
19 hurts. You are loved and you enrich the world.

20 CHAIRWOMAN BURTON: Heather Wilkie? You're
21 recognized.

22 HEATHER WILKIE: Good afternoon. My name
23 is Heather Wilkie, and I'm a licensed mental health
24 counselor. I'm also a queer woman and a parent of
25 an eight-year-old child.

1 For the past eight years, I've led an LGBTQ
2 youth organization called Zebra Youth in Orlando,
3 Florida, where I've seen hundreds of youth come
4 through our services needing life-saving care, which
5 we've provided.

6 We've been able to take them and help them
7 through gender-affirming care. What we know
8 statistically is that over half of the youth, as
9 indicated here in this room, have attempted suicide
10 in their life if they are gender-variant. I beg you
11 to please stop the nonsense --

12 CHAIRWOMAN BURTON: Thank you.

13 HEATHER WILKIE: -- and please let them
14 live their authentic lives.

15 CHAIRWOMAN BURTON: Annie Filkowski is
16 waiving in support. Stephanie Nolder, National
17 Association of Social Workers is waiving against.
18 Ashley Bailey is waiving in support. Stephanie
19 Nolder is waiving against. Rob Powers is waiving
20 against. Atticus Luby, L-u-b-y, is waiving against.
21 Grayson Powers is waiving against.

22 Jennifer Jane is waiving against. Jessica Powers is
23 waiving against. Hayden B. is waiving against.
24 Darren Ball is waiving against. Nicholas Machuca is
25 waiving against. Annie Filkowski, Florida Alliance

1 of Planned Parenthood Affiliates is waiving against.
2 Charlotte Keaton is waiving against. Parker Keaton
3 is waiving against.

4 I believe it's Cheryl Citeff, C-i-t-e-f-f,
5 is waiving against. Kevin Kempson is waiving
6 against. Cynthia Lacquer is waiving against.
7 Thomas Lober is waiving against. Robert Brown is
8 waiving against.

9 Avery Baylor is waiving against. Yenisbel
10 Vilorio is -- the State Innovation Exchange Action
11 is waiving against. NR Hines, ACLU, Florida is
12 waiving against. Lauren Kelly-Manders is waiving
13 against.

14 Victoria Throop is waiving against. Dana
15 Farmer is waiving against. Brian Marquez waiving
16 against. Jordan Rue waiving against. David Grann
17 with American Atheist, I believe is what it says, is
18 waiving against.

19 Aaron Keith is waiving against. Brittany
20 Williams also with American Atheist, is waiving
21 against. Corey Elaine DeSaaran (phonetic), I
22 believe, is waiving against. Heather McClain is
23 waiving against. Jackson Oberlink is waiving
24 against.

25 Kelsey Kliznik (phonetic), thank you, for

1 the Pat Health is waiving against. K. B. Francis is
2 waiving against. Michael Barrett, Florida
3 Conference of Catholic Bishops, is waiving in
4 support.

5 Billy John Hill Bardof is waiving against.
6 Natalie -- is there a Natalie Fadawn (phonetic) from
7 Miami, Florida?

8 Is there Natalie from Miami in the room?
9 We have a written record that she is waiving
10 against.

11 Mary Green is waiving against. Sylvia
12 Weber is waiving against. Icarus Jasper is waiving
13 against. Luis Rodriguez is waiving against.

14 Raphael Acosta is waiving against. And I
15 have Annie Filkowski, the Florida Alliance of
16 Planned Parenthood Affiliates waiving against.

17 Senators, we are now in debate. Is there
18 debate on the bill? Is there debate on the bill?
19 You'd like to go? A debate?

20 Senator Davis, you're recognized.

21 SENATOR DAVIS: Thank you, Madam Chair. I
22 know we all have said a lot and heard a lot today,
23 so I'm just going to repeat some of the things I
24 think bears repeating.

25 We've heard that this bill restricts access

1 to gender affirming care. We've heard that it
2 creates a potential for depression. Some have
3 suicidal thoughts, suicide attempts. The target is
4 on the back of the queer community.

5 Treatment of gender affirming care is not
6 experimental, a transphobic, extreme overreach by
7 the government, and the side effect to not having
8 this care is suicide.

9 And so those were the words that speaker
10 after speaker after speaker said. And all I could
11 hear was, love me as I am. Love me as I am.

12 Words hold an incredible amount of power.
13 And that's something that I think this legislature
14 should remember. Trans people are around 0.6
15 percent of the population in the United States, but
16 are more than four times likely to be victims of
17 violent crime.

18 And as we sit here, it simply feels like
19 what we've done today with this legislation is
20 vilify who you are.

21 LGBT youth, particular, our trans youth
22 have significantly higher rates of depression,
23 homelessness, and suicide. They're sent to
24 conversion therapy or kicked out or abused, or if
25 they're lucky, they have a supportive family, like

1 we've heard over and over today who loves them as
2 they are.

3 It's a proven fact that providing support
4 for them, even as simple as social transition, can
5 reduce their likelihood of suicide attempts by 73
6 percent. And it's one in three kids right now.

7 However, 35 percent of our trans kids are
8 likely to, again, attempt suicide before they're 18.
9 We heard that over and over again.

10 In my opinion, this bill would not only
11 disregard those kids, it would reinforce that high
12 suicide rate. It would keep our children hopeless,
13 and it's simply cruel. I think we need to be
14 careful of the rhetoric we create by hearing and
15 passing bills like this.

16 There are children out there who believe
17 they are better off dead because of the lack of
18 support. And all you've said today is, love me as I
19 am. Trans kids are rare, but they do exist.

20 This bill would be a massive step backwards
21 because of -- because simply all this bill does is
22 put more kids in harm's way.

23 I personally feel like this bill is
24 unconstitutional, and so with all of that, I know
25 you all know I'll be voting against this bill today.

1 And I simply urge my colleagues that will be voting
2 in support of this bill to look at what we're doing,
3 to listen to what's been said to us. And all you
4 should have heard is love me as I am.

5 Thank you, Madam Chair.

6 CHAIRWOMAN BURTON: Shall debate.

7 Senator Book, you're recognized.

8 SENATOR BOOK: Thank you, Madam Chair. And
9 it's tough to go after my colleague, Senator Davis.
10 I'd like to push back on something that the bill
11 sponsors started with when introducing this bill.
12 And that is we want to protect kids.

13 We all want to protect kids. Let's be
14 very, very clear about one thing. I have spent my
15 life protecting kids. I will spend the rest of my
16 life and my time when I'm no longer in the
17 legislature protecting kids.

18 The parents and adults who are here with
19 these children today want to protect kids. It may
20 not look the way you think it should, but we all
21 want to protect kids.

22 We all believe in parental rights, don't
23 we? Their rights as parents are the same as yours.
24 They may not think the way that you do, but they
25 want to protect their kids the way that it is their

1 right to do.

2 We know and have heard time and time again
3 the suicide rights that exist for this population.
4 We have a responsibility to allow parents the right
5 to protect their kids the way that they see fit.

6 I believe it's an extreme overreach when
7 we're talking about adults, adults to receive
8 gender-affirming care, putting block after block
9 after block.

10 All we do in this committee is talk about
11 telehealth and access to care. In rural
12 communities, if you say it out of one side for one
13 group, it should be the same for the other. Come
14 on, come on. This is wrong. And it's an extreme
15 overreach.

16 CHAIRWOMAN BURTON: Additional debate?
17 Senator Osgood, you're recognized.

18 SENATOR OSGOOD: Thank you. You know, I
19 have been toiling back and forth. I had a
20 conversation with Senator Yarborough, who I believe
21 in his own right, is doing what he feel is right.

22 And I've gone back and forth. I've
23 listened. I've been very thoughtful and also very
24 prayerful. And I know some might not want to hear
25 that, but that's a part of who I am.

1 And I thought about this from a perspective
2 as a parent. Decisions I would make as it relate to
3 my own child. I thought about the protection piece,
4 do I look to protect the child from suicide now or
5 from potential side effects in the future? That I
6 don't have any answers to.

7 Certainly was disturbed by all the
8 criminalization things that come forth and just
9 thinking that we have to find a way to live without
10 making everything where someone ends up in jail.

11 Then I thought about the parents' rights,
12 and when I was taking the task, because I believed
13 within everything that I stood for, that I should
14 use a mask to protect kids in school against COVID.
15 And I was constantly told that I was violating
16 parents' rights and choices when I still think today
17 that I saved thousands and thousands of kids' life.
18 And I'm still being told that I violated parents'
19 rights and choices.

20 And as I think through this bill and I see
21 children and I see adults totally separate, I do
22 think that we get to some age of maturation that we
23 should make decisions and be responsible for the
24 outcomes of those decisions as adults.

25 And as I continued to read and do research

1 and talk to different individuals, think about my
2 stepdaughter that I raised that's of the LGBT
3 community, it's just -- it's not as black and white.

4 Just because I don't understand some
5 elements don't mean that I hate anybody. I love
6 people. I think that we all are doing the best we
7 can to live in this world one day at a time with all
8 of our differences.

9 Being an African American person, I
10 understand that I have experienced some pains that
11 many people in this room have not. It doesn't make
12 me wrong and them right or vice versa.

13 So as we try to move forward, I came to a
14 place where, as a government entity, I think that
15 there are some limits. I think there are absolutely
16 -- with the background in public administration,
17 there are absolutely some things that the government
18 should not interfere with. That some things are
19 moral decisions based on individuals and whatever
20 they believe or not believe about whoever their
21 higher being is. I subscribe to that
22 wholeheartedly.

23 And it's just very difficult to ignore
24 pain. I have too many unanswered questions that I
25 don't want to make a decision and make a decision

1 that could potentially hurt someone even further.

2 I have some strong moral beliefs and my
3 dilemma is I don't have a way of abstaining if that
4 was my choice. It's been taken away.

5 I just think that this is something that
6 we're faced with that has been around for a while.
7 But because we have failed to be inclusive in our
8 discussions, in our deliberating, in our trying to
9 understand that we don't have what we need to -- I
10 don't have what I need to make solid concrete
11 decisions, but I do think that it is far, far
12 overreaching.

13 But, again, I don't think that anyone is
14 showing hate. I believe in my colleagues that are
15 here that I don't think that anyone here has a
16 spirit where they're trying to intentionally harm
17 someone. And I want to be fair in saying that
18 because I think it's very important as we move forth
19 as legislators. I'm kind of just tired of all the
20 one party against the other thing. I haven't found
21 anyone here to be where they're trying to harm
22 anyone. Just because you have a different
23 perspective, it doesn't mean you're trying to hurt
24 someone or retaliate against someone.

25 But for my own personal belief, I do just

1 think that it's too far overreaching, and that's why
2 I'm not supporting the bill. Thank you.

3 CHAIRWOMAN BURTON: Thank you. Additional
4 debate on the bill? Is there any additional debate?

5 Seeing none, Senator Yarborough, you're
6 recognized to close on the bill.

7 SENATOR YARBOROUGH: Thank you, Madam
8 Chair. Thank you members of the committee for
9 having this bill in front of you today.

10 Thank you. I wanted to say too, thank you
11 to everyone who took the time to come to today's
12 meeting. I know many of you waited for more than
13 two hours to speak, and I want you to know that I
14 have great respect for each of you, and whether we
15 align or differ on our opinions, the fact that you
16 came to share with the Committee is meaningful. So
17 thank you very much for that.

18 I also would like to address -- many
19 speakers mentioned instances of youth taking their
20 own lives or fearing for their lives. And I want
21 you to know or I'll just say speaking for me, your
22 life does have value. I reject the notion that an
23 individual's worth and dignity is limited to
24 whatever preference that they may choose with regard
25 to the topic that's before us today because it's not

1 limited to that.

2 Every person was created with extraordinary
3 worth, incredible value, and a unique purpose that
4 was from the time that they were created. You can't
5 change that.

6 Procedures and all of the other efforts
7 cannot fill the deepest needs in a human heart, and
8 they don't give you your worth and value because,
9 again, you possess that when you were created. In
10 fact, before you were even born, you've had those
11 traits.

12 So this legislation does not impact the
13 ability, we've talked about it of an adult in the
14 state to make a decision to pursue any treatment or
15 surgery related to sex reassignment.

16 And also, as we've discussed, the bill is
17 consistent with the Florida Board of Medicine and
18 Board of Osteopathic Medicines rules to restrict the
19 reassignment prescriptions and procedures for
20 children. That is the thrust of the bill.

21 The Physician Medical Board spent the past
22 eight months considering the research, listening to
23 experts, and hearing from the public, and they
24 determined these treatments to be harmful for minors
25 and the Board of Medicine's rule banning treatment

1 for minors was already set to go into effect this
2 Thursday, March the 16th. The bill codifies that
3 rule.

4 Additionally, as reported in the New York
5 Times in October of 2022, England's National Health
6 Service proposed restricting use of the drugs for
7 gender dysphoric children to research settings.
8 Sweden and Finland have also placed limits on the
9 treatment, concerned not just with the risk of
10 puberty blockers, but the steep rise in young
11 patients.

12 Adult patients, fully informed by their
13 physician and the nature and risks of sex
14 reassignment prescriptions and procedures, can make
15 a decision about these treatments for themselves,
16 and many here today have indicated that they have
17 made that decision.

18 The fact remains that when it comes to
19 children, these treatments are experimental.

20 As I said in my opening remarks, I believe
21 as lawmakers we do have to draw the line. When
22 drastic life-altering gender dysphoria therapies and
23 surgeries are being prescribed for children,
24 sometimes very young children.

25 I believe we need to let kids be kids and

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1 our laws need to set appropriate boundaries that
2 respect the rights and responsibilities of parents
3 while protecting children from the very serious
4 health and safety concerns associated with these
5 treatments.

6 I respectfully ask for the committee
7 support of this bill. Thank you.

8 CHAIRWOMAN BURTON: Onha (phonetic), please
9 call the roll on Senate Bill 254.

10 ONHA:
11 Senator Albritton.
12 (No audible response)
13 Senator Avila.
14 (No audible response)
15 Senator Book.
16 (No audible response)
17 Senator Broxson.
18 (No audible response)
19 Senator Burgess.
20 (No audible response)
21 Senator Calatayud.
22 (No audible response)
23 Senator Davis.
24 (No audible response)
25 Senator Garcia.

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1 (No audible response)
2 Senator Harrell.
3 (No audible response)
4 Senator Osgood.
5 (No audible response)
6 Chair -- sorry. Vice Chair Brodeur.
7 (No audible response)
8 Chair Burton?
9 CHAIRWOMAN BURTON: Yes.
10 By your vote, Senate Bill 254 will be
11 reported favorably as a committee substitute.
12 (END OF REQUESTED PORTION)
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1 CERTIFICATE OF TRANSCRIPTIONIST

2 I certify that the foregoing is a true and
3 accurate transcript of the digital recording
4 provided to me in this matter.

5 I do further certify that I am neither a
6 relative, nor employee, nor attorney of any of the
7 parties to this action, and that I am not
8 financially interested in the action.

9

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Julie Thompson

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Julie Thompson, CET-1036

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TRANSCRIPTION OF AUDIO RECORDING

FLORIDA HOUSE OF REPRESENTATIVES
HEALTHCARE REGULATION SUBCOMMITTEE MEETING
FLORIDA CHANNEL

Wednesday, March 22, 2023

Stenographically Transcribed Audio Recording By:
Terri L. Martin, Certified Shorthand Reporter

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1 Whereupon, the following proceedings were
2 transcribed from an audio recording:

3 CHAIR CLEMONS: Members, next up is HB 1421,
4 "Gender Clinical Interventions" by Chair Fine.

5 Before we begin, I want to lay out a roadmap
6 of -- Representative Dr. Massullo is here, too, to
7 present. I want to present a roadmap and layout of
8 how we will handle this bill.

9 We have approximately 72 or so speaker cards.
10 We'd like to hear from everyone that has traveled to
11 Tallahassee, and we will do our best to make sure
12 that everyone gets the appropriate time.

13 We're going to start out with a minute for
14 each person coming up. If you would just say your
15 name but dispense with some of the other things
16 because you're eating on your time. We would like
17 for you to use all of your minute to tell us why
18 you're for or against this particular piece of
19 legislation.

20 We'll be ending public testimony at an
21 ample time so that the members will have a chance to
22 debate on this bill, and we'll be voting on this
23 bill within two hours of this particular time which
24 will be 2:15-ish.

25 I would ask if the prior speaker has already

1 said some of your points that you go to your next
2 points to make sure that everyone gets something new
3 to debate.

4 And then we will begin. So, Chairman,
5 you -- one or both are welcome to explain your bill.

6 REPRESENTATIVE FINE: Thank you, Mr. Chairman.

7 And I recognize people have a lot to say on
8 this bill and there are other bills, so I'll keep my
9 opening very short.

10 HB 1421 deals with gender clinical
11 interventions. The bill, I would say, falls into four
12 categories of what it will do.

13 First, it will ban the surgery or drugs that
14 are used for the purpose of mutilation and castration
15 for children under the age of 18. Doctors who
16 participate in that moving forward will be -- I'm
17 sorry. I should step back. We have a strike-all, and
18 I'm starting to explain the strike-all. I don't know
19 if you want to skip this and go to the strike-all.

20 CHAIR CLEMONS: Any objections to -- it is
21 a strike-all bill, so if we could just dispense with
22 the other for your time.

23 Chair, would you please explain the
24 strike-all.

25 REPRESENTATIVE FINE: Yes, absolutely.

1 And so it does what I just said. It also
2 says, though, that doctors who engage in this
3 practice will be committing a third-degree felony
4 in the state of Florida.

5 Second, it says that in custody hearings
6 children who are at risk of being taken to do this
7 sort of clinical gender intervention, a court can
8 consider that in order to keep those children with
9 the parent that does not seek to do that to their
10 child.

11 The third -- as it relates to adults, it says
12 that no public funds can be used for these procedures.
13 It says that no health insurance can be used for
14 these procedures. Should you wish to do it as an
15 adult, you'll be paying for it yourself.

16 Third, it says you must have written consent.
17 The doctor must give written consent and provide
18 detailed information before an adult chooses to do
19 this sort of thing.

20 And, fourth, it creates a new cause of
21 action where if someone is unhappy about what has
22 happened, they will have 30 years in the case of
23 someone who is alive, 5 years in the case of someone
24 who has died in order to pursue a cause of action
25 related to any damage that they have received as a

1 result of this.

2 And then, finally, the bill states that
3 birth certificates will reflect biology, and they
4 will state what you were born as based on biology
5 at birth.

6 That, Mr. Chair, is the strike-all
7 amendment.

8 CHAIR CLEMONS: For members' edification
9 and people who are watching on The Florida Channel,
10 this is the strike-all, barcode 692881, so we're all
11 on the same page.

12 Any questions from members regarding this
13 strike-all amendment?

14 Any questions from members?

15 Questions from members?

16 You're recognized, Representative Hunschofsky.

17 REPRESENTATIVE HUNSCHOFSKY: Thank you, Chair
18 Clemons.

19 Representative Fine, I had a question
20 regarding the definition of gender clinical
21 interventions, lines 45 through 47. It means
22 procedures or therapies that alter internal or
23 external physical traits.

24 What is part of those -- what exactly are
25 all the internal or external physical traits that

1 fall under this?

2 CHAIR CLEMONS: Chair Fine.

3 REPRESENTATIVE FINE: I'm going to let the
4 doctor answer.

5 CHAIR CLEMONS: All right. Dr. Massullo,
6 you're recognized.

7 REPRESENTATIVE MASSULLO: Thank you,
8 Rep. Hunschofsky, for that question.

9 Internal changes would be changes to their
10 physiology, such as their hormone balance. External
11 changes would be changes to their anatomy, such as
12 their breasts being removed or their genitals being
13 removed or distorted in some way, shape, or form.

14 CHAIR CLEMONS: Follow-up, Representative
15 Hunschofsky.

16 REPRESENTATIVE HUNSCHOFSKY: Thank you, Chair
17 Clemons.

18 When a woman has breast cancer and has her
19 breasts removed, does that fall under this definition?

20 CHAIR CLEMONS: You're recognized for an
21 answer.

22 REPRESENTATIVE MASSULLO: Thank you,
23 Mr. Chair.

24 If a minor young lady would have breast
25 cancer, that would be a pathologic condition that

1 would be treated, and it would not fall under that
2 definition of gender reassignment.

3 CHAIR CLEMONS: You're welcome to follow up.

4 REPRESENTATIVE HUNSCHOFSKY: Thank you,
5 Mr. Chair.

6 And I'm not a medical doctor, nor am I an
7 attorney, so could you show me where in the amendment
8 it says that a person going through cancer and having
9 their breasts removed in that case would not fall
10 under this legislation?

11 CHAIR CLEMONS: Who's going to handle that
12 one?

13 REPRESENTATIVE FINE: I will.

14 I'm not sure how frequently 13-year-old girls
15 get breast cancer, but if it does happen on a
16 frequent basis, we're happy -- this provision only
17 deals with minors. I don't know how frequently
18 minors get breast cancer. Maybe it happens a lot.
19 That's news to me. But if it does happen, the
20 intention of the bill is not to do that. And
21 also the bill does say that they can be treated.

22 All right. No, no. Somebody hit the light
23 switch.

24 There we go.

25 CHAIR CLEMONS: Please proceed.

1 REPRESENTATIVE FINE: I will simply say if
2 there's an issue with a 13-year-old that gets breast
3 cancer getting treated, we will make sure that the
4 bill moving forward at the next stop addresses that.

5 CHAIR CLEMONS: Follow-up, Representative
6 Hunschofsky.

7 REPRESENTATIVE HUNSCHOFSKY: Thank you,
8 Mr. Chair.

9 So does that mean it's explicitly not
10 covered under this gender clinical intervention?

11 CHAIR CLEMONS: You're recognized.

12 REPRESENTATIVE FINE: Thank you, Mr. Chair.

13 I think it's covered by the definitions of
14 this bill. However, given this pervasive problem of
15 13-year-old breast cancer that you're worried about,
16 we will make sure -- we will take a look as this bill
17 goes through committee that any 13-year-old who gets
18 breast cancer will be able to have that treatment.

19 CHAIR CLEMONS: One more. You're recognized.

20 REPRESENTATIVE HUNSCHOFSKY: Thank you,
21 Mr. Chair.

22 And so it's not also for anybody under the
23 age of 18 covered in this section?

24 CHAIR CLEMONS: You're recognized.

25 REPRESENTATIVE FINE: This section deals

1 with minors. So, I guess, again the pervasive problem
2 of 17-year-olds getting breast cancer, we will also
3 ensure that they are not going to be restricted under
4 this bill.

5 CHAIR CLEMONS: You can have one more, sure.

6 REPRESENTATIVE HUNSCHOFSKY: Thank you.

7 Just a final. It bans the insurance
8 coverage, so would that also ban the insurance
9 coverage for a woman or a person of any age who has
10 breast cancer and would like to have their breasts
11 removed as part of that treatment?

12 CHAIR CLEMONS: You're recognized for an
13 answer.

14 REPRESENTATIVE MASSULLO: Thank you,
15 Mr. Chair.

16 No, that would not preclude them from having
17 their breasts removed or any other medical
18 intervention because it would not be part of the
19 definition of gender change.

20 CHAIR CLEMONS: One more. One more.

21 REPRESENTATIVE HUNSCHOFSKY: Last one.

22 Just because we didn't really show anywhere
23 in the bill that it wouldn't fall under that gender
24 change and because there's another section that
25 mentions that it wouldn't be covered by insurance,

1 will you be addressing those concerns in this bill?

2 CHAIR CLEMONS: Chair Fine, Chair Massullo.

3 REPRESENTATIVE FINE: Yes. Thank you
4 for the question.

5 We will ensure that the concern that you
6 specifically address -- we'll go back. We'll talk
7 to staff. We'll talk to attorneys. If that -- I
8 don't believe it is an issue. But if it is an issue,
9 we will make that amendment at the next committee
10 stop. That's certainly not the intent of the bill.

11 CHAIR CLEMONS: Other questions of the
12 sponsor?

13 Members, other questions of the sponsor?

14 REPRESENTATIVE BELL: Thank you, Mr. Chair.

15 And hopefully this question pertains to your
16 strike-all, what you're talking about. But I had an
17 opportunity to visit our Florida State Prison about
18 two months ago, and the prisoners that evolve in
19 there, they've already started hormone replacements
20 and other types of medications and have had some sex
21 changes on the backs of the taxpayers.

22 Would this stop this? This bill that you're
23 running, would it -- I mean, because they said they
24 were required, I think, by federal and state law that
25 they have to continue to give these hormone drugs

1 to them on the back -- like I said, on our price.

2 CHAIR CLEMONS: Chairman Fine.

3 REPRESENTATIVE FINE: Thank you, Mr. Chair.

4 Yes. Yes, it would, with one exception.

5 Anyone who is on these drugs prior to January 1 of
6 this year would be able to be weaned off them by the
7 end of the year. But no one new could go on and no
8 more surgeries. I mean, again, if the prisoner had
9 their own money to pay for this sort of thing, we're
10 not restricting it. But the taxpayer would not be
11 obligated. You would not be obligated to pay for
12 this sort of service.

13 REPRESENTATIVE BELL: Thank you so much.

14 CHAIR CLEMONS: It's your bill. Follow-up?

15 Representative Tant for a question, you're
16 recognized.

17 REPRESENTATIVE TANT: Thank you, Mr. Chair.

18 Thank you for indulging me on this question,
19 gentlemen.

20 In respect to the prohibition on gender
21 clinical interventions for minors and it says you
22 can't have therapies -- well, therapies that alter
23 internal or external physical traits, my son Jeremy
24 was born with Williams Syndrome. That comes with
25 short stature.

1 So for a male, we were on growth hormone
2 injections from the time he was 13 months old until
3 he was 14 in order to get him tall enough so that he
4 would be able to at least not fall into the four-nine
5 and under. And so I'm wanting to know whether or
6 not -- and at some point we were trying to elongate
7 his growth period to get him a little taller, and so
8 they put him on hormones and puberty blockers to help
9 him have more time to grow.

10 Will this affect that, your bill?

11 CHAIR CLEMONS: Chairman Fine.

12 REPRESENTATIVE FINE: Thank you, Chairman.

13 If you look at lines 55 through 65 of the
14 bill, that language is in there specifically for the
15 kind of issue that you describe.

16 CHAIR CLEMONS: Follow-up, Representative
17 Tant?

18 Other members -- go ahead. You can follow up.

19 Or I can come back to you.

20 Other members have questions?

21 Other members have questions?

22 Representative Skidmore for questions.

23 REPRESENTATIVE SKIDMORE: Thank you,
24 Mr. Chair.

25 Thank you, Rep. Fine and Rep. Massullo.

1 My question is actually on kind of the same
2 lines as Rep. Tant's questions but in regard to birth
3 control. So is this banning birth control for minors
4 in this particular section because it's hormone
5 related?

6 CHAIR CLEMONS: Chairman Fine.

7 REPRESENTATIVE FINE: I mean, birth control
8 is not used to change one's gender, so, no, this has
9 nothing to do with birth control.

10 CHAIR CLEMONS: Follow-up, Representative
11 Skidmore.

12 REPRESENTATIVE SKIDMORE: That's the question.

13 Thank you.

14 CHAIR CLEMONS: Representative Tant, I
15 want to come back to you. Do you have a question
16 of the sponsors?

17 Are there any other members that have
18 questions of the sponsors?

19 All right. Ranking Member Bartleman, you
20 have a question or series. You're recognized.

21 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

22 So from my understanding of the bill, this
23 is to impact children, but there are portions of your
24 bill that impact transgender adults. Correct? Can
25 you -- I'm asking which sections are those, and was

1 that intentional with the adult track in here?

2 Thank you.

3 CHAIR CLEMONS: You're recognized.

4 REPRESENTATIVE FINE: Thank you, Mr. Chairman.

5 The subject of the bill is gender clinical
6 intervention. It is not gender clinical interventions
7 for children. So the bill does have provisions that
8 relate to children and adults.

9 CHAIR CLEMONS: Follow-up, Representative
10 Bartleman.

11 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

12 What is the State's compelling interest to
13 interfere with adult's freedom to make these sort of
14 informed decisions for themselves?

15 CHAIR CLEMONS: Representative Fine.

16 REPRESENTATIVE FINE: Thank you, Mr. Chair.

17 The State is not interfering with an adult's
18 ability to make this decision.

19 CHAIR CLEMONS: Follow-up, Representative
20 Bartleman.

21 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

22 But it is, because you're limiting their
23 access to health care. So I'm asking why you say it's
24 not.

25 CHAIR CLEMONS: You can attempt that,

1 Dr. Massullo. You're recognized.

2 REPRESENTATIVE MASSULLO: Thank you,
3 Mr. Chair.

4 Rep. Bartleman, we're not limiting their
5 access to health care. We're making sure that they
6 have health care in a safe fashion. The main thing
7 this bill is doing for adults is making sure they
8 have informed consent for these procedures and
9 particular drugs that they're going to be taking,
10 that they have a full understanding of the side
11 effects and what the consequences may be.

12 We're also providing them with a cause of
13 action if those type of consequences and side effects
14 are such that would bring them into a part that they
15 would be dissatisfied or injured in some way, shape,
16 or form with that treatment.

17 The fact that we are not allowing insurance
18 to pay for these type procedures is because we feel
19 that they should be included as a cosmetic-type
20 procedure and not necessarily a procedure that would
21 improve their health.

22 CHAIR CLEMONS: Follow-up, Representative
23 Bartleman.

24 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

25 I guess for a lot of these individuals it

1 impacts their mental health. And we know that LGBTQ
2 have the highest suicide rates in the nation. So I
3 don't look at it as cosmetic. So when it's impacting
4 mental health, I'm asking do you think -- if it's going
5 to impact their mental health and a doctor says, This
6 is what we should be doing, a mental health doctor,
7 this is still going to prohibit the insurance from
8 covering this?

9 CHAIR CLEMONS: Representative Fine, I think
10 there was a question at the end about --

11 REPRESENTATIVE BARTLEMAN: Sorry, sir.

12 REPRESENTATIVE FINE: Again, nothing in this
13 bill will prevent an adult, if they so choose and
14 pay for it, to get these surgeries if they so desire.

15 CHAIR CLEMONS: Ranking member, any more?

16 Yes. Okay. You're recognized, Representative
17 Skidmore, for a question.

18 REPRESENTATIVE SKIDMORE: Thank you,
19 Mr. Chair.

20 On the section of the birth certificates,
21 I know that I was born Kelly Ann Palitano [phonetic].
22 Then I was Kelly Ann Palmer, and then I, you know,
23 got married and I'm Kelly Ann Skidmore. Then I found
24 out that I have a different biological father and
25 I'm Kelly Haims [phonetic]. So I know birth

1 certificates can be changed.

2 And so what is the specific point -- if a
3 person is transgender, why would you prohibit them
4 from having the reflection of that change just like
5 the change in my name? Why would they not be able
6 to change their birth certificate?

7 CHAIR CLEMONS: Chairman Fine.

8 REPRESENTATIVE FINE: Thank you, Mr. Chairman.
9 Your name can be changed. Your biology
10 cannot.

11 CHAIR CLEMONS: Follow-up, Representative
12 Skidmore.

13 REPRESENTATIVE SKIDMORE: Thank you.

14 Well, I think doctors would disagree with
15 you. That's the whole point of transgender surgery,
16 to reflect exactly who you are and who you feel you
17 are but were not born that way. So you can change
18 your biology. That is what is happening. You are
19 reflecting the biology that you feel is your true
20 biology, so your birth certificate would reflect
21 that.

22 CHAIR CLEMONS: Is there a question in
23 there, Representative Skidmore?

24 REPRESENTATIVE SKIDMORE: Yes.

25 REPRESENTATIVE FINE: I can answer.

1 CHAIR CLEMONS: Okay.

2 REPRESENTATIVE FINE: There are no doctors
3 that I'm aware of that believe you can change your
4 biology. There's some doctors that divorce biology
5 from gender. They say they're different. I'm not
6 aware of doctors who believe that you can change your
7 X and Y chromosomes which determine your biology.

8 I will also note that it is unsettled
9 whether you actually -- not all doctors have the
10 perspective that you're sharing. And we in this bill
11 are saying you will be reflected as your biology,
12 which is not changeable. You cannot change your
13 chromosomes.

14 CHAIR CLEMONS: Representative Skidmore.

15 REPRESENTATIVE SKIDMORE: Thank you,
16 Mr. Chair.

17 I'm going to move to a different section.
18 There was a bill, House Bill 241, The Parents'
19 Bill of Rights, that held it's a fundamental right
20 of parents to direct the upbringing, education, and
21 care of their minor children.

22 So how is it, you know, a parent deciding
23 that they -- you know, they are supporting their
24 child in their decision to have their bodies reflect
25 who they believe themselves to be not a parental

1 right?

2 CHAIR CLEMONS: Representative Fine.

3 REPRESENTATIVE FINE: Thank you.

4 There is no parental right to child abuse,
5 and children cannot consent to this because they
6 are of an age where they cannot make these decisions.
7 And so, given that, what we're focused on in this
8 bill are procedures that have irrevocable changes.

9 You'll note that the bill does not prevent
10 psychological treatment. It does not prevent someone
11 who wishes to dress as different than their biology
12 because those are things that you can then go back
13 and say, Well, I changed my mind.

14 But there are guardrails on what parents
15 can do with their children. It's the entire reason
16 we have DCF. So not to say this relates to that, but
17 there are limits on what parents can do in the
18 upbringing of their children.

19 CHAIR CLEMONS: Representative Skidmore,
20 you're recognized.

21 REPRESENTATIVE SKIDMORE: Thank you,
22 Mr. Chair.

23 Where is it defined anywhere that surgical
24 procedures are child abuse?

25 CHAIR CLEMONS: Representative Fine, you're

1 recognized.

2 REPRESENTATIVE FINE: It is not. That is
3 my opinion, and that is what is driving the bill.
4 And so we don't have to define it. We're simply
5 saying in this bill you won't be able to do it.
6 You're asking what my motivation is in answering your
7 question, and I have shared that.

8 CHAIR CLEMONS: One moment.

9 Further answering of Representative
10 Skidmore's question?

11 Okay. Do you have a follow-up, Representative
12 Skidmore?

13 REPRESENTATIVE SKIDMORE: Just a confirmation,
14 Mr. Chair, that that's just your opinion?

15 CHAIR CLEMONS: Representative Massullo,
16 you're recognized.

17 REPRESENTATIVE MASSULLO: Thank you,
18 Mr. Chair.

19 When you look at child abuse, we don't have
20 a list of things for child abuse. If you chopped
21 your son's arm off, that would be considered child
22 abuse. Any reasonable person would recognize that.
23 But I don't know that there's anyplace where it says
24 chopping your son's arm off would be child abuse.

25 We consider these procedures child abuse,

1 and we would like to think that there is a magnitude
2 of evidence to show those facts. So that's why this
3 bill is addressing it in such a fashion as it is.

4 CHAIR CLEMONS: Representative Skidmore.

5 REPRESENTATIVE SKIDMORE: Thank you,
6 Mr. Chair.

7 I'm not an attorney either, as Rep.
8 Hunschofsky said, but how do you suggest that it's a
9 fact --

10 CHAIR CLEMONS: You're recognized.

11 REPRESENTATIVE SKIDMORE: -- if you just
12 said it was your opinion?

13 CHAIR CLEMONS: You're recognized. Neither
14 one of you gentlemen are attorneys, but you're
15 welcome to give your opinions.

16 REPRESENTATIVE FINE: They often think I am,
17 so -- no, that's our opinion. We're sharing our
18 rationale. When we all present bills in this body,
19 our bills are informed by our opinions. This is our
20 opinion. We'll see if it's the opinion of this
21 committee. We'll see if it's the opinion of this
22 legislature.

23 But you've asked part of the reason. There
24 are many other reasons beyond that, including the
25 science, which no one has asked about. But it is

1 our view that doing this to children is child abuse.
2 That's one of the reasons why this bill is written
3 the way it is.

4 CHAIR CLEMONS: Representative Hunschofsky
5 for a question.

6 REPRESENTATIVE HUNSCHOFSKY: Thank you,
7 Mr. Chair.

8 I always say to people, like, our first job
9 here is to do no harm, and then our second job is to
10 solve problems.

11 So what problem is this legislation solving?

12 CHAIR CLEMONS: Representative Fine.

13 REPRESENTATIVE FINE: Thank you.

14 We are trying to do no harm. As science is
15 continuing to show, as we're seeing in Western
16 European countries, these procedures are experimental,
17 particularly as they're being done on children.
18 There's also evidence that they have catastrophic
19 side effects as they move down the road. We do not
20 believe our children should be used as guinea pigs,
21 and that is why we're making this decision. The
22 purpose of this bill is to do no harm.

23 CHAIR CLEMONS: Representative Hunschofsky
24 for a follow-up.

25 REPRESENTATIVE HUNSCHOFSKY: Thank you, Chair.

1 Did the Board of Medicine already ban these
2 procedures for minors?

3 CHAIR CLEMONS: Representative Fine for
4 an answer.

5 REPRESENTATIVE FINE: Thank you.

6 They did. But much as we saw when we dealt
7 with COVID regulations and, for example, school
8 boards who didn't think they had to follow executive
9 orders, it's one thing for it to be an executive
10 order or a decision of the Board of Medicine. It's
11 another thing for it to be a statute in the state
12 of Florida.

13 CHAIR CLEMONS: Follow-up.

14 REPRESENTATIVE HUNSCHOFSKY: Thank you,
15 Mr. Chair.

16 So you think that even though the Board of
17 Medicine said it that we need legislation that might
18 also incorporate unintended consequences, such as
19 women with breast cancer? You still feel this
20 legislation is necessary despite that decision?

21 CHAIR CLEMONS: Representative Fine.

22 And I thought you solved the breast
23 cancer question earlier.

24 REPRESENTATIVE FINE: No, but I would
25 like to answer that question.

1 No. 1, I don't know -- the full committee
2 had a presentation on this issue. We had the chairman
3 of the Board of Medicine come, and he said he thought
4 this bill would be helpful. That's No. 1.

5 And, No. 2, what I'm worried about is the
6 unintended consequences of experimental surgeries
7 like this on children.

8 CHAIR CLEMONS: Another follow-up? Sure.

9 Ranking Member Bartleman, you have another
10 series of questions. You're recognized.

11 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

12 So just now you shared with us that this was
13 about preventing what you think is child abuse, and
14 it needed to be cemented into law because the Board
15 of Education wants an extra step -- I mean, the Board
16 of Medicine. I apologize. However, your bill goes
17 beyond children. You have adults. You're impacting
18 their care. It's not child abuse for an adult to
19 make a decision about their lives and their medical
20 procedures.

21 So why are you taking this additional step
22 if the impetus of your bill is about children?

23 CHAIR CLEMONS: Representative Fine.

24 REPRESENTATIVE FINE: I think we're mixing
25 different issues here. Yes, this bill goes beyond

1 what the Board of Medicine does, and that's because
2 in the judgment of the sponsors this is what the
3 bill should do.

4 The Board of Medicine, I should be clear,
5 they did not ask us to do this. But we did ask the
6 question, when the chairman of the Board of Medicine
7 testified before the committee, did he think
8 legislation related to what they did would be helpful.
9 And they said yes. We did not ask the Board of
10 Medicine about some of these other issues. For
11 example, issues relating to birth certificates or
12 health insurance would not be within their purview
13 anyway.

14 CHAIR CLEMONS: Follow-up. I don't know
15 that he answered the last question.

16 REPRESENTATIVE HUNSCHOFSKY: Yeah, he didn't.
17 Do you want me to rephrase it?

18 CHAIR CLEMONS: Yes, just rephrase it,
19 because he was on the --

20 REPRESENTATIVE HUNSCHOFSKY: So if the
21 impetus is child abuse and children can't make their
22 decisions, do no harm, why in the free state of
23 Florida can't adults make decisions? You're
24 prohibiting them access to their medical coverage.
25 You're prohibiting them access to purchasing any

1 plans. Why are you taking it to the next level if
2 they should be free to make those decisions themselves
3 and they're adults?

4 So you're arguing children, but at the same
5 time you've now slipped in here that, by the way,
6 we're going to impact all adults from making any
7 medical decisions about themselves when it comes to
8 this.

9 CHAIR CLEMONS: Chairman Fine --

10 REPRESENTATIVE BARTLEMAN: Thank you.

11 CHAIR CLEMONS: -- you're recognized.

12 REPRESENTATIVE FINE: Thank you, Mr. Chairman.

13 First, I reject the presumption that we've
14 slipped anything in. The bill is very clear as to
15 what it does. We're not restricting an adult's
16 decision to make whatever decision that they want.
17 We're also protecting people's rights to not have to
18 pay for things that we believe are elective.

19 CHAIR CLEMONS: Other members have questions?

20 Representative Skidmore, you're recognized.

21 REPRESENTATIVE SKIDMORE: Thank you,
22 Mr. Chair.

23 Representative Fine, do you know that knee
24 replacements are elective surgery --

25 REPRESENTATIVE FINE: I'm going to --

1 REPRESENTATIVE SKIDMORE: -- that they're
2 elective?

3 CHAIR CLEMONS: Chair Massullo, you're
4 recognized.

5 REPRESENTATIVE MASSULLO: Thank you,
6 Mr. Chair.

7 Yes, knee replacements are elective surgery
8 because of the medical condition that precipitates
9 the fact that you need your knee replaced. So they're
10 elective only to the point where you're deciding the
11 time that they'll be done. But most of the time
12 people that have knee replacement, they have a knee
13 replacement because their knee needs replaced. It's
14 worn out. There's cartilage damage. There could be
15 bone damage. There's some medical condition that
16 actually determines the fact that you need your knee
17 replaced.

18 What these procedures are we believe aren't
19 necessary. We believe these individuals have issues
20 that are more psychologically driven that need therapy,
21 but the therapy doesn't have to have interventions
22 that have irreversible side effects and --

23 CHAIR CLEMONS: Representative Skidmore.

24 I'm sorry. I apologize.

25 REPRESENTATIVE MASSULLO: And getting back

1 to Rep. Bartleman's question also, the parts of this
2 bill does not reflect adults at all. As I mentioned
3 earlier, it empowers them with more informed consent.
4 The only thing it does is it limits insurance
5 companies from paying for these procedures which
6 we believe are more cosmetic oriented.

7 CHAIR CLEMONS: Representative Skidmore for
8 a follow-up, and then we'll go to Representative
9 Hunschofsky.

10 REPRESENTATIVE SKIDMORE: Thank you,
11 Mr. Chair.

12 So I have rheumatoid arthritis. I've had it
13 most of my life, since I was a small child. I needed
14 a knee replacement. It was elective surgery. My
15 insurance company at the time covered that elective
16 surgery, but it was still elective. I chose to do it.
17 I didn't have to do it. I could have done something
18 else. And that's what made it elective.

19 How are you suggesting, then, an adult
20 person -- understanding that you've got a problem with
21 the kids -- an adult person making a decision to have
22 a surgery that they feel is in their best health care
23 interests, just like I did? It is -- are you telling
24 us that it is your opinion that they should not be
25 entitled to that elective surgery?

1 CHAIR CLEMONS: You're recognized.

2 REPRESENTATIVE MASSULLO: Thank you,
3 Mr. Chair.

4 Rep. Skidmore, we're not mixing these types
5 of elective surgeries. The elective surgery that you
6 elected to do was because of your health condition.
7 If you would have elected to enlarge your legs to make
8 you taller, that would be an elective surgery that
9 I wouldn't want insurance companies to pay for,
10 because you were doing that more for cosmetic reasons.
11 And that is the elective-type procedures that
12 Representative Fine and myself would like to have
13 not covered through insurance.

14 CHAIR CLEMONS: One more. There's a
15 philosophical difference here, so one more question,
16 and then Representative Hunschofsky.

17 REPRESENTATIVE SKIDMORE: Thank you.

18 So, to be clear, transgender surgery is
19 cosmetic, in your opinion?

20 CHAIR CLEMONS: You're recognized.

21 REPRESENTATIVE FINE: My belief is that
22 surgery is intended to attempt to defy your biology
23 and is cosmetic, yes.

24 CHAIR CLEMONS: Representative Hunschofsky
25 for a question.

1 REPRESENTATIVE HUNSCHOFSKY: Thank you,
2 Mr. Chair.

3 And just to go back to the coverage, the
4 health insurance coverage regarding -- it says on
5 lines 151 through 153 -- and it has nothing to do with
6 youth or not youth -- *Coverage of certain treatment.*
7 *A health insurance policy may not provide coverage*
8 *for gender clinical interventions as defined in the*
9 *previous section.*

10 So will that mean that penile implants will
11 also no longer qualify to be covered by health
12 insurance under this bill?

13 CHAIR CLEMONS: Representative Fine.

14 REPRESENTATIVE FINE: Yeah. Chair Massullo
15 and I have never had to deal with that in our own
16 lives, so I'm not -- I don't know that health
17 insurance would cover that right now, but it's
18 something that we're certainly willing to look into.

19 CHAIR CLEMONS: Follow-up, Representative
20 Hunschofsky.

21 All right. Other members have questions?

22 And I would remind everyone we're on barcode
23 692881. This is the strike-all amendment.

24 Are there any other member questions?

25 One more question. The ranking member has

1 one more question. You're recognized.

2 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

3 I believe that mental health, physical
4 health -- practitioners that I go to look at the
5 whole patient. Not only have you restricted their
6 access to their health insurance or purchasing a plan,
7 this bill also limits their ability to get telehealth.
8 Why is that in here?

9 If you're saying that this is about kids;
10 this is about people -- and I am different because
11 I think you look at the whole patient, not just
12 the physical, but the mental -- why limit telehealth
13 then? Why take it all the way?

14 CHAIR CLEMONS: Representative Fine.

15 REPRESENTATIVE FINE: Sure. We believe --

16 Thank you, Mr. Chairman.

17 We believe, given the seriousness of the
18 procedure, it should be done with a doctor in person.
19 Again, that is our belief.

20 CHAIR CLEMONS: Representative Tant for
21 a question. You're recognized.

22 REPRESENTATIVE TANT: Thank you, Mr. Chair.

23 One of the things -- I'm not a parent of a
24 child who has struggled with this, but I cannot
25 imagine what it would be like to have a child in

1 your family who couldn't stand their own bodies to
2 the point that their mental health was affected and
3 suicide be on the brink.

4 In the bill we are restricting parental
5 rights for a child -- for a parent to be able to make
6 a decision to pursue the best care -- best mental and
7 physical health options for the child.

8 How does -- why are we doing that? What is
9 the concern you have with that? And why do we feel
10 like we need to do this?

11 CHAIR CLEMONS: Representative Fine.

12 REPRESENTATIVE FINE: Thank you.

13 That's a great question. Thank you for
14 the question.

15 I think of the story of Chloe Cole whose
16 parents were told when she was 13 years old they
17 could either have a dead daughter or a live boy.
18 So with that sort of threat being made by doctors,
19 they went and they authorized puberty blockers. And
20 at the age of 16, they had -- her breasts were
21 removed. As she testified before our committee, she
22 very quickly came to regret that. It has had
23 life-altering effects on her life.

24 I read a story just yesterday about a girl
25 also who had the same exact statements made to her

1 parents: You can have a live boy or a dead daughter.
2 They removed her breasts when she was 13 years old.
3 She now regrets it, and she has sued.

4 That is the kind of mutilation that this
5 bill seeks to stop.

6 CHAIR CLEMONS: Follow-up, Representative
7 Tant.

8 REPRESENTATIVE TANT: Thank you.

9 How many families -- what is your estimate
10 of how many people are facing this right now that
11 we're trying to cure?

12 CHAIR CLEMONS: Representative Fine, if you
13 can have an answer or share with us.

14 REPRESENTATIVE FINE: Thank you.

15 I'm not entirely sure what the question is.
16 But if the question relates to how frequently is this
17 happening, it's interesting, many of the practitioners
18 who are so proud of this, this -- what they refer to
19 erroneously as gender-affirming care, they're very
20 proud of it. Yet when it comes to sort of providing
21 information about the numbers, all the sudden they're
22 not all that happy to do it.

23 But we do have one example, just to give
24 you a sense. There is one doctor in Miami Beach --
25 or Miami. I don't know where in Miami -- who I

1 invited to testify before my committee. She markets
2 her services to girls on TikTok under the -- I'll
3 call it -- tradename Dr. Teetus Deletus. That is her
4 name, not mine. We invited her to come and explain
5 to our committee why this is so great. She's willing
6 to talk about why it's so great on TikTok to kids.
7 Why not come and talk to adults in the legislature?
8 She declined that invitation.

9 But she alone did 13 of these breast removals
10 on children last year in Florida, one doctor.

11 CHAIR CLEMONS: Follow-up, Representative
12 Tant.

13 No more.

14 Representative Hunschofsky.

15 REPRESENTATIVE HUNSCHOFSKY: Thank you,
16 Mr. Chair.

17 And just to follow along those lines, do you
18 know of any studies that could tell you what the
19 percentage of regret is that you mentioned?

20 CHAIR CLEMONS: Representative Fine or
21 Dr. Massullo, you're recognized, either.

22 REPRESENTATIVE MASSULLO: Thank you.

23 Thank you for that question.

24 In the most recent studies, it shows almost
25 80 percent of these children that do not have any

1 intervention change their minds by the time they get
2 to adulthood. That's an important fact to realize.

3 Also, some of the more recent studies from
4 the countries that had these procedures initiated
5 even before the United States have shown marked side
6 effects with bone development, particularly in men.
7 Also, we're seeing neural problems with increased
8 pressure in the brain which leads to a condition
9 called pseudotumor cerebri.

10 So there are irreversible factors that were
11 not taken into consideration when these procedures
12 and these therapies were initially initiated. There's
13 studies in Sweden that we could send you that shows
14 the movement now is to concentrate more on affirming
15 psychological care and not doing these surgical
16 and medical interventions worldwide, particularly
17 in Europe where they started the treatment.

18 REPRESENTATIVE FINE: I would --

19 CHAIR CLEMONS: Chair Fine.

20 REPRESENTATIVE FINE: If it's okay, I would
21 just add this movement, if you want to call it that,
22 really sort of got moving in Europe under something
23 called the Dutch Protocol. It sort of took off --
24 you would argue, I think those that disagree with
25 this bill, they were ahead of the curve with the

1 United States. They are now moving backwards.
2 Finland is saying, No, we're going back. This was
3 not good. Sweden is saying, Nope, this isn't good.
4 We're going backward. The U.K. just closed their
5 largest facility that dealt with this for many of
6 the same issues, because they've said that the
7 research is not good, and much of what is out there,
8 there's no longitudinal study. There's no long-term
9 studies. Many of the studies that have been relied
10 upon have not been constructed accurately.

11 What you have is you have an ideology that
12 is pushing medical treatments on children. And,
13 again, we're seeing in the countries that were doing
14 this years ago, they're now going, Okay, this was
15 a mistake. We're going to pull it back.

16 We're going to in Florida make sure we never
17 get to the place that those countries are now.

18 CHAIR CLEMONS: Representative Hunschofsky
19 for another one.

20 REPRESENTATIVE HUNSCHOFSKY: Thank you,
21 Mr. Chair.

22 And the only reason I was asking it -- and I
23 would love to -- if you could send me a link to the
24 study that you're citing, I'd appreciate it. Because
25 the study I saw was a review of 27 studies involving

1 almost 8,000 teens and adults who had had transgender
2 surgeries, mostly in Europe, the U.S., and Canada.
3 And 1 percent on average expressed regret, which is
4 kind of in conflict with the study that you're
5 referring to.

6 Would you be able to provide more information
7 on that study?

8 CHAIR CLEMONS: Representative Massullo.

9 REPRESENTATIVE MASSULLO: Thank you,
10 Mr. Chair.

11 In that study what was determined by several
12 investigators, they have a lot of selection bias, and
13 that was a very short-term study. Some of the more
14 recent studies that are longer term are showing
15 those individuals do have more regret. And when
16 you compare the amount of depression and suicidal
17 ideations with those individuals, they're actually
18 showing greater than the individuals that had no care.

19 And, yes, we'll be able to send those all
20 to you. I'm sure our aides are listening right now.

21 CHAIR CLEMONS: Representative Bartleman, one
22 question.

23 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

24 Once again, you're citing studies in Europe
25 that have to do with children, and I want to point

1 out that there are studies for adults that are over
2 18 -- as Representative Hunschofsky spoke of, you can
3 get a penile implant if you're over 18. You can get
4 a knee replacement. I can -- you talked about Chloe.
5 I can give you a list of names -- Ben, Jen -- tons of
6 them where people are very happy.

7 So my question is --

8 CHAIR CLEMONS: Questions, questions.

9 REPRESENTATIVE BARTLEMAN: Thank you, sir.
10 I'm going to do it.

11 So my question is everything you're saying --
12 I get you're protecting children; you think it's
13 child abuse. Why are you stopping adults from getting
14 insurance -- using insurance --

15 CHAIR CLEMONS: Representative Bartleman,
16 you've asked that question twice.

17 REPRESENTATIVE BARTLEMAN: Sorry.

18 CHAIR CLEMONS: And we do want to hear what
19 you have to say. Save that for debate, because we're
20 going to have plenty of time for all the members to
21 debate.

22 Are there other questions, questions of
23 the sponsors?

24 Questions of the sponsors?

25 Okay. Ladies and gentlemen, we are on the

1 strike-all amendment currently, and it is a strike-all
2 amendment, barcode 692881. We have some other
3 amendments. The first amendment to the amendment is
4 barcode 333093 and barcode 047519. Both of those
5 amendments have been withdrawn.

6 We do have a third amendment to the
7 amendment, barcode 853805, by Representative Skidmore.

8 And, Representative Skidmore, you're
9 recognized to explain your amendment.

10 REPRESENTATIVE SKIDMORE: Thank you,
11 Mr. Chair.

12 In the strike-all, there's new language in
13 regard to those who are currently receiving care, and
14 it extends that care only until December 2023. My
15 amendment deletes that line and allows those who are
16 currently under care since January of 2023 to
17 continue being able to receive their care.

18 CHAIR CLEMONS: You're recognized for an
19 answer, gentlemen.

20 REPRESENTATIVE FINE: I think she presented
21 her amendment.

22 CHAIR CLEMONS: Oops, she's not asking that
23 question.

24 Representative Skidmore, having explained her
25 amendment to the amendment, are there any questions

1 by the members to Representative Skidmore?

2 Yes, you're recognized.

3 REPRESENTATIVE BELL: Thank you, Mr. Chair.

4 Representative, is this a friendly amendment?

5 CHAIR CLEMONS: Representative Fine.

6 REPRESENTATIVE SKIDMORE: I don't think
7 it's appropriate for me to say.

8 CHAIR CLEMONS: Representative Fine.

9 REPRESENTATIVE FINE: No, it is not,
10 obviously, a friendly member, but their definition
11 for the people here of friendly amendment is an
12 amendment we would like to see added to the bill.
13 It is not.

14 The reason we have put in the weaning-off
15 period to the end of the year is to account for the
16 fact that we recognize that, you know, just sort of
17 going, boom, cold turkey with a lot of things isn't
18 a good decision. But we do not support this amendment.

19 CHAIR CLEMONS: Any questions of
20 Representative Skidmore on her amendment to the
21 amendment?

22 Any Representative Skidmore questions?

23 Any public testimony on the amendment to
24 the amendment?

25 Will Larkins, you would like to speak.

1 Please come up. You have one minute.

2 Come on up.

3 The clock is ticking, sir.

4 Ma'am, welcome.

5 MR. LARKINS: I'm sorry.

6 CHAIR CLEMONS: Just start over. I'll
7 start your clock all over.

8 MR. LARKINS: Thank you so much.

9 Hi. My name is Will Larkins. I'm an
10 18-year old senior at Winter Park High School and the
11 cofounder and president of my school's Queer Student
12 Union.

13 I encounter kids every day under the age of
14 18 who have been on gender-affirming health care for
15 a lot of their lives, and that health care has saved
16 their lives. By taking that away and by forcing
17 them to detransition, something that this amendment
18 would take out of the bill, you will kill them. I'm
19 telling you right now, look me in the eyes and know
20 that you will kill them if you pass this bill and if
21 you don't pass this amendment.

22 They -- when you're trans, you rely on being
23 able to be who you are. When you're born in the
24 wrong body, it is hell. That is how every trans
25 person I know has described it.

1 There's really no reason to do this. There's
2 really no reason to not let people change their
3 gender on their birth certificate and live their
4 lives as who they are.

5 I'm going to tell you once again, as
6 someone who encounters transgender minors on a
7 day-to-day basis, you will kill them if you force
8 them to detransition.

9 CHAIR CLEMONS: Thank you for being here
10 today.

11 MR. LARKINS: Have a beautiful day, y'all.

12 CHAIR CLEMONS: Is there any other public
13 testimony on the amendment to the amendment?

14 All right. We'll open the floor.

15 Oh, you have testimony on the amendment
16 to the amendment?

17 All right. Please come forward and hand
18 the sergeant your speaking card, please.

19 You're recognized.

20 Thank you. No, you're recognized. Yeah.

21 MR. BEATTY [phonetic]: Can we get a
22 clarification before the clock starts?

23 CHAIR CLEMONS: Clarification on what? This
24 is the amendment to the amendment?

25 MR. BEATTY: Yes, because that's --

1 CHAIR CLEMONS: This is Representative
2 Skidmore's amendment to the strike-all.

3 MR. BEATTY: That's what I was trying to get
4 to.

5 CHAIR CLEMONS: Perfect. And you would like
6 to speak to this amendment?

7 MR. BEATTY: The amendment that I asked to
8 speak to was the one that was the strike-all
9 amendment, which now --

10 CHAIR CLEMONS: It has already passed.

11 MR. BEATTY: So that's why I'm asking for
12 clarification. The strike-all now becomes --

13 CHAIR CLEMONS: You'll still have a chance.

14 MR. BEATTY: Please, sir.

15 CHAIR CLEMONS: You'll still have a
16 chance.

17 MR. BEATTY: Please, sir.

18 CHAIR CLEMONS: Yes, sir. Just let this
19 one go.

20 MR. BEATTY: Yes. And that's what I'm
21 trying to do, but for the rest of us, so we understand
22 in laymen's terms --

23 CHAIR CLEMONS: No, no. Time out.

24 MR. BEATTY: Yes.

25 CHAIR CLEMONS: You haven't lost the ability

1 to speak.

2 MR. BEATTY: Right.

3 CHAIR CLEMONS: We're going to take care of
4 Representative Skidmore's amendment. And then you'll
5 have a public testimony opportunity at a later time
6 for what's on the floor. Okay.

7 You haven't lost anything. Okay. We'll
8 call you back up. You'll be the first one.

9 MR. BEATTY: And I'm not trying to drag this
10 out, but I think other people, too, would like to
11 know so we're not confused. I think the last
12 individual was confused on what they were
13 speaking to. Okay? And I --

14 CHAIR CLEMONS: We're not confused now. And
15 I will announce -- okay. If you will have a seat,
16 I'll call you when it's your turn.

17 MR. BEATTY: Thank you, sir.

18 CHAIR CLEMONS: And I promise you you'll
19 have full time.

20 Are there any members that would like to ask
21 Representative Skidmore questions on her amendment
22 to the amendment?

23 Are we past that?

24 How about debate?

25 Anybody like to throw in some debate on

1 Representative Skidmore's amendment to the amendment?

2 Ranking Member Bartleman, you're recognized
3 for debate on the amendment to the amendment.

4 REPRESENTATIVE BARTLEMAN: I would just like
5 to comment that we know this bill is going to pass
6 today. It's going to pass in the House. However,
7 there are individuals out there who have been
8 receiving care for three or four years. They have
9 been living their lives a certain way, living their
10 lives as to who they are.

11 To force them now -- to force them to stop
12 taking it -- I know you're giving -- you said, Well,
13 you have until December to get off -- I'm telling you
14 this will do more harm than good. You're going to
15 prevent anyone from this date forward, from the
16 signature of this bill, from getting care. They're
17 not going to be able to get the hormones. They're not
18 going to be able to have the surgery. But if you're
19 currently in the middle of this treatment, to take it
20 away is just -- I can't imagine doing that to someone.

21 And even the Board of Health, who is
22 appointed by the Governor, grandfathered these
23 individuals in. There's like -- we have to have a
24 sense of humanity. You can't abruptly take away care
25 from everybody who's in it, especially three or four

1 years, if they started the puberty blockers at
2 11.

3 So I am asking everyone, you know that this
4 bill is going to pass, but to abruptly stop the care
5 of people who have been living their lives three or
6 four years is just horrific and will impact them.

7 And I have to tell you, I've spoken to
8 parents, and it is just as difficult for the parents
9 to know. I am friends with parents whose children
10 have transitioned, and it is very hard, because there
11 was a name and there was a child born. But they know
12 they have the right to make the best decision.

13 If you heard Jazz Jennings' mother speak,
14 that she knew that if she didn't make the decision
15 she needed to for her daughter that her daughter
16 would not be here today.

17 So these are people who have already had
18 this right. You're abruptly taking it away. You're
19 going against what the Board of Medicine put in
20 place. You're taking it even a step further.

21 So I am just asking you to please
22 grandfather these people in, please.

23 CHAIR CLEMONS: Further debate?

24 Further debate on Representative Skidmore's
25 amendment to the amendment? We're talking about

1 barcode 853805.

2 If there's no further debate, Representative
3 Skidmore, you're welcome to close on barcode 853805.

4 REPRESENTATIVE SKIDMORE: Thank you,
5 Mr. Chair.

6 I was a member of the committee that heard
7 the panel discussion. And while compelling, the
8 testimony -- it wasn't testimony. The panel
9 discussion by one panel member was one detransitioned
10 person, one.

11 What this bill will do is force every person
12 who is currently receiving care to detransition, to
13 become someone they are not, someone that they do not
14 see themselves as being for the rest of their life.
15 They have made this decision with their parents, with
16 their doctor to become who they believe themselves to
17 be. And they should be allowed -- despite your
18 cruelty to take this opportunity away from any person
19 in the future, those children should be allowed to
20 continue their care.

21 This amendment simply lets those folks who
22 have been receiving care since the beginning of this
23 year to become who they believe themselves to be with
24 the support and resources of their families to help
25 them through it.

1 The decisions, the parental rights, the
2 freedom, the things that we pretend to hold dear in
3 this legislature, I want those people, those children
4 and those families to be able to hold them dear too.

5 This amendment allows people who are
6 currently in treatment to continue their treatment,
7 and that's all it does.

8 And I would urge and appreciate your support.

9 CHAIR CLEMONS: Representative Skidmore,
10 having closed on her amendment to the amendment,
11 all those in favor of said amendment, please say
12 aye.

13 All those opposed, say no.

14 Members, by your vote I show the amendment
15 does not pass.

16 We are back on the main amendment, and we
17 have public testimony on the main amendment.

18 Now, everybody follow me. This is the main
19 strike-all amendment that was not amended.

20 Wendell, you're here representing yourself.
21 I promised you, Wendell, that you would have your
22 chance. Please come up. Share with us your
23 testimony.

24 Keep it brief. I've got one here for you
25 for this one.

1 Welcome.

2 MR. BEATTY: Representatives, Wendell Beatty,
3 Sergeant retired, 28 years combat veteran.

4 You know, gender dysphoria is real, and
5 WPATH's standard of care is a treatment plan for
6 people like me that have transgender gender
7 dysphoria.

8 You know, we talk about not allowing youth
9 to take care of themselves. I found out when I was
10 8; okay. When I was 10, my mom found out. She didn't
11 say a thing. My dad didn't say a thing. I had to
12 figure it out on my own; okay. Luckily, there were
13 distilleries and breweries around to help me stay
14 alive until the point where I got to speak to a
15 therapist.

16 You know, the Florida Constitution would be
17 a lot simpler to amend by the people if we would go
18 to Article I, Section 2, Basic Rights, and just say
19 everything is okay for everybody except transgenders.

20 I oppose this bill, and I hope y'all will too.

21 CHAIR CLEMONS: Any other public testimony
22 on the strike-all amendment?

23 Any other public testimony?

24 Any other members of the public that would
25 like to testify on the strike-all amendment?

1 Okay. Seeing none, Members, debate?

2 Debate on the strike-all?

3 Debate on the strike-all?

4 Seeing no debate on the strike-all,

5 Representative Fine or Representative Massullo, you're
6 welcome to close on your strike-all.

7 REPRESENTATIVE FINE: We'll waive closing.
8 We'll speak when we close on the bill.

9 CHAIR CLEMONS: Having waived close on the
10 strike-all, Sabrina, please call the roll of the
11 members.

12 THE CLERK: Representatives Abbott?

13 REPRESENTATIVE ABBOTT: Yes.

14 THE CLERK: Anderson?

15 REPRESENTATIVE ANDERSON: Yes.

16 THE CLERK: Baker?

17 REPRESENTATIVE BAKER: Yes.

18 THE CLERK: Bartleman?

19 REPRESENTATIVE BARTLEMAN: No.

20 THE CLERK: Bell?

21 REPRESENTATIVE BELL: Yes.

22 THE CLERK: Black?

23 REPRESENTATIVE BLACK: Yes.

24 THE CLERK: Borrero?

25 REPRESENTATIVE BORRERO: Yes.

1 THE CLERK: Chaney?

2 Franklin?

3 REPRESENTATIVE FRANKLIN: No.

4 THE CLERK: Hunschofsky?

5 REPRESENTATIVE HUNSCHOFSKY: No.

6 THE CLERK: Persons-Mulicka?

7 REPRESENTATIVE PERSONS-MULICKA: Yes.

8 THE CLERK: Rudman?

9 REPRESENTATIVE RUDMAN: Yes.

10 THE CLERK: Salzman?

11 REPRESENTATIVE SALZMAN: Yes.

12 THE CLERK: Skidmore?

13 REPRESENTATIVE SKIDMORE: No.

14 THE CLERK: Snyder?

15 REPRESENTATIVE SNYDER: Yes.

16 THE CLERK: Tant?

17 REPRESENTATIVE TANT: No.

18 THE CLERK: Tant?

19 REPRESENTATIVE TANT: No.

20 THE CLERK: Trabulsy?

21 REPRESENTATIVE TRABULSY: Yes.

22 THE CLERK: Chair Clemons?

23 CHAIR CLEMONS: Yes.

24 12 yeas and five nays.

25 CHAIR CLEMONS: Members, by your vote the

1 strike-all amendment passes.

2 Now we will have public testimony on the
3 bill.

4 Okay. Public testimony on the bill, and we
5 have quite a lot of members of the public that would
6 like to speak on this bill.

7 David Poole, you're recognized.

8 I want to keep them to about 60 seconds.

9 After that, we would ask Jonathan Webber to
10 come up.

11 David Poole, are you here?

12 David Poole, going once?

13 Okay. Waives in opposition.

14 Jonathan Webber.

15 And on deck is Renee.

16 Mr. Webber, welcome. Keep it to about a
17 minute.

18 MR. WEBBER: Appreciate it. Thank you.

19 My name is Jonathan Webber. I represent the
20 SPLC Action Fund. I do urge you to vote no on this
21 health care ban.

22 There is no credible evidence to dispute
23 the overall safety and efficacy of medical care for
24 transgender youth. Conversely, leading medical
25 organizations like the American Academy of Pediatrics,

1 American Psychological Association, the American
2 Medical Association, the Endocrine Society, and
3 dozens of other organizations representing thousands
4 of doctors and medical professionals support
5 gender-affirming care. This care saves lives by
6 reducing the mental and physical consequences of
7 untreated gender dysphoria.

8 This purposeful prohibition of a family's
9 access to widely accepted and proven effective medical
10 treatment is dangerous. Moreover, charging doctors
11 with a third-degree felony for doing what they are
12 trained and recommended to do to save lives is a
13 massive overreach of state government.

14 Make no mistake. This health care ban will
15 harm young people, question the custody of parents
16 desperate for care for their child, expand government
17 into the private lives of Florida citizens.

18 Please vote no.

19 Thank you.

20 CHAIR CLEMONS: Thank you for being here.

21 Renee, you're up.

22 And, Olivia, you're on deck.

23 You're recognized.

24 RENEE [no last name]: Thank you, Chair.

25 Look, I realize you do not care about

1 transgender people, so I'm not going to sit here and
2 talk about my personal story, because many of you have
3 demonstrated time and time again you don't care about
4 empathy.

5 So let's talk facts for a second. There's a
6 lot of misinformation that was disputed. I'm a
7 psychologist, a master's degree and a P.D. candidate.
8 And I can tell you unequivocally that less than
9 1 percent of trans people detransition. The majority
10 of them feel great when they do, and it saves their
11 lives.

12 Let's talk about two points on why this
13 is unconstitutional. I want to bring your attention
14 to section 1, lines 7 through 15, and section 4, lines
15 41 through 65.

16 Section 1 violates the Full Faith and Credit
17 Clause of the U.S. Constitution, Article IV, section 1,
18 which requires each state to recognize public acts,
19 records, and judicial proceedings of every other
20 state. By allowing a court in one state to disregard
21 a custody determination in another state, this
22 provision is unconstitutional.

23 Section 4 prohibits certain, quote, "gender
24 clinical interventions for minors and imposes
25 restrictions on physicians who perform such

1 interventions." This is unconstitutional because it
2 restricts the fundamental right to privacy and bodily
3 autonomy --

4 CHAIR CLEMONS: Let's bring it in for a
5 landing, please.

6 RENEE: Yes, sir.

7 -- as recognized by the *Planned Parenthood*
8 *v. Casey*, 1992. The Supreme Court has also
9 recognized --

10 CHAIR CLEMONS: Your time has ended.

11 RENEE: -- that individuals have the right
12 to make decisions about their bodies --

13 CHAIR CLEMONS: Olivia, you're next.

14 Thank you for being here.

15 Olivia.

16 Michael Barrett, you're after Olivia. If
17 you would stand up on the side and get ready to come
18 up if you would, please, Michael.

19 Olivia, welcome.

20 MS. SULLEN [phonetic]: Hi. My name is
21 Olivia Sullen.

22 I'm here as an ally and a proud big sister to
23 an incredible gender nonconforming boy. I'm also here
24 because no one is allowed to be mean to my brother
25 but me. And you're all being bullies if you pass this

1 bill. You are being children's first bullies, and you
2 are not allowing them to get treatment that is
3 lifesaving. You know this. If you vote against
4 this, you're voting against these kids' lives.

5 And so the Trevor Project estimates at least
6 one LGBTQ youth between the ages of 13 and 24 attempts
7 suicide every 45 seconds in the U.S. I would like to
8 take the rest of my time for you to think about that
9 life that will be considered to be taken in this time.

10 [Pause.]

11 CHAIR CLEMONS: Thank you.

12 Michael, you're next, with Maxx on deck.

13 Michael representing the Florida Conference
14 of Catholic Bishops.

15 MR. BARRETT: Thank you, Chair and Members of
16 the Committee.

17 Michael Barrett with the Florida Conference
18 of Catholic Bishops.

19 We deeply sympathize with anyone who
20 experiences gender dysphoria and recognize that it can
21 be intensely difficult. Therefore, it is important to
22 recognize that so-called gender-affirming protocols
23 lack long-term evidence of their efficacy and result
24 in irreversible physical damage to the patient.

25 Furthermore, there is significant evidence

1 that avoiding chemical or surgical interventions will
2 result in desistance in favor of biological sex for
3 most minors by the time they go through puberty.

4 Finally, no medical intervention can truly
5 realign a person's sex, which is an immutable
6 characteristic of each person. Medical care should
7 promote the flourishing of a human person.
8 Gender-affirming protocols fail to do this because
9 they fail to alleviate the problem they seek to
10 solve and because they cause damage to the patient's
11 body. Therefore, these protocols should be
12 prohibited.

13 Thank you, Representative Fine, for bringing
14 this good bill.

15 Please vote yes on HB 1421.

16 Thank you.

17 CHAIR CLEMONS: Thanks for being here.

18 Maxx. Maxx, you're up.

19 And, Sierra, please, you're on deck.

20 Welcome, Maxx.

21 MR. FENNING: Good afternoon.

22 My name is Maxx Fenning, and I'm the founder
23 and president of PRISM, a youth-led LGBT nonprofit in
24 South Florida.

25 I'm sure this tireless work to strip people

1 of their rights every chance you get is so exhausting.
2 Trust me, it is for us too. So I hope that we wake
3 you up today.

4 I hope you can look up from your phones when
5 hundreds of people come up to you crying, begging to
6 be seen as human beings, to be heard. I hope you
7 look them in their teary, puffy, beet-red eyes when
8 you tell them that you know better about their lives
9 than they do; when you pretend the science is on your
10 side when you know full well it is anything but; when
11 you pretend that your hands are tied behind your back
12 by the GOP zip ties and duct tape; while you drown in
13 two feet of water and pretend to be lost at sea so
14 you can look good in front of your melting wax figure
15 of a governor that will ride a ghost --

16 CHAIR CLEMONS: Sir.

17 MR. FENNING: -- circling the White House
18 and never be permitted --

19 CHAIR CLEMONS: Thank you.

20 Your time is up.

21 MR. FENNING: I hope you have the audacity.
22 You give us one minute to beg for mercy. If you're
23 going to be a murderer, then act like it.

24 CHAIR CLEMONS: Thank you for being here.

25 MR. FENNING: And if you won't --

1 CHAIR CLEMONS: Sierra, you're next.

2 MR. FENNING: Thank you for your time.

3 CHAIR CLEMONS: And, Will, you're on deck.

4 And, Kevin, you're after Will.

5 MS. BUSH RESTER: So I'm just going to jump
6 right in. When my brother was 7, we found out that
7 he had a genetic order called NF1 which was causing
8 a tumor to push on the puberty gland in his brain,
9 causing him to go through puberty and put his life at
10 risk at 7 years old. Luckily, my parents were able
11 to utilize puberty blockers, a therapy that this bill
12 would ban, to save my brother's life.

13 What makes my brother's case any more
14 medically lifesaving and helpful than hormone care
15 for trans youth? Because, unlike the opinion-based
16 language in this bill suggests, gender-affirming care
17 is medically necessary and lifesaving as well.

18 See, I actually mean it when I say I believe
19 in parental rights, and like many other parents, I
20 will do anything I can to protect my child or the
21 children in my community. So I'll tell you right now
22 that if y'all dare to come to my home or to the homes
23 of my neighbors to kidnap our children for utilizing
24 the same treatment my brother got, I'll need you to
25 remember that Florida has a "stand your ground" law

1 for a reason.

2 CHAIR CLEMONS: Thank you for being here.

3 Welcome back.

4 MR. LARKINS: Hi. Thank you for having
5 me back.

6 My name is Will Larkins. I'm an 18-year-old
7 senior from Winter Park High School.

8 This is complete government overreach. I
9 want to remind you all that we have other problems.
10 My English teacher is homeless and works two jobs
11 because we don't allocate enough money to the school
12 system.

13 And, once again, I'm letting you guys know
14 right now, I hope you can sleep well knowing that you
15 are killing kids, that by passing this law, which
16 I know you will because you don't care what your
17 constituents have to say, you are killing trans kids,
18 and you're destroying the lives of their families.

19 I have nothing else to say but that. Think
20 about it, every 45 seconds, like Olivia said.

21 CHAIR CLEMONS: Thank you for being here,
22 Will.

23 Kevin, you're next.

24 And Joe Saunders from Equality Florida,
25 you're next.

1 Kevin.

2 And, Joe, can you queue up, please?

3 Kevin?

4 All right. Kevin is not here. We'll
5 give you Kevin's time. Come on up.

6 Welcome, Joe.

7 After Joe will be Jon Harris.

8 MR. SAUNDERS: Good morning, Mr. Chair
9 and Members.

10 My name is Joe Saunders. I'm the senior
11 political director for Equality Florida, also a former
12 Member, served in the House from -- a while ago.

13 CHAIR CLEMONS: Welcome back.

14 MR. SAUNDERS: You know, there's clearly
15 something happening in conservative movements in
16 America today. As of today there are over 400 bills
17 introduced in conservative legislatures that work
18 to restrict the rights and freedoms of LGBTQ
19 Americans. Most of them are centered on transgender
20 Americans.

21 But with this strike-all today, I'm here to
22 make sure that you know and that the public knows that
23 this legislation is the most extreme attack on
24 transgender Americans that is filed in legislatures
25 today: government forced detransitions of young

1 people; the sweeping way in which it bans private
2 insurers, as we've heard, from offering health care
3 to people who need it; the way that it requires local
4 governments to ban health care and also to ban
5 contractors of local governments from providing
6 health care. Think about how many providers, how
7 many business are in contracts with the cities
8 and counties that you represent in your
9 districts. This is sweeping; it is extreme, and
10 we need adults in the room to say enough is enough.
11 This cannot be who the state of Florida is.

12 Thank you.

13 CHAIR CLEMONS: Thank you for being here, Joe.

14 Jon Harris, followed by Paul.

15 Good afternoon.

16 MR. MAURER: Good afternoon, Chair and
17 Committee Members.

18 Jon Harris Maurer, the public policy director
19 for Equality Florida.

20 HB 1421 deeply infringes on parental rights
21 and medical freedom, and it is a direct attack on the
22 existence of transgender Floridians, both minors and
23 adults.

24 This bill overrides parents' rights to seek
25 health care for their children, potentially lifesaving

1 health care accessed with the guidance of medical
2 professionals. Leading national health organizations
3 like the American Academy of Pediatrics, the American
4 Psychological Association, and the American Medical
5 Association support gender-affirming care for
6 transgender children.

7 But this is State-forced detransition. In a
8 matter of months, parents whose kids have been
9 successfully in care, who are thriving in care perhaps
10 for years, will be forced to terminate that care.

11 Its provisions also enable courts to change
12 custody agreements against a supportive parent,
13 depriving that parent of custody, treating them like
14 a child abuser simply for seeking care for their
15 child who is struggling.

16 This is also wildly overbroad, as previously
17 discussed. The ban on gender clinical interventions,
18 in fact, is in no way tied to gender dysphoria or
19 addressing gender transition. So when the bill
20 addresses, quote, "any other surgical procedures that
21 alter primary or secondary sexual characteristics,"
22 that includes breast augmentations and vasectomies.

23 CHAIR CLEMONS: Please wrap it up, please.

24 MR. MAURER: So those would no longer be
25 covered by insurance. When it addresses puberty

1 blockers, those would no longer be available to any
2 minors and, again, not covered by insurance.

3 Equality Florida fundamentally opposes this
4 bill and asks that you do the same.

5 CHAIR CLEMONS: Dr. Paul Ahrens, you're
6 recognized.

7 Letitia Harmon, you're up next.

8 Welcome, Dr. Ahrens.

9 DR. AHRENS: Good afternoon, Mr. Chairman and
10 Members.

11 My name is Paul Ahrens. I have a 40-year
12 career as a physician, 25 of which were with Florida
13 Public Health. I'm a constituent of Representative
14 Franklin.

15 Despite compelling testimony from individuals
16 and medical professionals about the life-affirming,
17 lifesaving benefits of gender dysphoria care, the
18 result of the hearing so far has been denial of
19 Medicaid reimbursement for essential gender
20 dysphoria services and rules by medical boards
21 prohibiting standard and vital care.

22 Why won't the powers that be listen to the
23 people? I think it's time to reexamine motivation.

24 In this and other states, officials have
25 apparently decided this is an easy way to harvest

1 votes to maintain a super majority against a
2 beleaguered powerless minority. In my book, that's
3 called bullying. This is a shameful bill based on
4 fringe theories and personal opinions rife with
5 cruelty and bullying.

6 The good news is that you can regain the
7 moral high ground and stop this here and now
8 today. Please, please vote down this awful bill.

9 CHAIR CLEMONS: Thank you for being here.

10 Letitia, you're up.

11 And, Wendell Beatty, you're on deck, please.

12 Welcome.

13 MS. HARMON: Letitia Harmon. I'm the policy
14 and research director for Florida Rising.

15 I'm here in opposition to this bill because
16 LGBTQ youth are four times more likely to attempt
17 suicide than their peers. Attacking our trans youth,
18 especially youth of color, is endangering lives.
19 Providing gender-affirming care is literally saving
20 lives.

21 One in four of transgender youth of color
22 attempted suicide in the past year. These are
23 children that we're talking about here. And if you
24 had the opportunity to save a child's life by
25 providing the necessary health care, by providing

1 them the therapy that they need -- these are children
2 who would rather commit suicide than go through life
3 without receiving the kind of affirming care that this
4 legislation bans. And if you could save a child's
5 life, why would you not do that?

6 Why would you not say, We see you; we honor
7 you; we see that you need to speak to someone to
8 figure this out. And there are ways to help you grow
9 and become fully who you are, and it may very well
10 change your entire perspective on life, so much so
11 that you want to continue living.

12 You could save a child's life by doing that.
13 And we urge you to do that, to stand with our youth,
14 to say: We see you; we honor your dignity; we
15 will provide you with health care. We will vote
16 no on this bill.

17 Thank you.

18 CHAIR CLEMONS: Thank you for being
19 here.

20 Wendell, one more bite at the apple.

21 Welcome back.

22 MR. BEATTY: Thank you, Mr. Chair.

23 Still Wendell Beatty, still gender dysphoric,
24 and still a veteran.

25 But WPATH works, so I guess good things are

1 worth repeating. Okay. It's a standard of care for
2 transgender people recognized by medical professionals
3 around the world. Please heed it. It saves lives.
4 This bill won't. It will be FUBAR upon delivery or
5 voted into law. Okay. And Florida is a free state,
6 and free states don't create refugees, which is
7 another thing this bill is starting to create.

8 Please oppose it. Please vote no.

9 CHAIR CLEMONS: Thank you again for
10 being here, Wendell. Thank you for your service.

11 Ryan Kennedy, you're up.

12 And, Patti Sullivan, you're after Ryan.

13 Welcome. And please keep it to about a
14 minute, please.

15 MR. KENNEDY: Thank you, Chair.

16 My name is Ryan Kennedy with the Florida
17 Citizens Alliance. We raise in strong support of this
18 bill today, and we thank the sponsor for bringing
19 it forward.

20 We believe that protecting children is a
21 strong, strong priority. It should be for any
22 government, any state, at the federal level.
23 Protecting children should be at the forefront, and
24 this is what this does, because these treatments are
25 experimental. They are dangerous, and they have a

1 lot of long-term side effects, as we have seen. And
2 even in Europe these gender clinics are closing down
3 that have done these procedures because they see the
4 side effects that it's causing in their children.

5 Why would we do the same in Florida by
6 allowing this to continue? This is why we should
7 support this bill. Vote yes.

8 Thank you.

9 CHAIR CLEMONS: Thank you for being here.

10 Patti Sullivan, you're up.

11 And, January Littlejohn, you're on deck.

12 Welcome.

13 MS. SULLIVAN: Thank you.

14 Patti Sullivan with Parental Rights of
15 Florida.

16 As many have already said and as the
17 representatives mentioned, Western European nations
18 are about ten years ahead of us with these studies.
19 And I've looked at many of these studies, and some of
20 them actually -- one of them out of Sweden argues
21 that medical transition is not the best option given
22 that medical transition suicide rate is actually 19
23 times higher than the normal average.

24 Also, WPATH itself is not a medical
25 association. Anyone can be a member of WPATH,

1 and you don't have to be a physician to do so. And
2 they, themselves, actually say in their writing that
3 they are not a standard of care, that they are
4 guidelines, recommended guidelines.

5 And so I would just ask you to vote and
6 support this. Many researchers have made it clear
7 that this is damaging to children, not only their
8 bodies, but in many other ways as well.

9 And the final point would just be that
10 puberty blockers, cross-sex hormones -- the puberty
11 blockers actually cause bone density loss in
12 children if they go through these puberty blockers
13 when they're minors. There are a lot of studies that
14 show the harm that happens to these children by taking
15 these drugs.

16 CHAIR CLEMONS: Thank you for being here.

17 MS. SULLIVAN: Thank you very much.

18 CHAIR CLEMONS: January Littlejohn, followed
19 by Aaron DiPietro.

20 Welcome.

21 MS. LITTLEJOHN: Thank you.

22 I am a mom and a licensed mental health
23 counselor in Florida.

24 Our daughter became confused about her sex
25 in 2020 after three of her friends claimed transgender

1 identities as well. We did not socially or medically
2 transition her. Instead, we worked with a licensed
3 counselor to help our daughter explore and resolve
4 co-occurring issues, including low self-esteem and
5 anxiety. We followed the path of watchful waiting,
6 and our daughter has desisted.

7 When a child is in distress or ill for any
8 reason, we look to doctors, and we trust them to give
9 us all treatment options available. I have spoken
10 to many parents in Florida, and that is not what is
11 occurring. They are not being told about watchful
12 waiting and that the majority of these children will
13 resolve their distress without intervention.

14 What parents are being told by doctors,
15 oftentimes in front of the child, is that affirmation
16 and medicalization is their only treatment option to
17 avoid the impending suicide of their child.

18 Suicide is told to parents as if it is a
19 guaranteed outcome versus a risk factor. And as a
20 mental health provider, I can tell you that there
21 are ethical ways of treating suicidal ideation.

22 CHAIR CLEMONS: Ms. Littlejohn, I've kept
23 everybody else within time. Please conclude.

24 MS. LITTLEJOHN: Yes, sir.

25 Making irreversible changes to children's

1 bodies before they can consent is not one of them.

2 I support this bill.

3 CHAIR CLEMONS: Thank you for being here.

4 Mr. DiPietro, followed by Ryan Kennedy.

5 Welcome.

6 MR. DIPIETRO: Thank you, Chair.

7 My name is Aaron DiPietro with the Florida
8 Family Policy Council, and we are in strong support
9 of HB 1421 and appreciate the support of the sponsors
10 very much.

11 So this bill helps kids struggling to embrace
12 their biological sex by protecting them from harmful
13 drugs and procedures. We should not be teaching
14 children who are struggling with their identity to
15 despise and hate their own bodies and feel that the
16 only way to be able to love themselves is to do harm
17 to their own physical bodies.

18 Giving children puberty blockers, cross-sex
19 hormones, and transgender surgeries violates the
20 first duty of medicine, to do no harm. A child who
21 identifies as the opposite sex deserves compassion
22 and mental health care. They should never be
23 chemically and surgically castrated or sterilized.

24 The pharmaceutical industry is pushing these
25 harmful experimental treatments on children to line

1 their own pockets. The transgender surgery market
2 is expected to reach nearly \$1 billion by 2024. We
3 must protect children and parents from being pressured
4 by ideologically and financially motivated gender
5 clinics into agreeing to these harmful experimental
6 treatments.

7 CHAIR CLEMONS: Please bring it in together.

8 MR. DIPIETRO: The proposal ensures
9 Florida's children receive help, not harm; treatment,
10 not transition; and protection, not politics.

11 We encourage you to support the bill.

12 Thank you.

13 CHAIR CLEMONS: Thank you for being here.

14 Julie Framingham, followed by Robert
15 Framingham, from New Port Richey.

16 Are you here?

17 After the Framinghams, it will be John
18 Labriola.

19 Welcome.

20 MS. FRAMINGHAM: Thank you.

21 I'm the mother of a 28-year old man who has
22 been identifying as transgender for the past six
23 years. While there are undoubtedly various
24 contributing factors responsible for the increase in
25 all the young adults who are experiencing this, I ask

1 that this committee support this bill.

2 I can tell you that my own son was diagnosed
3 by a Florida licensed therapist with borderline
4 personality disorder which was the root cause of his
5 severe depression and anxiety and his hatred for
6 himself. He has not gotten better with hormone
7 treatment. He has resisted therapy because he thinks
8 that the hormones are going to solve his problem.
9 He also wishes to get surgery.

10 And I can just tell you that it's really
11 difficult to see him the way that he is where he has
12 really kind of wasted six years of his life. He
13 dropped out of school because of his depression.
14 He's a very smart young man, and he's really
15 harmed his future by what he's doing.

16 So thank you very much.

17 CHAIR CLEMONS: Thank you for being here.

18 Mr. Framingham.

19 And after him, John Labriola.

20 Welcome.

21 MR. FRAMINGHAM: Mr. Chairman and Committee
22 Members, I strongly affirm this bill. I am very much
23 in favor of it.

24 My wife just spoke to you about my son, so I
25 am the father of a young man who dresses in female

1 clothes. And he has some serious mental disabilities,
2 and they're not getting better by his transitioning.
3 He's been transitioning for six years now.

4 And when he was young, he loathed himself.
5 He allowed his teeth to rot under his braces until
6 every tooth in his mouth has now got a root canal.
7 He has one implanted tooth. I paid \$160,000 copay
8 to keep his teeth going so that he would have teeth
9 in his head.

10 Now, clearly, there's a disconnect between
11 what he thinks he wants to be and should be and how
12 to live and what his body -- what he sees his body
13 as. But he wants to take -- to have surgery to
14 correct that disconnect. And I really think that a
15 mental health program would help him a whole lot.
16 And I think that this bill will -- by accenting mental
17 health will do wonders, will save children and --

18 CHAIR CLEMONS: Thank you.

19 MR. FRAMINGHAM: -- I think that one
20 thing should be --

21 CHAIR CLEMONS: Your time.

22 MR. FRAMINGHAM: All right. Thank you.
23 Thank you.

24 CHAIR CLEMONS: Thank you so much for coming
25 from New Port Richey.

1 Thank you.

2 Anthony -- sorry -- John Labriola.

3 MR. LABRIOLA: Good afternoon, Committee
4 Members.

5 The alarming rise in the sexual mutilation or
6 chemical castration of minors is easily the most
7 horrifying consequence of the LGBTQ movements's
8 increasingly aggressive indoctrination and grooming of
9 children. And that's what this is.

10 Treating a mental disorder with surgery is
11 not good science. It is malpractice. And it's an
12 agenda driven by ideology, not science, as has
13 been mentioned several times before.

14 Gender ideologues don't care about children's
15 health, and they're willing to sacrifice them and their
16 health and their lives on the altar of their perverted
17 agenda while unethical pharmaceutical companies and
18 gender clinics are getting rich off of these horrific
19 treatments.

20 Contrary to what's been said over and over
21 again by the LGBTQ ideologues in this room, passing
22 this bill will reduce the suicide rate and will be
23 an act -- major affirming act of saving people's
24 lives, saving children's lives.

25 So thank you.

1 CHAIR CLEMONS: Thank you for being here.
2 Anthony Verdugo. I believe that's correct.
3 Welcome, Anthony.
4 After that is Armando Pamar [phonetic].
5 Welcome.

6 MR. VERDUGO: Good afternoon, Mr. Chair and
7 Vice Chair, Members of the Committee.

8 I'm Anthony Verdugo, executive director of
9 Christian Family Coalition Florida, and we rise in
10 support of this bill, of HB 1421.

11 Look, children are beautiful as they are,
12 and they can have happiness and find happiness in
13 their own body. That's the message that we need to
14 send out.

15 All of you here who are supporting this bill
16 are heroes. Thank you for the work that you do.
17 You're extending mercy through legislation. We know
18 what happens when children are submitted to genital
19 mutilation. Depression, anxiety, and suicide results.

20 Sweden, who has conducted the most thorough
21 studies, shows that 20 percent of these individuals
22 eventually commit suicide.

23 So thank you for what you're doing, for
24 extending mercy and compassion to parents and children
25 all across the state.

1 Thank you, Representative Fine, for
2 presenting this great bill.

3 Please vote yes.

4 CHAIR CLEMONS: Thank you for being here.

5 Armando Pamar. Welcome, Armando. You're
6 recognized.

7 MR. PAMAR: Yes. Thank you, sir.

8 My support for the bill comes from my work
9 experience. I have been for over 14 years working as
10 a mental health technician. I've been at Memorial
11 Hospital and at Florida State Hospital. I have been
12 seeing some dealing with these issues, not necessarily
13 for an operation, but for their confusion when they
14 first come out. After that, they are suicidal. I
15 have had that at the Florida hospital.

16 And I will support this bill a hundred
17 percent.

18 CHAIR CLEMONS: Thank you, Mr. Pamar.

19 Are there any members of the public who have
20 not already spoken that would like to speak on this
21 bill?

22 Any members of the public who have not
23 already spoken?

24 Seeing none, then, Members, we are going to
25 move into debate.

1 We are now open for debate on the bill.

2 Who would be first?

3 Representative Anderson, you'll be
4 first. You're recognized.

5 REPRESENTATIVE ANDERSON: Thank you,
6 Mr. Chair.

7 And thank you, Chairmen -- and I say that as
8 a plural -- for working on this legislation.

9 I am one of the members that sit on Chairman
10 Fine's Healthcare Committee. I know some others here
11 are as well. And I remember a few weeks ago when we
12 had that panel presentation, and I'm reminded of that
13 during this conversation today, and I remember the
14 feelings that we all had on that committee. I don't
15 think there was a dry eye on that committee that
16 day.

17 And I remember leaving that room wondering
18 what is it that we can do to solve this. And we heard
19 from experts from all over the country on this subject.
20 I believe we actually had some subject matter experts
21 that were from Europe as well, so I can say throughout
22 the world.

23 And I'm thankful that you gentlemen are
24 working on this and finding a solution to this
25 problem. I know how hard it is to work on this. I

1 know how important it is. And I would challenge any
2 of the members of this committee here that if you're
3 questioning why we need this type of legislation, go
4 back and watch the footage from that panel discussion
5 in that Healthcare Committee.

6 So I will be up on this bill. And I thank
7 you for bringing this legislation.

8 CHAIR CLEMONS: All right. Ranking Member
9 Bartleman, you're recognized for debate.

10 REPRESENTATIVE BARTLEMAN: Thank you, Chair.

11 That panel did not include the hundreds and
12 thousands of success stories. That panel did not
13 include people who were happy about their transition.
14 That panel did not include other doctors who would
15 speak to the benefits.

16 Everyone who spoke today was speaking about
17 children. And everyone supports parental rights,
18 but I really feel that we only support those parental
19 rights that align with the philosophy of the majority
20 of this House.

21 There are many parents who want the right to
22 make decisions for their children that they feel are
23 in the best interests of their children, not in this
24 bill, but in another bill. If you want to talk about
25 doing something less invasive to help your child

1 with their dysmorphia, let them try pronouns. We're
2 not even going to allow that in this state. That's
3 not a medical intervention. That's in an education
4 bill.

5 This bill also attacks adults, and that's a
6 big problem I have. Because if this is really a free
7 Florida, when you reach the age of 18, you should
8 be allowed to make medical decisions for yourself,
9 and those decisions should be made holistically, not
10 just about your physical health, but your mental
11 health. And this bill is denying health insurance
12 coverage that is currently in place for these
13 individuals. So now you're taking away an option
14 for someone, and so I do not agree with that at all.

15 And the hardest pill for me to swallow with
16 this bill is the inhumanity of not grandfathering
17 individuals in who have been receiving care for four
18 or five years. It is inhumane and devastating to do
19 that to somebody.

20 Now, in my Florida, we love everyone. We
21 accept everyone. And as someone who loves someone,
22 loves multiple people who have transitioned and who
23 are currently transitioning, I'm going to leave you
24 with what they told me: *I am scared. I am scared --*
25 *this is an adult. I am scared. This is so harmful*

1 to me, and I am incredibly scared about my safety and
2 the safety of my peers.

3 We are vilifying a group of individuals.
4 If this is about kids and the adults in this room
5 think this is the best decision for children, then be
6 transparent and just make this bill about children.
7 But it's not. It's going a step further and
8 infringing on the rights of adult Floridians and their
9 access to care by denying them health insurance
10 coverage.

11 So if the bill was -- it's just -- if it's
12 about kids, keep it there. But it's not. And mark
13 my words, there will be more to come. And you're
14 vilifying one group of individuals. They already have
15 the highest suicide rates. And it's hard for them to
16 come up and share their stories, and they do not feel
17 heard.

18 So I am asking you before we get to the vote
19 on the floor, which is going to pass, to consider the
20 grandfather clause. Please speak to people who are in
21 this who are dealing with this now and their families
22 are dealing with it, and please listen to the adults
23 who have success stories and are happy with their
24 lives and don't take it that extra step. Let those
25 adults live their free lives in the free state of

1 Florida.

2 Thank you.

3 CHAIR CLEMONS: Representative Hunschofsky
4 for debate.

5 REPRESENTATIVE HUNSCHOFSKY: Thank you,
6 Mr. Chair.

7 There's so much to unpack here. Let me start
8 by saying thank you to everybody who came out today
9 to speak, and thank you to all the people who reached
10 out to me privately.

11 We've heard a lot about feelings and opinions
12 on things. I went directly to the bill, to sections
13 of the bill in my questioning I have problems with,
14 mainly that section, lines 45 to 47 that says
15 "procedures or therapies that alter internal or
16 external physical traits." And that was the
17 definition for gender clinical interventions. And
18 that covered -- this bill also covers health insurance
19 for adults. So it could include not allowing health
20 insurance to cover a mastectomy for a grown woman,
21 and that is specifically in the amendment. That is
22 not my feelings, but literally something that is
23 very unclear here.

24 External physical traits aren't defined
25 either. So does that mean when a child is in an

1 accident and a limb needs to be removed that that
2 can't be done, that a scar can't be fixed?

3 There are a lot of questions, in my opinion,
4 from a technical perspective in what is written in
5 this bill that I hope will get clarified at some
6 point.

7 My personal concern and feeling with this is
8 that we are so intent on judging a certain group of
9 people that we -- we're not clear and very broad in
10 many of the definitions in here.

11 Additionally, adding the statute of
12 limitations, which right now I believe under medical
13 malpractice in a civil action can't exceed a 7-year
14 period, we're now extending it to 30 years here.

15 So that if somebody had a breast augmentation or, as I
16 mentioned earlier, a penile implant, they could now go
17 back and it would be 30 years because those are not
18 clear in the gender clinical intervention definition.

19 We talk about parental rights. We talk about
20 freedom. We talk about respecting veterans.

21 And, Wendell, I just want to thank you for
22 your service.

23 My personal concern in a lot of the dialogue
24 that is associated with this is we only care about
25 parental rights when we agree with the choice the

1 parent makes. We only support veterans when we agree
2 with the choices that the veterans make. We only
3 support freedom when we agree with the choices that
4 the people make.

5 And this type of discussion keeps coming up
6 over and over again. I have several friends whose
7 children have transitioned, and they're doing great.
8 They're living successful lives, and they did what was
9 best for them.

10 As a mother, I keep going back to how we're
11 talking about human beings. And I don't know where
12 we end up when we continue to talk about human beings
13 like they're not here, like their experiences don't
14 count and don't matter.

15 When I talk to my kids, I let them know that
16 what their life has been like isn't like what
17 everybody's life has been like and that we all as
18 citizens, as just decent human beings have an
19 obligation to not only tell our stories, but to hear
20 other people's stories, and that at least when we are
21 talking about someone else's experience, that we do
22 so with the utmost care, compassion, and respect.
23 Because if we believe in God or someone, whoever
24 else, then the very least we can do when discussing
25 matters about human beings is to do so with the utmost

1 respect and compassion.

2 I will be down on this bill today for a lot
3 of reasons and very specifically for the technical
4 reasons that I believe the language is very general,
5 is not specific enough, is now changing civil statutes
6 of limitations for things like a nose job, that it is
7 denying insurance to things that it wouldn't have
8 before. And I hope that at the very least as we go
9 forward that when we are talking about other human
10 beings and their experiences that we do so with
11 respect and compassion.

12 Thank you.

13 CHAIR CLEMONS: Representative Black in
14 debate. You're recognized.

15 REPRESENTATIVE BLACK: Thank you,
16 Mr. Chairman.

17 Thank you, Representatives, for bringing
18 this good bill.

19 I want to thank you for your courage and for
20 offering a simple, common sense, and very
21 forward-looking piece of legislation, for recognizing
22 an essential truth, and that is that these children
23 are actually victims, once called patients, because
24 we allowed ideology to masquerade as medicine.
25 Thank you for putting a stop to it. Thanks for making

1 sure that Florida does not have to repeat the
2 tragedies that have been undergone in Europe.

3 I thank you. I look forward to cosponsoring
4 this legislation. I encourage all of my colleagues
5 to vote yes.

6 CHAIR CLEMONS: Vice Chair Borrero, you're
7 recognized in debate.

8 REPRESENTATIVE BORRERO: Thank you, Chairman.

9 Members, you've heard in this committee from
10 the other side talk about how somehow if we pass this
11 bill we are going to kill people. Nothing could be
12 further from the truth. In fact, what this bill
13 actually does, it saves lives.

14 I wonder why the other side hasn't talked
15 about the people that this bill -- that gender
16 transition actually kills. In fact, you've heard
17 the term "deadnaming," because that is exactly what
18 happens when someone transitions to another gender.
19 That child, that son, that daughter, that brother,
20 that sister that you once knew is no more. That
21 person no longer exists. He changes his gender and
22 is no more.

23 This bill, what it actually does is it saves
24 lives. It saves them. It doesn't kill them. And it
25 recognizes who they are in the eyes of God.

1 Members, I encourage all of you to support
2 this very good bill and to save lives.

3 CHAIR CLEMONS: Representative Rudman in
4 debate. You're recognized.

5 REPRESENTATIVE RUDMAN: Thank you, Mr. Chair.

6 Representative Fine, Dr. Massullo, I just
7 wanted to lend my voice in support of your bill. I
8 also wanted to dispel a few rumors here today.

9 We've heard that, you know, some of us must
10 feel like these lives don't matter or that somehow
11 we don't hear them or, even worse, that we don't
12 care. Well, let me tell you, as a family doctor, I
13 have at least three patients that I'm aware of who we
14 currently see for gender dysphoria.

15 Now, these patients know when they make the
16 appointment, they know when they see me that I am not
17 going to prescribe off-label hormones for their usage.
18 They know they're not getting testosterone; they're
19 not getting estrogen from me. They know they are not
20 getting a referral to a surgeon.

21 What they do get from me, they get my most
22 valuable commodity. They get my time. We sit and we
23 talk about the issues they're struggling with. We'll
24 talk as long as it takes, and my staff will be the
25 first to tell you that.

1 So this argument that somehow we don't hear
2 them or we don't want to see them or we don't even
3 care about them, that is patently untrue.

4 And so I just wanted to let you be aware of
5 that because we're hearing kind of the other side of
6 the story, and I can tell you from experience that
7 that is not true. We care deeply for these patients.

8 And because I do care deeply for these
9 patients, I'm up on your bill.

10 CHAIR CLEMONS: Are there other members who
11 would like to debate this bill?

12 Other members like to debate this bill?

13 Representative Skidmore, you're recognized
14 for debate.

15 REPRESENTATIVE SKIDMORE: Thank you,
16 Mr. Chair.

17 You know, it's hard. It's really hard to
18 make these decisions for people when I really think
19 they should be able to make these decisions for
20 themselves. And we philosophically just disagree.

21 I know that Representative Fine and
22 Representative Massullo think they're doing a good
23 thing here. And everyone who votes yes on this bill
24 thinks they're doing a good thing here. And those of
25 us and my colleagues who have spoken before me who

1 oppose this bill oppose it because we think you're
2 doing a bad thing. We both think we're helping
3 people. We both think we're saving lives. And so
4 who's right and who's wrong?

5 I find it interesting when we think about
6 the panel discussion and that there wasn't a dry eye
7 in the room because one person talked about her
8 detransition. But who was crying for everyone else
9 who came up here today, who begged you to listen to
10 them and hear their story and how they felt saved by
11 their treatment, by their gender-affirming care?

12 So we're picking the winner and we're picking
13 the loser based on who actually emotionally spoke to
14 us or made us cry. And we need to get out of
15 everybody's business. These are health care
16 decisions, just like abortion. These are personal
17 health care decisions. And I don't know why all my
18 conservative friends want to get in everybody's
19 business. I really thought we were about less
20 government, fewer taxes. Apparently that script is
21 flipped. We want to tell everybody what they can
22 and cannot do and who they can and cannot love and
23 how to plan for families and what books to read and
24 what classes to take and so many things where
25 government doesn't belong.

1 This is a very personal decision. We want
2 to empower families. Let's empower families. Let's
3 let them make the best decisions for their children
4 with their doctors, doctors, who do this work.
5 Instead, we're going to criminalize physicians, which
6 it shocks me that physicians are supporting. We're
7 going to criminalize doctors for doing the care that
8 they've been trained to give.

9 These are decisions that government doesn't
10 belong in.

11 I'm not changing anybody's mind, I understand
12 that. But I want you to think about why Chloe made
13 you cry but Wendell didn't, and look inside your heart
14 and figure out why that is.

15 CHAIR CLEMONS: Any further Member wish
16 to debate?

17 Any further Member wish to debate?

18 You're welcome to debate.

19 REPRESENTATIVE BELL: Thank you, Mr. Chair.

20 I wasn't going to debate, but after hearing
21 both sides, I feel like I just need to say something.

22 As a parent, a mother of two daughters that
23 never came to me and wanted a sex change, their
24 friends never wanted a sex change, I never have lived
25 in that world of sex changes, but I do sympathize

1 with the ones that do want it. However, you should
2 not be making a decision for your child under the
3 age of 18 to change them.

4 And I applaud both Chairs here for the guts
5 to do this. Three years ago I was sitting -- actually
6 it was over in the Senate, and we listened to people
7 that paraded their children up in front of us, an
8 8-year-old child that they did -- mutilated him. It
9 was a little boy, changed him into a little girl, and
10 he wished that he could be a boy again.

11 There was a woman that her father had three
12 boys and -- I'm sorry -- three daughters, and she was
13 the fourth daughter. And he changed -- started
14 giving her male hormones when she was 6 months old
15 and changed her into a man. She did not want that.
16 Now she has hair on her chest, hair on her face.
17 She was changed. And she said that she would like to
18 be a woman again, but her life has been
19 destroyed.

20 If somebody wants to change their sex, let
21 them do it when they're 18 years old, but don't do it
22 on the backs of the taxpayers. I don't feel like I
23 should pay for anybody to have a sex change, period.
24 But we are sympathetic. And for the other side to sit
25 here and call us -- you know, we have no heart for

1 these people, we do have hearts. But a colleague
2 told me earlier -- said, you know, we're not trying to
3 hurt them; we're trying to help them.

4 So I thank you for allowing me to speak.
5 I hope this bill passes.

6 Thank you again to the sponsors. I thank
7 you for your courage because this should have been
8 done three years ago and we're just now doing it.

9 Thank you.

10 CHAIR CLEMONS: Any further Members wish
11 to debate?

12 Seeing no further debate, Members, you're
13 welcome to close on your bill.

14 You're recognized, Representative Massullo.

15 REPRESENTATIVE MASSULLO: Thank you,
16 Mr. Chair.

17 Members, you have a very difficult job,
18 particularly when we have issues like this that are
19 hard. They bring out a lot of emotions, and we're
20 just people. We're human beings. And those emotions
21 often lead us sometimes to extremes, to thinking about
22 bullying and falsehoods and trying to get to a point
23 where really we're trying to make a subject into
24 something that makes us feel better.

25 But our primary role as legislators, as

1 lawmakers of Florida, or any state, is to protect our
2 citizens. And no matter what opinions we have, we
3 have to work hard to strive to get to the truth. And
4 I want to just leave you with three truths:

5 No. 1, since I started walking these halls
6 in 2016 by the grace of the individuals that felt to
7 put their trust in me to come up here and help make
8 laws and represent them, the number of individual
9 minors with gender dysphoria has tripled, tripled.
10 We don't see that in just about any other field of
11 medicine regarding pathology. These individuals, as
12 you've heard from testimony, have comorbidities,
13 psychological issues, issues with their experiences
14 and their environment that we need to take into
15 consideration. That's one truth.

16 The second truth is there's no such thing as
17 someone being able to change their sex. They may be
18 able to change the way their body works, their
19 physiology. They may be able to change their
20 appearance. But they are born either one sex or
21 another, or some individuals are born intersex that
22 have a chromosome or other type of genetic anomaly.
23 This bill doesn't deal with those individuals. It
24 doesn't deal with the individuals that Representative
25 Tant basically explained. This deals with individuals

1 that have a sense that they don't belong to the sex
2 that they actually were born to have.

3 And we do vary in our basic psychology
4 oftentimes. And, Representative Skidmore, I agree
5 with you. Sometimes we have different opinions on
6 what's right and what's wrong. That's what makes our
7 government so collaborative. That's what makes us
8 get to decisions that actually make sense. But I have
9 to disagree with you because there are truths, and in
10 medical care we are to do no harm.

11 And the third truth I want to leave you all
12 with are these procedures, these treatments do much
13 more harm than good. And for us to continue those
14 would be disgraceful as a state, and as a person in
15 the medical profession, I would not be able to live
16 with myself and allow those to continue to occur.

17 Chair Fine.

18 REPRESENTATIVE FINE: Thank you. Thank you,
19 Dr. Massullo. It's an honor to work with you on this
20 bill.

21 Ranking Member Skidmore said that we can't
22 change minds, and maybe we can't, but I can assure
23 you of this: God blessed me with the ability to talk,
24 and I'll never stop using it to do right.

25 Representative Hunschofsky, you pointed out

1 lines 45 to 47 of the bill, and you said you worried
2 about things like breast surgeries for adults and
3 things like that. I just want to remind people, you
4 have to read the whole section. And if you go through
5 48 to 53, it does make it clear this is about sex
6 reassignment and puberty blocking.

7 That said, we will make sure the concern that
8 you have is addressed, because that's certainly not
9 our intent.

10 Representative Bartleman, this bill does not
11 affect an adult's ability to make the decision that
12 they want to make. We're not doing that. They can
13 do it. What it says is that a 13-year-old or a
14 14-year-old or a 16-year-old should be an adult before
15 they make those decisions. We are not -- yes, we're
16 saying that other people don't have to pay for it.
17 I think that is a pretty reasonable statement to make.
18 We're not restricting their ability to do whatever
19 they want to their bodies as an adult.

20 I don't think the folks who speak in
21 opposition of this bill are villains. I think they're
22 victims. And I think what we've heard in this debate
23 and what will continue here is the weaponization of
24 two things. The first weaponization is the fake
25 science. We heard this with COVID, right, the science

1 has established. Now, I believe in the vaccine,
2 got them all. COVID almost killed me. But we were
3 told the science said if you get the vaccine, you
4 won't catch it. Remember? Wasn't true. It did keep
5 you from dying, but they said you wouldn't catch it,
6 and that was not true. They said the science
7 establishes we should keep all of the schools closed.
8 Children's lives are going to be changed forever
9 because they were kept out of school for so long.

10 And in this instance we get told the science
11 has established because there's some group -- and
12 it's been mentioned -- called WPATH that's gotten all
13 of these groups to agree. Well, I want you to know
14 what they all agreed.

15 You were probably all horrified when
16 Representative Bell talked about a child being given
17 these things when they were 6 years old or 3 years old
18 or 6 months old. I bet all of you thought no one
19 would ever do that. I bet the people who oppose this
20 bill said that's insane.

21 Well, this so-called scientific group, they
22 made a choice in their last set of recommendations.
23 They deleted the minimum age recommendations for all
24 of it. They're not even willing to say this shouldn't
25 happen to a 1-year-old or a 2-year-old. The

1 weaponization of science. The science is not in
2 agreement on this. We talked about Finland. We
3 talked about Sweden. We talked about the U.K. It is
4 not established.

5 But I think there's also a weaponization of
6 another word, a weaponization of the word "care." It
7 is not health care to cut someone's body parts off.
8 That is not care. And it is not care to give someone
9 drugs to stop the natural-occurring process of
10 puberty, which we now know from the studies have
11 effect on their bone density and, think about it,
12 their brains that are developing. That is what the
13 science shows. This is not care. They are not
14 villains; they are victims.

15 But we also know that most of the people who
16 this happens to have comorbidities. Chloe Cole --
17 and there are many like this -- she had autism, but
18 they didn't deal with that. They told her parents,
19 You can have a dead daughter or a live boy.

20 You know who loses in this bill? Dr. Teetus
21 Deletus, who's figured out a way in her plastic
22 surgery business -- most plastic surgeries in her
23 business you do have to pay for out of pocket. And I
24 had a plastic surgeon come to me and say, Why do
25 people like this? Because they figured out a way to

1 get to the holy grail, insurance; someone else pays.

2 You know who else loses? Somebody that I
3 hear my colleagues often have issues with, Big Pharma,
4 \$12,000 a year to help with this. They're not
5 villains; they are victims.

6 I know a thing or two about being bullied.
7 I'm not going to talk about it today, but we do this
8 bill to protect children. We do this bill to protect
9 a girl who when she was 13 years old -- think about
10 what you wanted when you were 13 years old -- and who
11 doctors -- and, by the way, what is generally
12 considered one of the better hospitals in this country,
13 told her parents, Dead daughter, live boy. They put
14 her on these drugs at 13, and at 16 they cut her
15 breasts off. And we heard her here.

16 But her story isn't even the worst.
17 Yesterday I read about Layla Jane. They put her on
18 these drugs at 11 years old. They cut her breasts
19 off at 13. This is not care. This is an abomination.

20 You have the chance today to make sure
21 this doesn't happen in Florida.

22 With that, I ask for your favorable support.

23 CHAIR CLEMONS: Representatives Fine and
24 Massullo having closed on House Bill 1421, Sabrina,
25 please call the roll.

1 THE CLERK: Representatives Abbott?

2 REPRESENTATIVE ABBOTT: Yes.

3 THE CLERK: Anderson?

4 REPRESENTATIVE ANDERSON: Yes.

5 THE CLERK: Baker?

6 REPRESENTATIVE BAKER: Yes.

7 THE CLERK: Bartleman?

8 REPRESENTATIVE BARTLEMAN: No.

9 THE CLERK: Bell?

10 REPRESENTATIVE BELL: Yes.

11 THE CLERK: Black?

12 REPRESENTATIVE BLACK: Yes.

13 THE CLERK: Borrero?

14 REPRESENTATIVE BORRERO: Yes.

15 THE CLERK: Chaney?

16 Franklin?

17 REPRESENTATIVE FRANKLIN: No.

18 THE CLERK: Hunschofsky?

19 REPRESENTATIVE HUNSCHOFSKY: No.

20 THE CLERK: Persons-Mulicka?

21 REPRESENTATIVE PERSONS-MULICKA: Yes.

22 THE CLERK: Rudman?

23 REPRESENTATIVE RUDMAN: Yes.

24 THE CLERK: Salzman?

25 REPRESENTATIVE SALZMAN: Yes.

1 THE CLERK: Skidmore?

2 REPRESENTATIVE SKIDMORE: No.

3 THE CLERK: Snyder?

4 REPRESENTATIVE SNYDER: Yes.

5 THE CLERK: Tant?

6 REPRESENTATIVE TANT: No.

7 THE CLERK: Trabulsy?

8 REPRESENTATIVE TRABULSY: Yes.

9 THE CLERK: Chair Clemons?

10 CHAIR CLEMONS: Yes.

11 THE CLERK: 12 yeas and 5 nays.

12 CHAIR CLEMONS: Members, by your vote please

13 show this --

14 THE SECRETARY: I'm sorry. 12 yeas and

15 5 nays.

16 CHAIR CLEMONS: Members, by 12 yeas, 5 nays

17 please show that HB 1067 [sic] passes.

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CERTIFICATE OF REPORTER

STATE OF IOWA)

COUNTY OF WARREN)

I, Terri L. Martin, Certified Shorthand Reporter, certify that I was authorized to and did stenographically transcribe the foregoing audio recording to the best of my ability and that the transcript is a complete record of my stenographic notes.

Dated this 25th of August, 2023.

/s/ Terri L. Martin

Terri L. Martin, CSR, RPR, CRR

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TRANSCRIPTION OF AUDIO RECORDING

FLORIDA SENATE

FISCAL POLICY COMMITTEE MEETING

FLORIDA CHANNEL

Thursday, March 23, 2023

8:30 a.m.

Stenographically Transcribed Audio Recording By:
Terri L. Martin, Certified Shorthand Reporter

Med Def_001913

1 Whereupon, the following proceedings were
2 transcribed from an audio recording:

3 CHAIR HUTSON: All right. Members, we're on
4 our last bill. That is tab 5.

5 Before I get to that, a little bit of
6 housekeeping I have that either was misplaced or
7 came in late. But on Senate Bill 210, Kasey Denny
8 from Palm Beach County was waiving in support on that
9 bill.

10 Tab 5, CS for SB 254, "Treatments for
11 Sex Reassignment" by Senator Yarborough.

12 Senator Yarborough, you're recognized to
13 explain the bill.

14 SENATOR YARBOROUGH: Thank you, Mr. Chairman
15 and committee. Good morning.

16 Parents have the right and responsibility
17 to raise their children as they see fit, and
18 government intervention should be a last resort. I
19 filed this legislation because I believe as lawmakers
20 we do have to draw the line when drastic, life-altering
21 gender dysphoria therapies and surgeries are being
22 prescribed for young children.

23 Our laws should set appropriate boundaries
24 that respect the rights and responsibilities of
25 parents while protecting children from the serious

1 health safety and welfare risks.

2 I also believe our laws should firmly respect
3 that both parents have a right to be involved in the
4 upbringing of a child. One parent should not be able
5 to unilaterally attempt to change the sex of their
6 child. With the exception of extreme circumstances,
7 custody arrangements typically honor the rights of
8 both parents to be involved in major decisions and
9 events in a child's life. If one parent is attempting
10 to authorize drastic, life-altering sex reassignment
11 therapies and surgeries, then, by all means, the other
12 parent should have the ability to have a court review
13 the custody agreement.

14 Since I filed this bill, I have listened
15 to feedback and answered important questions from
16 those who opposed the bill as well as those who
17 support it.

18 In order to clear up any misconceptions
19 about the child custody provisions of the bill, I
20 proposed a PCS in a Health Policy Committee which
21 that committee adopted.

22 The bill has three goals: First, to protect
23 Florida's children from being subjected to
24 irreversible and life-altering sex reassignment
25 prescriptions and procedures; second, to require that

1 when adults seek these prescriptions and procedures,
2 the treatments can be legally provided only after the
3 patient has been informed of the nature and risks of
4 the treatment in order to make a prudent decision;
5 and, third, to protect against the expenditure of
6 state funds for these sex reassignment treatments.

7 So, first, with regard to protecting
8 children, the bill has a number of provisions to
9 protect children from being subjected to the
10 treatments. The bill amends Florida's child custody
11 statutes to give courts in the state jurisdiction
12 to enter, modify, or stay a child custody
13 determination relating to a child in the state to
14 protect the child from being subjected to sex
15 reassignment prescriptions or procedures.

16 Next, the provision provides courts with
17 discretion to determine whether and how to act to
18 protect the child. The provision does not require
19 a court to take any specific action or require a
20 court to ignore a child custody determination made
21 by a court of another state.

22 The bill prohibits Florida health care
23 practitioners from providing these treatments for
24 children, but makes an exception for children who
25 were already receiving prescription treatments when

1 this bill would become law. The bill requires that
2 the continuation of prescription treatment for such
3 children must be administered by a medical doctor or
4 osteopathic physician and must be consistent with
5 emergency rules adopted by the Board of Medicine
6 and the Board of Osteopathic Medicine. These boards
7 have spent the past eight months extensively reviewing
8 research, hearing from medical experts, and listening
9 to the public on this very issue and are the
10 appropriate bodies to determine standards of care for
11 these children who are already receiving the
12 prescriptions.

13 The bill creates a third-degree felony for
14 health care practitioners who willfully or actively
15 participate in violating the prohibition against
16 providing these treatments to a child.

17 The bill amends existing law relating to
18 authority for the Department of Health to issue an
19 emergency order suspending the license of a
20 practitioner who is arrested for violating certain
21 crimes. The bill adds the crime of providing these
22 prescriptions or procedures to a child to that list.

23 And the bill provides that any hospital,
24 ambulatory surgical center, or physician's office
25 registered for the provision of office surgery must

1 provide a signed attestation to ACHA or DOH, as
2 applicable, that they do not offer or provide sex
3 reassignment treatments for children, except for
4 those who are already being treated before this bill
5 would become law, and also do not refer such patients
6 to other providers for the treatments. A facility's
7 failure to provide this attestation will lead to
8 revocation of the facility's license or registration.

9 With regard to protecting adults, if an
10 adult decides to seek treatment with sex reassignment
11 prescriptions or procedures, the bill ensures that
12 only licensed medical doctors and osteopathic
13 physicians can lawfully provide such treatment. The
14 physician providing the treatment must take certain
15 measures to inform the patient of the nature and
16 risks of the treatment while physically in the same
17 room as the patient, using forms approved by the
18 Department of Health. The patient must provide
19 voluntary written informed consent before treatment
20 can commence.

21 The bill provides that a health care
22 practitioner other than a physician who provides
23 these treatments or a physician who provides the
24 treatments without obtaining voluntary informed
25 consent commits a first-degree misdemeanor.

1 Lastly, with regard to protecting state
2 funds, the bill creates a prohibition against the
3 expenditure of state funds for these treatments by a
4 governmental entity or organizations contracted by the
5 State to manage the provision of Medicaid services or
6 to manage the state's mental health and substance
7 abuse providers.

8 Mr. Chair and committee, that is the bill.

9 CHAIR HUTSON: Thank you, Senator Yarborough,
10 for explaining that bill.

11 Members, if we want to do questions after,
12 we can take up the amendments first, if that's all
13 right with you. So let's go ahead -- without
14 objection, let's take up the first amendment. That's
15 barcode 212692 by Senator Jones.

16 Senator Jones, you're recognized to explain
17 the amendment.

18 SENATOR JONES: Thank you so much, Mr. Chair,
19 and thank you, Senator Yarborough.

20 Members, this amendment, it deletes the
21 requirement for a physician providing sex reassignment
22 treatment to be physically in the same room as the
23 patient when meeting requirements related to informed
24 consent. So that's practically talking about
25 telehealth. It deletes the requirement that only

1 an allopathic or osteopathic physician may prescribe,
2 administer, perform sex reassignment treatments.

3 This portion that I'm doing this amendment
4 for is to ensure because -- according to the bill
5 sponsor, he's made mention that it's protecting
6 children. But based on what's in -- how it's
7 currently written, this would prevent adults from
8 being able to get the health treatment that they
9 would need.

10 So if it's about the children, then, of
11 course, I think we should leave it at that. But I
12 think adults are wise enough to make the decision for
13 themselves, and we shouldn't be taking that type of
14 treatment away from them, especially if they're
15 looking to do it through telehealth.

16 That is the amendment, Mr. Chair.

17 CHAIR HUTSON: Thank you.

18 Any questions on the amendment, Members?

19 All right. Seeing none, I've got Aurelie
20 Colon -- is that correct -- of the National Latina
21 Institute for Reproductive Justice Florida. She's
22 waiving in support. Kara Gross with ACLU Florida
23 is waiving in support. We have one speaker, Jon
24 Maurer with Equality Florida.

25 You are recognized to speak for the

1 amendment.

2 MR. MAURER: Good morning, Chair and
3 committee members. My name is Jon Harris Maurer,
4 and I'm the public policy director for Equality
5 Florida, and Equality Florida supports this good
6 amendment.

7 The bill sponsor mentioned that this is
8 necessary for protecting adults. This is, in fact,
9 patronizing and insulting to adults who have been in
10 care for many years. We're not talking about people
11 who are making an urgent decision. We're not talking
12 about minors who may struggle with informed consent.
13 These are adults who have been seeing providers for
14 potentially decades about surgery, therapies that
15 they consider to be incredibly [cough].

16 We're talking about limiting their access to
17 telehealth. We know that telehealth is incredibly
18 important for a lot of our rural communities where
19 they have limited access to services. We're talking
20 about ensuring that these adults can still seek care
21 from RNs and HRNs who deliver an incredible amount of
22 gender-affirming care. Again, these are qualified
23 professionals, and we're talking about adults who
24 should be able to make these decisions.

25 We know that we've talked a lot in this

1 session about medical freedom, and this is an issue
2 that we should be preserving that sort of freedom.
3 We opened this meeting by talking about liberty and
4 justice for all. We're asking for the liberty for
5 these adults to be able to continue accessing care in
6 the way that they have for years. We support the
7 amendment.

8 CHAIR HUTSON: Thank you very much.

9 Any debate on the amendment?

10 Senator Yarborough, you're recognized in
11 debate.

12 SENATOR YARBOROUGH: Thank you, Mr. Chair.

13 I appreciate the amendment, Senator Jones,
14 and we had the opportunity to talk about this in the
15 other amendment yesterday. This is an unfriendly
16 amendment. At this time we have a duty to protect
17 the public and ensure public safety when authorizing
18 treatments that are inherently dangerous.

19 So similar to how we have addressed treatment
20 for medical marijuana and abortion, this bill follows
21 the same approach. It only authorizes physicians to
22 treat patients for sex reassignment treatment. The
23 treatments have the potential for life-altering
24 effects and should be provided by our most highly
25 educated and trained health care practitioners,

1 as well as being regulated in a heightened manner and
2 differently than most other medical treatments.

3 So, for that reason I would ask the
4 committee to oppose the amendment.

5 CHAIR HUTSON: Thank you, Senator Yarborough.
6 Any other debate?

7 Seeing none, Senator Jones, you're recognized
8 to close on your amendment, barcode 212692.

9 SENATOR JONES: Thank you so much, Mr. Chair.

10 Members, just for clarity, this body has --
11 we have done extensive work on telehealth, and we
12 have focused on children. But this bill drastically
13 reduces the essential medical care for transgender
14 adults. I think Jon made it clear just a few
15 minutes ago that these treatments pertain to adults
16 who go to receive this treatment. I think we are
17 setting a dangerous precedent about government
18 interference in the personal decision-making for the
19 adults. And banning telehealth and banning qualified
20 nursing professionals from being able to administer
21 this prescribed medical care to the informed
22 consenting adults, we all, I think, can agree that is
23 wrong, and it's a large barrier to access for our
24 transgender community, many who already face massive
25 disparity in health care and receiving treatment.

1 That is the amendment and my close.

2 Thank you.

3 CHAIR HUTSON: Close on the amendment.

4 All in favor of the amendment, say yea.

5 All opposed, say nay.

6 Show the amendment not adopted.

7 We're now on amendment -- unless there's
8 objection, which there is not, we will take up the
9 late-filed amendment, barcode 350064, by Senator Jones.

10 Senator Jones, you're recognized to explain
11 the amendment.

12 SENATOR JONES: Thank you so much, Mr. Chair.

13 Members, this amendment more particularly --
14 last -- just the day before yesterday, we voted on a
15 bill that spoke about protecting children. And I went
16 into detail about the suicide rate of not just
17 transgender youth, but LGBTQ youth. West Virginia
18 passed a similar type of legislation in what we are
19 doing today; matter of fact, basically the same type
20 of legislation that we're proposing to pass today.

21 As you all know, West Virginia is an
22 extremely Republican-dominated legislature. But their
23 bill that they have contains an exemption. It's a
24 significant exemption that they have in West Virginia
25 to the medication and therapy ban for young people

1 under the age of 18, but for those who are at risk
2 of suicide. Their Senate majority leader -- his name
3 is Dr. Tom Takubo -- he's a physician. And what he
4 put forth would allow some transgender youth to
5 continue receiving medical interventions under certain
6 circumstances, including hormone therapy, if they
7 experienced severe gender dysphoria.

8 For those who are not clear on gender
9 dysphoria, by medical professionals it is defined as
10 a severe psychological distress experienced by those
11 whose gender identity differs from their sex
12 assignment at birth.

13 One of the things that Dr. Takubo said
14 while he was making his speech on the Senate floor,
15 he said that it referenced 17 peer-reviewed studies
16 showing a significant decrease in the rates of
17 suicidal ideation and suicide attempts among youth
18 with severe gender dysphoria who have access to
19 medication therapy. And he went on to say: *These*
20 *kids struggle. They have incredible difficulties.*

21 Knowing that we just passed out of
22 committee the bill about protecting children, I
23 think that -- I don't believe anyone on this
24 committee want to see children do harm to themselves.
25 And so this amendment protects children, especially

1 children who have been diagnosed with severe gender
2 dysphoria. But here's the thing. It's by two
3 medical or mental health practitioners. I'm going
4 to repeat, two medical or mental health practitioners.

5 In our last committee, one of my colleagues
6 made the comment that we need to not operate on
7 hypotheticals, but we need to operate in facts. That
8 is what was said. Well, here are the facts: 80
9 percent of the young people who suffer from gender
10 dysphoria have attempted suicide or have considered
11 some kind of self-harm to themselves, 80 percent.

12 And so all this amendment is doing is
13 saying -- we're not changing anything. We're saying
14 that those young people who experience severe gender
15 dysphoria, that the doctor -- you need two doctors,
16 the medical and/or a mental health professional, to
17 make that decision.

18 And in the amendment, it says: *The minor*
19 *has been diagnosed with severe gender dysphoria by*
20 *at least two medical and/or mental health practitioners*
21 *with certain qualifications. The diagnosing*
22 *practitioners express in writing that treatment with*
23 *sex reassignment prescriptions or procedures is*
24 *medically necessary to treat the minor and limits*
25 *self-harm or the possibility of self-harm. The minor,*

1 the minor's parents, other persons charged to make
2 decisions about the minor's care, and the minor's
3 primary physician agree in writing with the treatment.
4 The use of sex reassignment prescriptions is limited
5 to the lowest dosage necessary to treat the minor's
6 psychiatric condition and not for the purpose of
7 sex reassignment.

8 But I also want to take you on to line 29
9 of the amendment. It says: *Notwithstanding the*
10 *subparagraph, sex reassignment prescriptions or*
11 *procedures -- listen to this part -- may not be*
12 *provided to the minor if the minor is prepubescent,*
13 meaning that they have not hit puberty yet.

14 So I want to make it clear that this is
15 something that we are talking about, children who
16 are experiencing severe gender dysphoria to prevent
17 them from doing any harm or committing suicide.

18 And that is the amendment, Mr. Chair.

19 CHAIR HUTSON: Thank you, Senator Jones,
20 for thoughtfully reading your amendment in full.

21 Do we have any questions on Senator Jones'
22 amendment?

23 Any questions?

24 Okay. Seeing none, we have Kara Gross with
25 the ACLU of Florida waiving in support -- I'm sorry --

1 waiving in opposition -- waiving in support of the
2 amendment -- waiving in support of the amendment.

3 We have Aurelie Colon, National Latina
4 Institute for Reproductive Justice of Florida,
5 waiving in support of the amendment.

6 And, last, Jon Harris Maurer with
7 Equality Florida who will speak in support of the
8 amendment.

9 You're recognized, sir.

10 MR. MAURER: Thank you, Chair.

11 Committee members, this amendment is about
12 saving lives. It is very narrowly tailored. We're
13 talking about young people who are at risk of severe
14 gender dysphoria and at risk of self-harm who may
15 already be engaging in self-harm.

16 As a parent -- and I know many of you are
17 parents -- I can't imagine the State interfering to
18 tell me what sort of care I could or could not access
19 if my child were in such a state.

20 Again, we've talked about how incredibly
21 narrow this is, especially when it requires that at
22 least two medical professionals or mental health
23 professionals have diagnosed the minor with severe
24 gender dysphoria; when they've stated in writing
25 that such care is necessary to treat the psychiatric

1 condition and prevent self-harm; that the parents
2 and guardians agree with providing that health care
3 and that the care is at the lowest possible dosage to
4 address that severe gender dysphoria; and that, even
5 in those cases, no care would be prescribed for a
6 minor who has not yet gone through puberty.

7 Again, this is about ensuring those parental
8 rights and that parents have these sort of options to
9 take care of their kids when they are at their most
10 endangered state.

11 We hope that you'll see that and support
12 the amendment.

13 Thank you.

14 CHAIR HUTSON: Thank you.

15 Members, I have no other appearance cards
16 on the amendment.

17 Any debate on the amendment?

18 Senator Berman, on debate.

19 SENATOR BERMAN: Thank you, Mr. Chair.

20 And I think this amendment is really well
21 drafted, narrowly drafted. I mean, we heard that
22 it won't apply until someone reaches puberty. The
23 group that we're talking about is a small -- probably
24 a pretty small group of people, but it's a group
25 that needs our help and that we need to show some

1 grace to. We understand these are people who are
2 in extreme distress, and we have an opportunity here
3 to make their lives better, allow them to not live in
4 a situation that could be life-threatening for them.

5 And the fact that this was done in West
6 Virginia, at a doctor's -- by a legislator who is a
7 physician, gives it all the more credence. He
8 obviously understood what was at stake here. And I
9 think all of us should recognize what's at stake and
10 support this good amendment.

11 Thank you.

12 CHAIR HUTSON: Thank you.

13 Any other debate on the amendment?

14 Seeing none, Senator Yarborough, you're
15 recognized in debate -- I'm sorry. Senator Yarborough,
16 you're recognized in debate on the amendment. It's
17 not about your amendment, so you're recognized.

18 SENATOR YARBOROUGH: Okay. Thank you.
19 Thank you, Mr. Chairman.

20 So I, again, appreciate the amendment by a
21 friendly member on this. I would call it unfavorable
22 at this time or unfriendly.

23 Some of the risks associated with hormone
24 therapy for children include, if it is related to
25 males transitioning to female, in addition to a

1 moderate risk of developing many, many conditions,
2 some of those include breast cancer, coronary artery
3 disease, cerebrovascular disease, gallstones, elevated
4 triglycerides, tumors, et cetera, and then also
5 females seeking to transition to males could develop
6 severe liver dysfunction, coronary artery disease,
7 cerebrovascular disease, hypertension, or breast or
8 uterine cancer. And that's with regard to what
9 the therapy could lead to for children.

10 Also, there is a lot of ambiguity and
11 uncertainty out there. We've heard some speak about
12 it. We've had -- I know the House had a panel
13 discussion about this subject last month, I believe
14 it was, with Chloe Cole. And I've done a lot of
15 research on her story, listened to her speak on
16 different occasions, and also done some reading on
17 that. And she has said that she was talked into
18 going into these treatments, but she wasn't provided
19 with all of the risks that could come as a result of
20 that. And now she is facing lifelong, drastic
21 consequences as a result and is now in her efforts to
22 detransition because of that. And she, I think, has
23 just turned 18 -- 17 or 18 years old.

24 And so we need to be very careful with this.
25 This could leave individuals sterile. It could

1 prevent them from having a family or producing a
2 family of their own one day. This is very risky,
3 and that's why we should be all the more careful as
4 we move forward with this.

5 So I believe it's important to protect all
6 children from these harmful treatments. I would
7 encourage every parent whose child is struggling
8 with depression or considering self-harm to seek
9 mental health treatment.

10 My last comment, Mr. Chair, would be that --
11 and I was going to save this for later in my close,
12 but we do need to be very careful with this because
13 this can have those lasting impacts on our young
14 people. And if there are health care practitioners
15 out there who are saying that the only way that
16 gender dysphoria can be cured is by doing these types
17 of surgeries, we ought to be very careful about that
18 because there are other options out there.

19 Thank you.

20 CHAIR HUTSON: Thank you, Senator Yarborough.

21 Any other debate?

22 Seeing none, now, Senator Jones, you're
23 recognized to close on your amendment.

24 SENATOR JONES: Thank you so much, Mr. Chair.

25 Members, 17 peer reviews; 17 peer reviews

1 that Dr. Takubo, who's also the majority leader,
2 spoke of, 17 peer reviews.

3 My colleague just made mention of the panel
4 that happened in the House. It was a one-sided
5 discussion in the House that happened, and I also
6 want to make it clear that it was one case that we're
7 talking about that my colleague just made mention of.
8 And the side effects that Senator Yarborough just
9 made mention of, how many commercials have y'all
10 seen where if you take this medicine, here are all
11 the things that come with the risk of taking this
12 particular drug? Y'all have seen the commercials
13 before: You take this, it cures this, but this is
14 what the problem is. It's the same thing. These are
15 the side effects. It's the same thing. So I don't
16 want us to confuse that. Right?

17 Let's go back and let's focus on the facts
18 that we're talking about. We're talking about
19 protecting children. We're talking about almost
20 less than 1 percent of children who experience
21 gender dysphoria, less than 1 percent, but 80 percent
22 of them have attempted some type of self-harm to
23 themselves.

24 Now, wherever we stand on this, that's one
25 thing. But we're talking about we're going to

1 protect children, Well, let's hold up our end of
2 the bargain and protect children.

3 And that is the amendment.

4 CHAIR HUTSON: Having closed on your
5 amendment, all in favor of the amendment, say yea.

6 All opposed, say nay.

7 Show the amendment not adopted.

8 I see four hands. We're going to take a
9 roll call vote on the amendment.

10 Please call the roll on the amendment.
11 And let me make sure we're in the proper posture.
12 We're on -- we're going to call the roll on
13 barcode 350064.

14 THE CLERK: Senator Albritton?

15 SENATOR ALBRITTON: No.

16 THE CLERK: Senator Berman?

17 SENATOR BERMAN: Yes.

18 THE CLERK: Senator Boyd?

19 SENATOR BOYD: No.

20 THE CLERK: Senator Burton?

21 SENATOR BURTON: No.

22 THE CLERK: Senator Calatayud?

23 SENATOR CALATAYUD: No.

24 THE CLERK: Senator Collins?

25 SENATOR COLLINS: No.

1 THE CLERK: Senator DiCeglie?
2 SENATOR DICEGLIE: No.
3 THE CLERK: Senator Garcia?
4 Senator Jones?
5 SENATOR JONES: Yes.
6 THE CLERK: Senator Mayfield?
7 SENATOR MAYFIELD: No.
8 THE CLERK: Senator Osgood?
9 SENATOR OSGOOD: Yes.
10 THE CLERK: Senator Rodriguez?
11 SENATOR RODRIGUEZ: No.
12 THE CLERK: Senator Simon?
13 SENATOR SIMON: No.
14 THE CLERK: Senator Thompson?
15 SENATOR THOMPSON: Yes.
16 THE CLERK: Senator Torres?
17 SENATOR TORRES: Yes.
18 THE CLERK: Senator Trumbull?
19 SENATOR TRUMBULL: No.
20 THE CLERK: Senator Wright?
21 SENATOR WRIGHT: No.
22 THE CLERK: Senator Yarborough?
23 SENATOR YARBOROUGH: No.
24 THE CLERK: Vice Chair Stewart?
25 SENATOR STEWART: Yes.

1 THE CLERK: Chair Hutson?

2 CHAIR HUTSON: No.

3 And by your votes barcode 350064 is reported
4 not favorable.

5 We're now back on the bill. Are there
6 questions on the bill?

7 Senator Jones, you have questions. I'm
8 going to open it up. You guys can go back and forth.

9 SENATOR JONES: Thank you so much, Mr. Chair.
10 I guess I want to start off with, Senator
11 Yarborough, on the number of cases that has warranted
12 this particular piece of legislation.

13 SENATOR YARBOROUGH: Thank you, Mr. Chair.

14 We're okay to go back and forth, Mr. Chair?

15 Okay. Thank you.

16 Senator Jones, can you clarify your question?

17 SENATOR JONES: Yes. Sorry about that.

18 Yes.

19 I just want to know, how many cases of
20 children or youth reassignment have we seen here in
21 the state of Florida, that you know of?

22 SENATOR YARBOROUGH: Thank you through
23 the Chair to Senator Jones and the committee.

24 I don't have a total number of those
25 procedures right in front of me, Senator. I would

1 have to research that to see if we're able to obtain
2 it and get it back to you.

3 SENATOR JONES: Yes. Thank you so much,
4 Senator Yarborough.

5 To my understanding, the number is
6 practically zero.

7 Could you explain the impetus for the
8 two-year freeze on procedures for proposing amendments
9 to a comprehensive plan -- oh, sorry. I'm sorry. I'm
10 reading my -- wrong question. Excuse me, Mr. Chair.

11 Let me go back. Okay. Perfect.

12 Sorry about that, Mr. Chair.

13 I want to look at the medical implications.
14 Can you talk to us about the medical implications
15 associated with someone who abruptly stops taking any
16 medication or don't receive any type of treatment,
17 Senator Yarborough?

18 SENATOR YARBOROUGH: Thank you through
19 the Chair to Senator Jones and the committee.

20 I appreciate that. That's a very fair
21 question, Senator.

22 So in our bill, building off the premise of
23 what you just asked in your question, we don't call
24 for the abrupt ending of that. If you have a minor,
25 for example, who has been receiving these treatments,

1 then we allow the Board of Medicine and the Board
2 of Osteopathic Medicine to develop rules that would
3 address any discontinuation. But our bill does not
4 contemplate an abrupt stop very much for the reasons
5 I think you're bringing up, because we would not want
6 to cause, you know, any adverse medical episodes to
7 occur which we know sometimes can happen if you
8 abruptly stop medications. So that is not in the
9 bill.

10 SENATOR JONES: Thank you, Senator Yarborough.
11 Senator Yarborough, are you aware of any
12 other law that criminally punishes a doctor for
13 prescribing a legal medication?

14 SENATOR YARBOROUGH: Thank you, Senator.
15 Outside of our abortion standards, I'm not
16 aware of one.

17 SENATOR JONES: Thank you, Senator Yarborough.
18 My last question is have you spoken to any
19 parents of young people or parents in general about
20 their child who probably have experienced some type
21 of gender dysphoria?

22 SENATOR YARBOROUGH: Through the Chair,
23 yes, sir.

24 SENATOR JONES: Thank you, Mr. Chair.

25 CHAIR HUTSON: Any other questions on the

1 bill?

2 Senator Berman, I'll open it up so you can
3 go back and forth.

4 SENATOR BERMAN: Thank you, Mr. Chair.

5 So the bill defines sex reassignment
6 prescriptions or procedures like puberty blockers
7 and hormone therapies. That's lines 136 through 175.

8 If a child needs puberty blockers because
9 they're having an early growth spurt, would they be
10 able to get the puberty blockers and hormone therapies?

11 SENATOR YARBOROUGH: Thank you through
12 the Chair to Senator Berman and the committee.

13 If you pick up, Senator Berman, starting on
14 line 51 on page 6 of the bill, we outline several
15 exceptions that would allow for continued treatment.
16 Some of those include: Line 157, external biological
17 sex characteristics that are unresolvably ambiguous;
18 159, a disorder of sexual development in which the
19 physician has determined through genetic or
20 biochemical testing that the patient does not have a
21 normal sex chromosome structure, et cetera. And
22 then it goes on -- those are the main two, but it
23 goes on to talk about some of those exceptions that
24 you're asking about.

25 SENATOR BERMAN: Okay. So thank you,

1 Mr. Chair.

2 I know that my daughter -- she probably
3 wouldn't appreciate me outing this, but it's fine.
4 She had to -- she took a growth hormone, and one of
5 the things that was discussed was giving her a puberty
6 blocker in order to allow her growth spurt to last
7 for a longer period of time. Thankfully, we didn't
8 have to do it.

9 But in that situation, would the child be
10 able to get a puberty blocker so that they could
11 take -- so that they would be able to complete their
12 growth hormone treatment?

13 SENATOR YARBOROUGH: Thank you, Mr. Chair.
14 Through the Chair to Senator Berman and the committee.

15 So, again, referencing on line 152:
16 *Treatment provided by a physician who in his or her*
17 *good faith clinical judgment performs procedures or*
18 *provides therapies to a minor*, what you're describing
19 there -- and I don't know all the details -- and
20 that's okay -- of that situation, but if it's in the
21 good faith clinical judgment of the physician, then
22 that is not contemplated to be restricted under our
23 bill, Senator.

24 SENATOR BERMAN: So then the question becomes
25 why is it okay for minors with endocrine conditions

1 but not gender dysphoria?

2 SENATOR YARBOROUGH: Thank you through the
3 Chair to Senator Berman and the committee.

4 So our goal is to protect children, and
5 outside of these exceptions, I do not believe,
6 which is why I put the bill in front of you today for
7 consideration or filed the bill, that any of the
8 treatments or procedures should happen if you don't
9 have one of these exceptions, Senator.

10 SENATOR BERMAN: Thank you.

11 Would this legislation prohibit a 17-year-old
12 from receiving breast implants if it's not for the
13 purpose of gender dysphoria?

14 SENATOR YARBOROUGH: Thank you through the
15 Chair to Senator Burton -- no -- Senator Berman.
16 Excuse me.

17 SENATOR BERMAN: Colleen looked a little
18 shocked there.

19 SENATOR YARBOROUGH: Sorry.

20 No. The answer is no.

21 SENATOR BERMAN: And so why is it okay to
22 have breast implants if it's not for gender dysphoria?

23 SENATOR YARBOROUGH: Thank you through
24 the Chair to Senator Berman.

25 Senator, as I've said before and as I

1 outlined in my opening and I said a minute ago in
2 response to Senator Jones's amendment, I am not of
3 the belief that this would be -- that these types of
4 procedures or treatments are the only remedy for
5 something like gender dysphoria. That is not to be
6 taken lightly. That's a serious issue that I know
7 individuals are facing, but I do not believe that
8 that is the only option that can be pursued or should
9 be pursued in a case like that.

10 SENATOR BERMAN: Thank you.

11 So to go back to one of the questions that
12 Senator Jones asked -- I don't know if we got an exact
13 answer. So do you have any data on the number of
14 transgender youth in Florida that have received the
15 surgical treatments that you're seeking to ban?

16 SENATOR YARBOROUGH: Thank you through the
17 Chair to Senator Berman.

18 I do not have that data. We can seek to get
19 that, Senator, but I don't have that in front of me
20 today.

21 SENATOR BERMAN: Okay. Next question.
22 Nurses currently provide gender-affirming care to
23 adults. So now we're in the adult area. But your
24 bill restricts the sex reassignment prescriptions
25 or procedures to physicians. That's lines 211

1 through 216.

2 What is the State's compelling interest
3 now, after decades of practice, for banning nurses
4 from delivering this health care to adults?

5 SENATOR YARBOROUGH: All right. Thank
6 you, Senator.

7 I was getting some clarification, actually,
8 on your last question, and then I'll speak to the --
9 or on your prior question, and then I'll speak to that.

10 So total in the state for these type of
11 procedures is 32. That's adults.

12 Are 12 of those minors?

13 12 of those are minors.

14 SENATOR BERMAN: Oh, so it's a total --

15 SENATOR YARBOROUGH: That's the answer
16 to the previous question.

17 SENATOR BERMAN: Okay. Let's just make
18 sure we get it correct. So it's a total of 32. And
19 of those 32, 12 are children. Is that what you're
20 saying?

21 SENATOR YARBOROUGH: A total of 12 children,
22 Senator, and then 32 adults. I'm sorry to confuse
23 on that. So the total --

24 SENATOR BERMAN: So it's 44?

25 SENATOR YARBOROUGH: 44, yes.

1 SENATOR BERMAN: Okay. And then now the
2 next question about why we're prohibiting nurses,
3 banning nurses from delivering the health care to
4 adults.

5 SENATOR YARBOROUGH: Yes, ma'am. Thank
6 you.

7 And I think you referenced line 211. Is
8 that correct, Senator?

9 SENATOR BERMAN: Correct, 211 to 216.

10 SENATOR YARBOROUGH: So because we are
11 taking this so seriously because of the potential
12 negative effects that can come as a result -- I do
13 disagree with the characterization that was made
14 about we are preventing adults from being able to
15 access it. I know there are the elements about maybe
16 not as readily available via telehealth or some of
17 that, but we are not saying that they cannot access
18 these kinds of treatments or procedures if they
19 choose to do so. But we are taking it so seriously
20 that we believe the physicians, the least they can do,
21 is inform the adults of the risks that are inherent
22 with these types of treatments. Maybe some of
23 them already do that. I'm sure there are. But we
24 need to take this very seriously, and that's why
25 we're putting in it has to be a physician licensed

1 under these chapters and it has to be in the same
2 room.

3 And I mentioned this in previous committee
4 too, it is for the pharmaceuticals, but if they are
5 continuing to take a treatment that they're already
6 taking, they don't have to do an informed consent
7 every refill that they pursue. It would only be if
8 there's a new prescription that's prescribed following
9 that.

10 SENATOR BERMAN: So if you're saying --
11 I understand that when people who say they have to
12 drive for hours to get their medicine because they
13 don't have access to somebody who can give it, you
14 know, and they've been getting it from nurses -- so
15 you're saying in that situation they will not be able
16 to get their medicine? They're going to have to find
17 someone else who will give them their medicine?

18 SENATOR YARBOROUGH: Through the Chair to
19 Senator Berman.

20 What we're saying again, Senator, is that
21 we're taking this very serious. And under the
22 provisions of the bill, it would have to be that they
23 are in the same room as the physician for this to be
24 prescribed.

25 SENATOR BERMAN: Okay. Thank you.

1 And final question. So, you know, I have a
2 concern that this is going to impact doctors who want
3 to come to our state and our ability to attract and
4 retain top talent and possibly even our economy.

5 Can you address that issue?

6 SENATOR YARBOROUGH: Thank you. Through
7 the Chair.

8 Senator, can I just ask do you mean overall
9 or just as it relates to minors or adults or --

10 SENATOR BERMAN: No, I think overall. I
11 mean, I think it has a chilling effect when we pass
12 laws like this that hurt certain communities. So
13 I think it's an overall effect. I just want to hear
14 your response to that.

15 SENATOR YARBOROUGH: Sure. Yes, ma'am.
16 Thank you. I appreciate the clarification.

17 So I believe we need to send a signal as a
18 state that we are kid friendly and that we are putting
19 parents in charge of their children's health care and
20 that when it comes to things that could be
21 drastic, life-altering surgeries and treatments
22 for children, that we as lawmakers, as a legislature,
23 as a state, take it very seriously with regard to
24 these elements that can have serious, serious
25 long-term consequences for children.

1 That's the message that I want to send,
2 which is why I filed this bill.

3 SENATOR BERMAN: But you do recognize that
4 you're not just referring to children, we're also
5 affecting adults in this bill?

6 SENATOR YARBOROUGH: Senator, thank you.
7 I'm sorry. No, I was just going to say, Yes, ma'am,
8 I understand the breadth of the impact. Yes, ma'am.

9 SENATOR BERMAN: Okay. Thank you.

10 CHAIR HUTSON: Any other questions?

11 Senator Stewart. And I'll open the floor so
12 you can go back and forth.

13 SENATOR STEWART: Thank you very much.

14 I just have a couple of questions.

15 The effective date -- I've read through the
16 whole bill -- it's mentioned many times, July 1, 2023.

17 Can you confirm that?

18 SENATOR YARBOROUGH: Thank you, Mr. Chair.

19 Line 317: *This act shall take effect upon*
20 *becoming law.*

21 SENATOR STEWART: Oh.

22 SENATOR YARBOROUGH: So that would be if we
23 pass it, then when the Governor signs it, it goes into
24 effect.

25 SENATOR STEWART: Okay. Yeah, I missed that.

1 And then I wanted to ask, many may have
2 entered into with their physician or a center into a
3 treatment plan. Now, if they've not yet been given a
4 medication but it's part of their treatment plan,
5 how does this bill affect those arrangements?

6 SENATOR YARBOROUGH: Thank you. Through
7 the Chair to Senator Stewart and the committee.

8 Could you clarify whether you mean adults or
9 children? Because we do make a distinction on that.

10 SENATOR STEWART: Children or adults.
11 You know, they enter into some type of plan. I'm
12 assuming adults would be excluded but --

13 SENATOR YARBOROUGH: Thank you, Senator.

14 So, again, speaking a little bit to what we
15 mentioned before, on page 6, picking up at line 151,
16 we have some exceptions. So if there is treatment
17 that was already -- there's some exceptions for
18 continued treatment for what was already being
19 provided for a minor who was born with certain
20 conditions.

21 And then also our bill does not contemplate
22 a hard stop to the treatments to where it could result
23 in a critical, you know, severe medical episode. So
24 that's something we were very, very careful to make
25 sure our bill would not stop right away. And even

1 the Board of Medicine rule that they adopted said
2 that if there were already minors who were already
3 receiving treatments, this rule that went into effect
4 last week, that they could continue to do so.

5 So ultimately it is the goal to have these
6 discontinued for minors, but we're going to allow the
7 boards to make the determination as to when that
8 would be appropriate.

9 SENATOR STEWART: One -- just let me
10 reclarify what I just heard.

11 So if there has been a treatment plan,
12 because they had visited their doctor or they had
13 visited a clinic, and that plan includes medication,
14 but not right away, but there is a plan in place to
15 begin all that, this bill would not affect those
16 agreements -- a plan to proceed?

17 SENATOR YARBOROUGH: I appreciate the
18 question, Senator.

19 So it would affect if they are not already
20 on the drug or on the treatment as of the effective
21 date of the bill becoming law. Then even if there
22 was a treatment plan that had been developed, they
23 cannot then start the treatment. Just because the
24 plan is in place, if they were not already on the
25 drug, then they cannot then start the drug as of the

1 effective date of the bill.

2 SENATOR STEWART: Thank you. That
3 answered that question.

4 SENATOR YARBOROUGH: Yes, ma'am.

5 CHAIR HUTSON: Any other questions?

6 Okay. Seeing none, we're on comment.

7 I have Jorge Chamizo, Do No Harm Medicine,
8 waiving in support; Aurelie Colon with the National
9 Latina Institute of Reproductive Justice Florida
10 waiving in opposition; Annie Filkowski with the
11 Florida Alliance of Planned Parenthood Affiliates
12 waiving in opposition; Barney Bishop with the
13 Florida Smart Justice waiving in support; and then
14 Yenisbel Vilorio with the State Innovation Exchange
15 Action waiving against.

16 Now I have the speaker cards that are
17 coming up.

18 Jackson Oberlink with Florida Rising.

19 And you're recognized.

20 MR. OBERLINK: Good morning.

21 Thank you.

22 I just wanted to get up here today -- I don't
23 have anything prepared. I'm here representing
24 Florida Rising to oppose this bill because this is
25 so personally vial and disgusting to me.

1 Some of my closest friends and family members
2 are part of the trans community. I, myself, am a
3 member of the LGBT community. My best friend, Caleb,
4 is a trans man. And when he was 11, he got into his
5 parents' bed late at night, and he was crying, and he
6 told them: I love you both so much. I don't
7 want to kill myself. I'm a man.

8 And his parents -- his dad, a Roman
9 Catholic -- you know, didn't know what trans was.
10 They didn't know what to do, but they listened to him.
11 And so they took him to doctors. They took him to
12 professionals, and they worked together to make a
13 plan to help him, to save his life. And Caleb
14 medically transitioned.

15 Caleb is now a 21-year old college student
16 at Florida State University. He's about to graduate
17 with a bachelor's of science in environmental science.
18 He's an amazing advocate for environmental issues.
19 He's the vice president of the FSU Environmental
20 Service program. He does cleanups every weekend.
21 You know, he's the president of the FSU Surfrider
22 Club, fighting for ocean advocacy, just truly amazing
23 things.

24 And some of you today voted against an
25 amendment by Senator Jones -- thank you very much for

1 that good amendment -- that could save people's lives,
2 kids like him. And so you get up here and you pass
3 bills like this, and some of you still want to
4 consider yourselves allies to the queer community.
5 Don't bother showing up at Pride. Don't bother
6 considering yourself an ally. You are killing trans
7 kids.

8 And this isn't coming from out of nowhere.
9 This is, like, a purposeful effort happening across
10 the country funded by far right Christian fascist
11 billionaires, like the Betsy DeVos family, that this
12 is not some altruistic reason that you have for
13 passing this bill.

14 So --

15 CHAIR HUTSON: You need to stick to the bill.

16 MR. OBERLINK: Yes. Thank you.

17 Please vote against this bill. This is
18 terrible. You are killing trans kids.

19 Thank you.

20 CHAIR HUTSON: Thank you.

21 Julie Framingham, you may speak. You
22 are recognized.

23 MS. FRAMINGHAM: Good morning.

24 Yes, my name is Julie Framingham, and I'm
25 coming here to urge you to pass this bill. I

1 completely support it. I'm the parent of an adult
2 biological male who has been identifying as
3 transgender for the last six years. He's 28 years
4 old now. He was diagnosed a number of years ago with
5 several mental health disorders, including anxiety,
6 depression, borderline personality disorder. He was
7 online. He saw an outlet online and discovered the
8 transgender community. And he was given this
9 affirmation-only kind of approach, which meant that
10 he had been in therapy with a very good therapist here
11 in Florida, a licensed therapist who had diagnosed his
12 conditions. He dropped out of therapy because he
13 believed that, you know, having the wrong sex hormones
14 and the affirmation-only counseling was all he needed.

15 I can tell you that after he began taking the
16 wrong sex hormones that his depression and anxiety
17 worsened to the extent that he dropped out of college.
18 He never finished his degree. He spent many years
19 kind of floundering in minimum wage jobs. There were
20 brief periods where he was off of the prescriptions
21 simply because he did not have insurance and did not
22 have a car and could not get easily to a doctor, so
23 there were months at a time where he lapsed. He was
24 always better after being off the estrogen and the
25 other drugs. He would stabilize a bit, and then, you

1 know, it -- I can tell you that if I had known he was
2 having such severe problems -- I suspected he was
3 depressed when he was a minor in high school, but I
4 did not know how severely disordered he was.

5 And knowing that there are valid and
6 long-tested psychological treatments such as
7 dialectical behavioral therapy, which is the gold
8 standard for conditions like borderline personality
9 disorder -- there are many successful treatments that
10 have been used and that are things that he could have
11 benefitted from. But instead he chose not to. I
12 couldn't control that because he was over 18 at that
13 point.

14 But the affirmation-only approach, I mean,
15 it only pushes one way, and that's in favor of the
16 drugs and the surgeries.

17 You know, I can't -- I mean, I can tell you
18 that -- I mean, we have a relationship with our son.
19 I love my son. He was a wonderful son. And I really
20 miss him. We have a relationship. I still love him,
21 but it's always like the elephant in the room while
22 we pretend that he's not wearing women's clothes --
23 and I'm not a big gender stereotype kind of person.
24 I mean, I don't wear dresses. I don't have long hair.
25 I don't carry a purse. I don't care about stereotypes,

1 but I do care that people know who they are. I don't
2 have a problem with the gays and lesbians. That's
3 fine. You know, they know who they are. But we're
4 talking about a psychological condition where people
5 are told that they cannot be helped other than with
6 this affirmation approach. And they are living, you
7 know, a situation where it's not real.

8 So I would ask you to please pass this bill.
9 I think it will do more good than harm. I am
10 connected to many, many families here in Florida who
11 have the same situation.

12 CHAIR HUTSON: Thank you.

13 MS. FRAMINGHAM: And they're afraid to speak
14 because they're afraid that they will lose their jobs.

15 CHAIR HUTSON: Thank you very much.

16 MS. FRAMINGHAM: Thank you.

17 CHAIR HUTSON: Appreciate you coming up.

18 Robert Framingham next.

19 MR. FRAMINGHAM: Good morning.

20 I'm the father of that son, and I just note
21 that the transgender train is just rushing down the
22 tracks. Somebody needs to put the brakes on. This
23 bill will do that, I think. It's certainly a step in
24 the right direction. I support it 100 percent.

25 CHAIR HUTSON: Thank you.

1 MR. FRAMINGHAM: Thank you.

2 CHAIR HUTSON: Reverend Dr. Russell Meyer.
3 Following him, we'll have Renee on deck.
4 You're recognized.

5 REVEREND MEYER: Thank you, Mr. Chair,
6 Senators.

7 I'm a pastor of the Evangelical Lutheran
8 Church in America, and this past week our presiding
9 bishop issued a statement on caring for trans people.
10 I'd like to share a portion of that with you:

11 *As we approach March 31, many people are*
12 *preparing to recognize Transgender Day of Visibility,*
13 *an international day to celebrate the contributions of*
14 *transgender people and raise awareness about the*
15 *deadly injustices they face.*

16 *As bishop of this church, I am concerned that*
17 *the rights of transgender and nonbinary Americans*
18 *have been targeted all over this nation. We may have*
19 *differing opinions on matters related to sexual*
20 *orientation and gender identity, but we must always*
21 *uphold the dignity and humanity of everyone. These*
22 *disagreements do not allow us to accept actions that*
23 *dehumanize, discriminate against, or objectify any*
24 *individual or group.*

25 *We must stand together, Dear Church,*

1 *faithfully advocating for the full humanity and*
2 *dignity of all people. Let us recognize and*
3 *affirm the humanity of our transgender and nonbinary*
4 *siblings. Let us advocate for their dignity. Let us*
5 *continue to be guided by God's love and compassion*
6 *as we seek justice and equality for everyone.*

7 We said the Pledge of Allegiance of justice
8 and equality for everyone. What this bill does is
9 say a certain kind of person really doesn't exist.

10 I have advanced degrees in religious
11 doctrine, and I'm telling you this bill is religious
12 doctrine in disguise. What this bill says is there
13 are really only two kinds of people, and we're going
14 to force people into those two settings, when across
15 human history, in culture after culture, there has
16 been a wide spread of different expressions of human
17 being.

18 We're not just our chromosomes, and we're not
19 just two kinds of chromosome matches. There's
20 diversity in chromosomal life. Some of it doesn't
21 last very long. And there's diversity across the
22 human specter in our endocrine and hormonal systems.
23 And there are a few number of people in our society
24 for which the two do not match up nicely. And people
25 struggle with that, in our churches, our families,

1 with transgender children, that they are prayerfully
2 and faithfully trying to seek what's right for their
3 child. This bill would deny them their rights. They
4 are actively engaged in conversations of saying, We
5 have to leave Florida before the State takes away our
6 children the way the State used to take away children
7 from Indian families in the Great Plains.

8 We must respect people for who they are and
9 how they are made, and families who are struggling
10 with these issues need the support of professionals
11 who have some understanding of it. This is trying to
12 force people into square holes when they're not
13 square pegs.

14 I plead with you not to go down this path of
15 signaling out probably the smallest demographic in
16 our country in order to look like you're doing
17 something good. This is religious doctrine in
18 disguise, and it religiously punishes people who
19 don't agree.

20 I ask you listen to this call for God's love
21 for all humanity and let parents work with their
22 doctors to do what they believe is right for their
23 child.

24 Thank you.

25 CHAIR HUTSON: Thank you.

1 Next we have Renee, then Ryan Kennedy is
2 on deck.

3 You are recognized.

4 RENEE [Last name unknown]: Thank you, Chair.

5 I just want to recognize the previous
6 statement, the sentiment, and I deeply appreciate it.

7 I find this discussion today very troubling
8 and very distracting to my personal life. I'm a
9 PhD candidate at the Institute of Technology. I'm a
10 data scientist, entrepreneur, and community builder.
11 And I employ people here in Florida. I pay taxes here
12 in Florida. I own a home here in Florida. I've been
13 here for almost 10 years now.

14 And being transgender should be the least
15 interesting thing about me. Unfortunately, my very
16 existence becomes politicized. So I'm not at work
17 today. I'm not doing what I'm supposed to be doing,
18 what I love, which is working in Blockchain and
19 teaching people about a new financial money system
20 that can unlock a whole new way of living.

21 This bill is not about protecting kids. It's
22 about protecting the fear of cis people suddenly
23 becoming trans. That doesn't happen. Trans people
24 have always been trans. They realize they're trans.
25 Your child is not going to magically become trans

1 just because they have a transgender friend.

2 This bill is not about parental rights. It
3 might be about the parental rights of conservative
4 Christians or bigots or people who would go to great
5 lengths to abuse their children just to keep them from
6 being who they want to be.

7 This bill terrifies me because I grew up
8 with incredibly religious, abusive, conservative
9 parents who haven't talked to me for well over a year.
10 I've had a very difficult year financially,
11 emotionally. Despite that, it has been the best
12 choice of my life. And I'm sad I can't call them and
13 tell them and let them know when I accomplish things
14 because they have chosen to make their decisions
15 based on religious doctrine only.

16 I want to quote one of the Senators -- and I
17 won't call out any names, but there's a key word here
18 that's really important. He said that he believes
19 that there is no better treatment for gender dysphoria.

20 First, to my knowledge, most of you are not
21 medical care providers, nor have you had any formal
22 medical training.

23 Second, belief; we're talking about beliefs
24 today. We're not talking about science. We're not
25 talking about equality for all. We're talking about

1 beliefs. A minority, mind you, a minority of people
2 in this country are far right-wing radical Christians.
3 Despite that, somehow you are governing the narrative
4 of our society, and you are no longer allowing this
5 society to flourish. You're not allowing me to
6 flourish.

7 I strongly oppose this bill. I encourage
8 you to be introspective. I encourage you to realize
9 that your beliefs should not be how we craft
10 legislation in what is supposed to be a free state
11 where integrity and humanity is for everyone.

12 Please oppose this bill.

13 Thank you.

14 CHAIR HUTSON: Thank you.

15 Next I have Ryan Kennedy, Florida Citizens
16 Alliance. You are recognized. And on deck is
17 Michael Barrett.

18 MR. KENNEDY: Thank you, Chair. Thank you,
19 Committee.

20 My name is Ryan Kennedy, Florida Citizens
21 Alliance, a group of over 250,000 supporters across
22 the state of Florida. Two-thirds of them are
23 parents.

24 We rise in strong support of this bill today.
25 We believe that care and compassion towards children

1 should always be used as a first and foremost
2 approach. A lot of these treatments are very high
3 with side effects. The long-term side effects of
4 them are really high.

5 In Europe and a lot of different countries
6 right now they are banning these treatments, the
7 transgender surgeries and the treatments in general.
8 And a lot of these are secular nations, more secular
9 than the United States is. And they've decided to go
10 that route because of the studies done and what they
11 have seen in their nations because of the long-term
12 side effects.

13 We believe that in our country it's utmost
14 important that the government protects their citizens.
15 And for this reason we ask you to vote yes on the bill.

16 CHAIR HUTSON: Thank you.

17 We've got Michael Barrett up with the Florida
18 Conference of Catholic Bishops. And following him is
19 Jon Harris Maurer.

20 MR. BARRETT: Thank you, Chair and
21 Members of the Committee.

22 Michael Barrett with the Florida Conference
23 of Catholic Bishops. We encourage you to vote yes on
24 SB 254.

25 We deeply sympathize with anyone who

1 experiences gender dysphoria and recognize that it
2 can be intensely difficult. Therefore, it is
3 important to recognize that so-called gender-affirming
4 protocols lack long-term evidence of their efficacy
5 and result in irreversible physical damage to the
6 patient.

7 Furthermore, there is significant evidence
8 that avoiding chemical or surgical interventions will
9 result in desistance in favor of biological sex for
10 most minors by the time they go through puberty.

11 Finally, no medical intervention can truly
12 realign a person's sex, which is an immutable
13 characteristic of each person.

14 Medical care should promote the flourishing
15 of the human person. Gender-affirming protocols fail
16 to do this because they fail to alleviate the problem
17 they seek to solve and because they cause damage to
18 the patient's body. Therefore, these protocols
19 should be prohibited.

20 Thank you, Senator Yarborough, for this good
21 bill. Please vote yes on SB 254. Thank you.

22 CHAIR HUTSON: Thank you.

23 Jon Harris Maurer is up, and then John
24 Labriola is up after that.

25 MR. MAURER: Thank you, Chair and Committee

1 Members.

2 Equality Florida fundamentally opposes Senate
3 Bill 254. This bill parlays misunderstanding and fear
4 about this healthcare into a manufactured moral panic
5 for political points. In doing so, it tramples
6 parental rights, medical freedom, and sound science.

7 Let's be clear, leading national health
8 organizations, like the American Academy of
9 Pediatrics, the American Medical Association, the
10 American Psychological Association, support
11 gender-affirming care for transgender children and
12 certainly adults.

13 The government should never participate
14 in taking custody away from a parent who's relying on
15 this sort of widely accepted science to find care for
16 their child.

17 Relatedly, the State should not be
18 imprisoning health care providers for providing
19 potentially life-saving health care that millions of
20 practitioners and professional associations support.
21 This care has existed for decades.

22 And when we talk about side effects, we have
23 to realize that these are the same therapies that
24 are being prescribed for nontransgender children
25 broadly, and yet those are not under attack today.

1 Earlier we voted down, unfortunately, an
2 amendment on the basis of talking about and invoking
3 some of those side effects, and yet that was an
4 amendment aimed at prohibiting suicide. How can we
5 balance that against those sort of alleged side
6 effects?

7 The State of Florida shouldn't be interfering
8 with these sort of personal medical decisions,
9 including for adults, as you already discussed.

10 We ask you to vote down this bill.

11 CHAIR HUTSON: Thank you.

12 John Labriola is up, and then Kara Gross is
13 on deck.

14 You're recognized.

15 MR. LABRIOLA: Good morning.

16 My name is John Labriola. I'm here on
17 behalf of the Christian Family Coalition. And we
18 attended the committee hearing in the House on this
19 particular bill where there was an excellent
20 presentation regarding the red herring of suicide
21 which you hear over and over again from the other side.

22 The over 15-year study that was conducted,
23 which is in Sweden, which is the most comprehensive
24 study that's been conducted in this area, actually
25 showed that people who had undergone transgender

1 surgery were 20 times as likely to commit suicide as
2 their comparable peers.

3 So clearly this is a lifesaving measure
4 that you all are considering here. It's not going to
5 kill kids. It's going to preserve them from deep
6 harm that will lead to suicide if they undergo these
7 radical and barbaric surgeries.

8 Sweden was the very first nation to authorize
9 legalized transgender treatments for people, and
10 they've come out in favor of doing exactly what this
11 body is looking to do right now, and that is to ban
12 these treatments on minors. If Sweden is doing that,
13 I mean, this is a no-brainer that Florida should
14 definitely do it as well.

15 The House bill is a little bit stronger in
16 terms of the tapering off of treatments. We would
17 ask you to look -- consider that in the final bill,
18 because the harm that would be caused in these
19 children who continue these treatments for the
20 rest of their lives, potentially, could be devastating.

21 So thank you. And, again, please vote
22 yes on this.

23 CHAIR HUTSON: Thank you.

24 Kara Gross is up. Following her will be
25 Aaron DiPietro.

1 MS. GROSS: Good morning, Chair Hutson
2 and Members of the Committee.

3 I'm Kara Gross, the legislative director and
4 senior policy counsel for the ACLU of Florida, and
5 the ACLU of Florida opposes this bill.

6 SB 254 is dangerous, cruel, and inhumane.
7 It is designed to inflict harm on individuals
8 experiencing gender dysphoria and prevent them from
9 accessing the health care they need. It is an extreme
10 example of government overreach into private medical
11 decisions.

12 The Governor and members of the legislature
13 like to tout parental rights, but this bill takes
14 away the right of parents to provide lifesaving care
15 to their children. Parents and not politicians
16 know what is best for their own children, and they
17 should feel free to access the health care they need
18 in consultation with their medical providers without
19 governmental interference.

20 The bill will drastically threaten the lives
21 of trans children in Florida, and it will criminalize
22 health care providers who provide medically safe and
23 appropriate standards of care.

24 Under this bill parents of trans children
25 will face a grim choice, either move their families

1 out of Florida to seek evidence-based, medically
2 necessary care for their children or stay in Florida
3 and risk their children's well-being. All Floridians
4 should have the freedom to access the medical care
5 they need to survive. These are the most basic of
6 human rights.

7 And I just want to be clear that the bill
8 sponsor and others keep talking about protecting
9 minors, and gender-affirming prescription medications
10 we're talking about, prescription medications, they do
11 not harm minors. Forcing minors to have children
12 against their will harms minors.

13 We also talk a lot about the long-term
14 consequences of these prescription medications. And
15 many people here have discussed today that these
16 prescription medications are allowed and okay and
17 approved if there is an endocrinology issue with the
18 child or for other reasons, but they are not approved
19 if the intent has to do with gender dysphoria.

20 So the same exact medication that is approved
21 for some is not allowed for others under this bill.
22 And I ask you why is that? If this is about
23 protecting children, we are allowing doctors to
24 prescribe some medications -- the same medication
25 to some people, but not others. So why is it okay to

1 protect -- how is that protecting children? If we
2 are -- if this medication is so dangerous, why are
3 we allowing it to be used for children that are not
4 suffering from gender dysphoria?

5 Thank you. I urge you to vote no on this
6 bill.

7 CHAIR HUTSON: Thank you.

8 Aaron DiPietro is next. On deck will be
9 Jude Spiegel.

10 You are recognized.

11 MR. DIPIETRO: Thank you, Chair.

12 Aaron DiPietro with the Florida Family Policy
13 Council. We are in strong support of SB 254.

14 Currently -- so the reason why we are here
15 at this point -- gender dysphoria has been an issue
16 that has been, you know, around for quite some time,
17 and we definitely are sympathetic and compassionate
18 with those that are struggling with. However,
19 recently, within the last, really, five to ten
20 years -- and researchers from both the left and right
21 have pointed out this phenomenon -- we have had a
22 rise not in traditional gender dysphoria cases, but
23 in cases caused by social contagia, particularly
24 among young teenage girls in which they are on social
25 media seeing the idea of gender, you know, transition

1 as being something that is hip, that is cool. And it
2 is taking advantage of many of these young girls at a
3 time where they're going through tremendous changes
4 in their life through puberty, and there's a lot of,
5 you know, confusion that is going on with them.

6 So we've seen that as being a factor in terms
7 of the rise in these cases here. So many of these
8 cases are not actually real gender dysphoria cases.
9 They are cases of social media contagia and social
10 media influences.

11 We firmly support this bill because we
12 believe that every child deserves a natural childhood,
13 one that allows them to experience puberty and other
14 natural changes that shape who they will become.

15 We believe that children should be taught to
16 embrace and love their bodies, not to hate and then
17 despise themselves and feel that the only way that
18 they can be able to love themselves is to harm
19 themselves and cut off body parts and subject
20 themselves to harmful sterilization and castration
21 methods.

22 We believe that children are not able to
23 comprehend and fully appreciate the risks and life
24 implications, including permanent sterility, that
25 results from the use of puberty blockers, cross-sex

1 hormones, and drastic surgical procedures.

2 We must protect children and parents from
3 being pressured by ideologically and financially
4 motivated gender clinics into agreeing to these
5 harmful experimental treatments. We have seen time
6 and time again in Europe, many of the nations that
7 have preceded us in these types of treatments, that
8 they are drastically cutting back because of the data
9 that is showing the harmful side effects and long-term
10 implications of these types of treatments.

11 And also I would point out that in this
12 committee, even though there's been the appeal to
13 many medical organizations for their support of these
14 types of treatments, that none of these organizations
15 came here to testify today.

16 And I would point out as well, one standard
17 that has been brought up is the WPATH standards
18 internationally. The issue is -- and WPATH admits
19 within those statements and the procedures, the
20 guidelines, that they are guidelines and not standards
21 of care. We do not have any standards of care from
22 WPATH to go on. And that is a high standard. For the
23 lawyers in the room, standards of care is one of the
24 highest levels. It's almost like the strict scrutiny
25 of the medical community. It is evidence based.

1 So we encourage this committee to support
2 this good bill, and we thank Senator Yarborough for
3 bringing this forward.

4 Thank you so much.

5 CHAIR HUTSON: Stay right there. We have
6 got one question.

7 Senator Jones, I'm going to open it up so
8 you can go back and forth and don't have to go through
9 me.

10 SENATOR JONES: Thank you, Chair.

11 Thank you so much for your presentation.

12 How many of those researchers have you read
13 yourself?

14 MR. DIPIETRO: A good number. And I've also
15 read studies that have kind of referenced some of
16 those.

17 SENATOR JONES: How many of them were peer
18 reviewed?

19 MR. DIPIETRO: A good number. And I'd be
20 happy to get some of those for you as well.

21 SENATOR JONES: How many cases in
22 Florida are you speaking of?

23 MR. DIPIETRO: In terms of in the state
24 of Florida?

25 SENATOR JONES: Yeah. Because you made

1 mention of that you -- based on the research, there's
2 been an uptick in Florida. How many?

3 MR. DIPIETRO: In Florida -- I know a lot of
4 the research more nationally, but I can look into
5 that.

6 SENATOR JONES: How many in Florida?

7 MR. DIPIETRO: In terms of Florida, I
8 would be happy to look into those.

9 SENATOR JONES: Yeah. The number is zero.
10 How many since 2018?

11 MR. DIPIETRO: Based off which cases?

12 SENATOR JONES: Based off what you just
13 made mention of in your testimony, how many in
14 Florida, as far as you are concerned, since 2018
15 have received this type of care?

16 MR. DIPIETRO: I believe that those
17 numbers were mentioned by Senator Yarborough, but
18 I'd be happy -- so I would definitely defer to
19 him.

20 SENATOR JONES: Less than 143.

21 MR. DIPIETRO: Okay.

22 SENATOR JONES: And you made mention of,
23 as far as social media is concerned -- my last
24 question, Chair.

25 You said social media has influenced

1 this uptick that we're speaking of. Does the
2 research speak about social media?

3 MR. DIPIETRO: Some of the research has.
4 I would point to, actually, liberal researcher
5 Abigail Shrier's work on that.

6 SENATOR JONES: Liberal research. Okay.
7 My last final question to you is you
8 made mention of Europe and a lot of this research
9 that happened. What is the one exception that
10 many of these researchers that you're speaking of
11 as far as puberty blockers -- what is one exception
12 that they have made mention of where these
13 individuals should receive treatment?

14 MR. DIPIETRO: I'm not aware of that,
15 but I'd be happy to --

16 SENATOR JONES: Absolutely. All the
17 peer reviews, the exception is where youth need
18 to receive this type of treatment is for youth
19 under extreme conditions who have gender
20 dysphoria.

21 Thank you so much.

22 MR. DIPIETRO: Thank you.

23 CHAIR HUTSON: Thank you very much.

24 All right. Jude Spiegel, and following
25 would be Maxx Fenning.

1 You are recognized.

2 MR. SPIEGEL: Hi, I'm Jude Spiegel, and I
3 really don't want to be here, like, I had to take
4 time out of my life, drive four hours and end up here.

5 I just want to know, why are you afraid of
6 transgender joy and happiness? I am a transgender
7 parent of two gender nonconforming children, one who
8 does happen to claim to be the gender opposite of the
9 one assigned at birth. It has nothing to do with me.
10 He has no idea what transgender is, just own choices.
11 And I'm here because I have the right to decide
12 what medical care my children receive.

13 I grew up suicidal and confused, knowing
14 society believed who I am is wrong. I've never
15 identified solely as a woman from childhood onward.
16 Before social media, I knew I was not a girl. I do
17 not want this for other children. I do not want any
18 child to do what I did to myself.

19 I do not want to have to flee my home state
20 of 28 years, but you're forcing my family out. You
21 took away Medicaid coverage for 9,000 transgender
22 people in the state of Florida, including me. Is
23 that not enough? And now you want to ban insurance
24 from covering gender-affirming care completely. And
25 I receive my care via telehealth because I'm a busy,

1 working parent. We have told you time and time again
2 that these actions will kill people, and you've shown
3 that you don't care if we live or die. You're not
4 protecting me or my family. Message received?
5 Our blood is on your hands.

6 And I just want to say that I love my
7 children, Morgan and Hazel, and I'm here for you guys
8 above all else.

9 Trans rights are human rights, and you've
10 proved that you don't see us as human.

11 Thank you.

12 CHAIR HUTSON: Maxx Fenning is up, followed
13 by Nick Carey.

14 MR. FENNING: Good morning.

15 My name is Maxx Fenning, and I'm the founder
16 and president of PRISM, a youth-led nonprofit that
17 works to expand access to LGBTQ-inclusive education
18 and sexual health resources for young people in
19 South Florida.

20 My question to you all is why. You've heard
21 what this will do. You already knew what this would
22 do. So why do you feel the need to attack our
23 community in every facet of life and at every avenue
24 and every single chance you get? Haven't you done
25 enough? Why?

1 I know you will come on that mic after 100
2 people have almost unanimously told you to stop this.
3 You'll arrive at your bully pulpit and spew your
4 toxic diatribes and feigned sympathies that tell us
5 that we are wrong, that the media is blowing this
6 out of proportion, that there's simply a lot of
7 emotion in this room, even though the facts, not
8 feelings, show that gender-affirming care is
9 lifesaving care, with consensus from every major
10 medical association in the United States, even though
11 the authors of almost every study cited in the
12 Florida Department of Health's request of the Board of
13 Medicine made a similar decision last year, came out
14 publicly to state that their research was
15 misrepresented to justify denying this care to people
16 for political gain.

17 Even with all of that, you will tell us that
18 we are wrong. Don't treat us like children. Don't
19 treat us like the children you take away from us.
20 Don't treat us like the children you deny health care
21 for. Don't treat us like the children you are
22 hell-bent on driving 6 feet under as you place the
23 bottom of your dress shoes and heels on their necks.
24 Don't treat us like children when you have forced us
25 to grow up way too fast just so we can fight for our

1 right to exist. You took our childhoods away from us
2 already.

3 I said it in the House yesterday, and I will
4 say it again and again and again. If you're going to
5 be a murderer, then act like it. And if you won't,
6 then I urge you to vote no.

7 Thank you for your time.

8 CHAIR HUTSON: Thank you.

9 Nick Carey, and then followed by Sierra
10 Bush Rester.

11 You're recognized.

12 MR. CAREY: And now these three remain:
13 faith, hope, and love, but the greatest of these is
14 love.

15 Who are you showing love to in this? I
16 believe God doesn't make mistakes. Just as he created
17 me as a cis gender man, he created these fine people
18 over there to be who they are. And who are you to
19 deny them who they are? God calls us to love our
20 neighbors and protect our neighbors. And I ask you,
21 who are you protecting? Because it's only your
22 snowflake feelings.

23 This is the epitome of you trying to force
24 your woke opinions on these fine residents and
25 citizens. How dare you. How dare you use faith.

1 How dare you.

2 That's all I have to say.

3 CHAIR HUTSON: Thank you very much.

4 Sierra Bush -- is it Rester? Okay.

5 You're recognized.

6 MS. BUSH RESTER: I wasn't here for the
7 beginning of the meeting. Is there any limit to time?

8 CHAIR HUTSON: No, ma'am. You can go as
9 long as you need to.

10 MS. BUSH RESTER: Okay. Thank you.

11 I had a long and short version, so --

12 CHAIR HUTSON: I mean, hopefully, you don't
13 go, like, ten minutes, but --

14 MS. BUSH RESTER: No. It will be --

15 CHAIR HUTSON: -- a couple of minutes is
16 fine.

17 MS. BUSH RESTER: Yeah. Okay.

18 So banning hormone therapy and hormone
19 blockers from minors not only takes away lifesaving
20 and necessary medical treatment for trans youth, but
21 it also puts the medically fragile and children with
22 genetic disorders at significant health risk.

23 My family carries the genetic disorder
24 called NF1 that causes noncancerous tumors to grow on
25 the nerves. When my brother was 7, we found out that

1 one of those tumors was pushing on the puberty gland
2 in his brain. Fortunately for my brother, this was
3 15 years ago, which meant my parents were able to
4 utilize hormone blockers, a therapy this bill would
5 ban, to save my brother's life.

6 You might say, Well, this bill wouldn't stop
7 medical procedures like that, not when it's medically
8 necessary. But I challenge that because
9 gender-affirming care for trans youth is just as
10 medically necessary and lifesaving as the hormone
11 blockers my little brother got.

12 NF1 has a 50 percent hereditary rate, and I
13 am a carrier. If it turns out that my son has NF and
14 I need to get the same lifesaving treatment that my
15 brother got, I will, regardless of the legal
16 consequences. And I'll tell you right now, if y'all
17 dare come to my home or to the homes of my neighbors
18 to kidnap my children, the children of my community
19 from the parents who seek to utilize the same
20 treatment that saved my brother's life, I would ask
21 you to remember that Florida has a stand your ground
22 law for a reason.

23 CHAIR HUTSON: Thank you.

24 Members, that's all the appearance cards
25 that I have.

1 We are now on debate on the bill. Any
2 members wish to debate?

3 Senator Berman in debate.

4 SENATOR BERMAN: Thank you, Mr. Speaker.

5 This is a really troubling bill that we're
6 hearing today, so I kind of want to divide it into
7 two parts. I want to talk first about the adults
8 and then about the children.

9 So for adults, we're banning telehealth,
10 which is something we have adopted in this
11 legislature through so many other forums, and we've
12 seen the benefits of it. So I don't understand why
13 we're singling out this particular group, although I
14 guess that's part of the basis for that. And we're
15 also banning qualified nurse professionals from
16 administering prescribed medical care to informed,
17 consenting adults.

18 So I just can't understand in the, quote,
19 free state of Florida why we are stopping people from
20 doing things that have been going on for years.

21 So on the adult side, I think it's extremely
22 hypocritical what we're doing to the transgender
23 adults here in our state.

24 And then I want to talk about the children.
25 So we asked the question how many children are

1 affected? And the answer was 12. We are spending
2 hours and hours of our taxpayer money to talk about
3 this issue for 12 children. I just don't understand
4 why we can't let people -- parents make the
5 decisions that they want to make with their children
6 and instead we're going to spend so much time and
7 effort on that.

8 Puberty blockers are used for many other
9 things. You heard one example about tumors. They're
10 used for precocious puberty. They're used for growth
11 issues. If they're going to be used for these other
12 issues, there's not -- obviously there's not a
13 medical contravention about them, so why are we
14 saying they can't be used for these children?

15 And, you know, I asked the question about
16 breast implants. A 17-year-old can get breast
17 implants, but we're not going to allow the situation
18 if the person has gender dysphoria. It's just crazy
19 to me that we're doing this.

20 And, you know, we've heard some testimony
21 about social contagia. I don't -- you know, one of
22 the things I think we need to recognize is we're not
23 talking about giving any child any kind of treatment
24 until after puberty. Nothing happens until we get
25 to puberty. So this is not going to be a social

1 contagia.

2 You know, look at the people who came to
3 testify here today. This is a very difficult decision.
4 People don't just wake up and say, Okay, today I'm
5 going to be transgender. It is gut-wrenching. You
6 know, we've heard from some of the people who
7 testified. I know some people who have made the
8 decision. It is not something that is done because
9 it's, quote, trendy. And we see the numbers. I mean,
10 you're talking about 12 children. You're not talking
11 about, you know, some kind of mass decision-making.
12 And I find that very disingenuous.

13 And I just really want to say that it's
14 important for -- you know, we've seen that leading
15 or national health organizations support
16 gender-affirming care. We can all agree that the
17 State of Florida should not be making medical
18 decisions for us, nor should they stand between
19 parents, medical providers, and trans youth.

20 I question our sense of decency, and I think
21 that we need to vote no on this bill because this
22 really is going to harm our transgender community,
23 and it sends a message to the rest of the country
24 that Florida is not open for freedom unless it's the
25 freedom that is being top down from the government.

1 Thank you.

2 CHAIR HUTSON: Any other debate?

3 Senator Thompson.

4 SENATOR THOMPSON: Thank you, Mr. Chair.

5 Senators, on June 12 of 2016, I represented
6 the community where the Pulse Nightclub shooting
7 occurred. And there were 49 people who were killed
8 at the Pulse Nightclub and 51 who were wounded and
9 had to be taken to the hospital. And I attended a
10 lot of vigils after that shooting. I participated in
11 marches after that shooting because of the pain of
12 seeing the lives of these individuals snuffed out
13 because they didn't fit someone's notion of what was
14 acceptable in the community.

15 And what we're doing here today is a very
16 serious kind of thing. We're saying that if you don't
17 fit our notion of what's acceptable, then you are not
18 desired; you can't be who you are.

19 One of the vigils that I attended was in a
20 church, and there was a young Black woman there who
21 was in tears. I went to comfort her, and she said,
22 I'm crying because it feels so good to be allowed in
23 a church. And I asked her what she meant, and she
24 said when she came out and told people who she really
25 was, she was expelled from her church. And you would

1 think the church is the place you go for love and
2 acceptance. She was expelled from her church.

3 She was put out of her home by her parents
4 because she didn't fit someone's notion of what is
5 desirable and what is acceptable.

6 So we're stigmatizing people here today
7 because they don't fit our notion of what's acceptable.

8 And what this comes down to for me is that
9 government should not be making medical decisions for
10 individuals. I am aware of a time when government
11 systematically sterilized Black women because the
12 government didn't think that they should reproduce.
13 That was the government that did that.

14 And I'm aware of the Tuskegee experiment
15 where Black men who had syphilis were allowed to have
16 that disease progress so that the government could
17 observe what happened in the last stages of syphilis.
18 That was the government.

19 And here we are today as elected officials
20 saying the government should make decisions regarding
21 what happens to youth, what happens to adults, whether
22 parents should continue to embrace their children if
23 their children don't fit our notion.

24 And so this is wrong. And I don't know what
25 happened to the idea that the government that governs

1 best is the government that governs least. What
2 happened to that? That's what I've been hearing people
3 say that they want government -- the government that
4 governs less, limited government. Well, here we are
5 today going against people who are trained and who
6 have said that affirming care is needed. And those
7 organizations include the American Academy of
8 Pediatrics, the American Psychological Association,
9 the American Psychiatric Association, the Pediatric
10 Endocrinology Society, and the American Medical
11 Association. And we don't have medical training,
12 and these individuals, these organizations, these
13 associations have supported gender-affirming care.
14 And as the government, we're saying no.

15 And I think that this is overreach. I think
16 that this stigmatizes people in our community and
17 makes it acceptable then for people to act in ways to
18 eliminate them. And so I'm asking that we be the
19 government that governs least and vote no on this
20 bill.

21 Thank you, Mr. Chair.

22 CHAIR HUTSON: Senator Stewart in debate.

23 SENATOR STEWART: Thank you, Chair.

24 You can't take gay out of gay, and you can't
25 take trans out of trans. We are who we are, and they

1 are who they are. And I think the need for medical
2 care is the same for trans as it is necessary for
3 cancer patients.

4 And I think that -- I know that we all
5 disagree on many things when we come up here, but my
6 opinion is we should leave people alone to do what it
7 is that is necessary for them and their mental and
8 their physical well-being.

9 CHAIR HUTSON: Any further debate?

10 Senator Torres in debate.

11 SENATOR TORRES: Thank you, Mr. Chair.

12 And as many of you know, the last session
13 transgender came up. I'm a great -- I'm a grandfather
14 to a transgender granddaughter. I hear this and I
15 wonder why are we doing this again? Why are we going
16 after children?

17 You know, when you see a child grow in the
18 stages and develop, you support that child. You give
19 that love to that child 100 percent. And does my
20 love change because the child is transgender? Not one
21 bit. It grows more. Why? Because you want to show
22 support. You want to encourage that child, what they
23 dream of, what they want to do, give them that hope,
24 that energy to continue with their life, because you
25 don't know how far they can take this.

1 This bill is too broad, denying medicines.
2 Transgender comes in different colors. It goes in
3 every family across our state. I have a friend of
4 mine, we went through the academy in the police
5 department in New York. I've known him over 35 years.
6 Real conservative, nice guy, real conservative. He
7 never figured that his family -- he would face a
8 transgender child. Today -- today that transgender
9 child is helping him take care of his wife, and
10 he's so proud of his transgender child -- grandchild
11 coming to help him in time of need.

12 You see, you don't know. You sit here today,
13 Senators. You don't know what is in store for you
14 tomorrow or a year from now or five years from now
15 when you do have grandchildren or, like myself, have a
16 great grandchild. You show the support all the time
17 because that's how you feel. They're part of your
18 blood. And that's the same way these families feel
19 out here. They want to show support, not take away.

20 We say parents are in charge. They're not,
21 not according to this. We're taking away. You can't
22 do that. You cannot do that. These children are
23 going to grow up. They're going to be citizens here
24 in the state. They're going to be professionals in
25 this state. They're going to have their own families

1 in this state. And what we do today is going to
2 reflect on them.

3 Are we putting fear on those who are harmless
4 because they have a different lifestyle, because they
5 want to live differently? We can't do this. We can't
6 continue doing this.

7 All I can say is that I know in my family,
8 we see my granddaughter grow up and study and progress.
9 My daughter came here when she was in the House and
10 spoke about this. And you know my daughter. She is
11 Representative Amy Mercado. And this is something
12 that I'm not ashamed to say. I'm proud of my family.
13 I'm proud of what we stand for, because we never know
14 what's in store for anybody, and we encourage you to
15 support us for these children.

16 So I ask you, Senators, you can stop this
17 bill today by voting no.

18 Thank you, Mr. Chair.

19 CHAIR HUTSON: Thank you, Senator Torres.

20 Any other debate?

21 Seeing none, Senator Yarborough, you're
22 recognized to close on your bill.

23 SENATOR YARBOROUGH: Thank you, Mr. Chairman.
24 Thank you to the senators who debated on the bill and
25 also to the members of the public who came, and some

1 came from great distances, as we usually have with a
2 lot of bills we take up, especially bills like this
3 that rightfully get a lot of attention. So thank
4 you for your time and patience. You had to wait
5 quite a bit, and I know the House is taking up issues
6 as well. So I thank you for that.

7 I did want to address a few points, Mr. Chair,
8 before I get into the close that I had kind of
9 prewritten, but there were some comments that were
10 made both by members of the public and by some
11 colleagues that I just want to make sure we have the
12 right understanding about what the bill does, what it
13 doesn't do, and all of that just to clear that for
14 the record and for moving forward.

15 So one of the points that I do need to go
16 back to is when we had the discussion among us during
17 questions, I do want to clarify the point on the
18 numbers that I gave you as far as what had taken
19 place in Florida. That was based on what was covered
20 under Medicaid before the rule went into effect to
21 say that that was not allowed to be covered under
22 Medicaid, both for adults and for minors.

23 So those numbers that I mentioned were
24 under Medicaid. We don't have any way of knowing
25 what's happening out there in the commercial market,

1 so it could be a much higher number. I would imagine
2 that it probably is, but I don't know for sure. So I
3 don't really know a way that we can get that. But as
4 far as our Medicaid coverage, the numbers I mentioned
5 earlier for adults and children was last year based on
6 Medicaid numbers. So I wanted to make that point and
7 clear up the record.

8 Another comment was made -- this was by a
9 member of the public -- that there's no exceptions,
10 you know, to what parents can do and work out with the
11 doctors of the children. I think in response to two
12 senators during questions, I outlined in the bill we
13 have written in there plainly that if there are issues
14 that minors are experiencing and if a health care
15 practitioner in their good faith clinical judgment
16 says that the minor should continue on that, that
17 is an exception in the bill.

18 So that statement was not correct, and that
19 is in the bill. It's written plainly in the bill.

20 Another statement was made that we're not
21 medical doctors. We heard that with some other debate
22 we've had on other issues this week in different
23 spaces. So one of the great things about the
24 legislature is that we're a citizen legislature, and
25 all of us sitting up here would not be sitting up

1 here if the Constitution that governs our state didn't
2 allow us to sit up here. The House would not be
3 seated. The Governor and all the Cabinet members
4 would not be seated.

5 We meet the criteria to sit here as senators
6 and as legislators, and we don't have to have any
7 certain degree to do it. And that's the great part,
8 because that means anybody who meets the criteria to
9 be a registered voter and be of a certain age can run
10 for these offices and serve here.

11 So I'm not coming hard against that, but I
12 just want to make sure we understand. We deal with
13 so many issues here in the legislature. This one
14 touches into medical and into legal. But we have
15 agriculture, which I'm not an expert in. We have
16 other issues, education. We have transportation and
17 economic development. We're not experts in every
18 field, so we do have experts that give us a lot of
19 input, but then we have to divide all of that input
20 and make the best decision that we believe best serves
21 the constituents in our districts and in our state.

22 So we don't have to possess a certain degree
23 just to sit here. That doesn't mean we take the
24 issues lightly. I don't take lightly what we're
25 doing in front of us today, but I will push back some

1 on that notion that we're not experts and, you know,
2 we shouldn't be doing this. This is what we were
3 elected to do, and all of these different policies
4 come before us, budgetary and policywise.

5 As far as the projection toward us about we
6 shouldn't govern by beliefs, well, the way that laws
7 go into effect, it all has to be member driven. You
8 have to have a House member and you have to have a
9 senator to introduce a bill, and that's the only way
10 that a law can get in, or it can come through a
11 committee, but those are made up of members too.
12 That's the only way laws can come into existence, at
13 least in our state. I don't know of any other
14 state that does it different. But if you don't have
15 it member driven -- and as a side note, every member
16 has their own set of beliefs -- then you have no laws.
17 So we can't change the current law, nor can we add new
18 laws or repeal or do anything else if we don't have
19 that come through members.

20 Again, all of us are qualified to sit here,
21 just as anyone else who fits that criteria under our
22 state Constitution.

23 So I would be concerned if someone said they
24 had no beliefs, and that doesn't mean it has to be
25 religious. You can have very strong beliefs that

1 aren't informed by religion. But all of us have
2 a belief system of some sort, religious or not.

3 Another item that was mentioned was that
4 we're not allowing for those who are struggling with
5 gender dysphoria, if there are youth who are
6 struggling with gender dysphoria, to receive the
7 treatments. Well, I disagree with that, because there
8 can be an intersection between some youth who may fit
9 the criteria that we just talked about in the
10 exceptions. Some of them may be struggling with
11 gender dysphoria.

12 So they're not exclusive to the point of it's
13 only this or this. There can be some who are
14 struggling with it that then are able, under the
15 exceptions we've laid out in the bill, to continue to
16 receive treatments. They're not necessarily exclusive.

17 So those are most of the points. The only --
18 those are points for most of the speakers.

19 The only other thing I would mention -- and I
20 appreciate the debate from my colleagues. I mentioned
21 in committee earlier this week, I think it was in
22 Health Policy earlier this week on another bill --
23 maybe education -- Senator Thompson, you mentioned as
24 far as those that don't fit the notion and they may
25 not be desirable. It reminds me of a quote that I

1 mentioned -- and I'm just speaking for me. But your
2 comment reminded me of this. So earlier this week I
3 said a quote. I think it was Morgan Freeman. Again,
4 I may be mistaken. My research shows it's Morgan
5 Freeman, the actor, who said: *Just because I*
6 *disagree with you on something doesn't mean that I*
7 *hate you. It means I disagree with you.*

8 That's true for me. And you may disagree
9 with even making that statement. It wasn't mine, so
10 I'm not laying claim to it. There are those who do
11 hate if they disagree. But just because you disagree
12 with somebody doesn't mean you hate them or that you
13 have a hate. It doesn't mean we should hate.

14 So I reject that. I don't think just because
15 I put this in front of the Senate to consider that
16 that means I hate anybody. I can fiercely disagree.
17 I believe this is right or I wouldn't have filed it,
18 I can tell you that. But that doesn't mean I hate
19 anybody just because I disagree with them.

20 So I agree with what he said. It doesn't
21 mean that we hate each other. It just means we
22 disagree. So I want everyone to know, and kind of
23 dovetailing off that, it's been mentioned about those
24 who may take their lives or fear for their lives that
25 are struggling with this. So I want everyone to know

1 that your life has value. And I also do reject the
2 notion that an individual's worth and dignity is
3 limited to whatever preference they may choose related
4 to the topic before us today.

5 Every single person was created with
6 extraordinary worth, incredible value, and has a
7 unique purpose. And this has been true about you
8 since before you were born, and you can't change it.
9 Procedures and other efforts like this can't fill the
10 deepest needs in a human heart. The world wouldn't
11 be the same without you, and harming yourself is
12 never the answer. And that's true for adults and
13 child alike.

14 The legislation does not impact the ability
15 of adults in the state to make a decision to pursue
16 any treatment or surgery related to sex reassignment.

17 As we've discussed, the bill is consistent
18 with the Florida Board of Medicine and the Board of
19 Osteopathic Medicine's rules to restrict sex
20 reassignment prescriptions and procedures for
21 children. The board spent the past eight months
22 considering medical research, listening to experts,
23 and hearing from the public. They determined the
24 treatments to be harmful for minors, and the Board of
25 Medicine's rule, again, went into effect banning

1 treatment for minors last Thursday, March 16. The
2 bill before us codifies this rule.

3 And then, additionally, as reported in the
4 *New York Times* in October 2022, England's National
5 Health Service proposed restricting use of the drugs
6 for gender-dysphoric children to research settings.
7 Sweden was mentioned earlier, but also Finland has
8 placed limits on treatment, concerned not just with
9 the risk of puberty blockers but the steep rise
10 in young patients.

11 Adult patients fully informed by their
12 physician of the nature and risks of sex reassignment
13 prescriptions and procedures can make a decision about
14 these treatments for themselves. And many here today
15 have indicated they've made that decision.

16 Members, the fact remains, when it comes
17 to children these treatments are experimental. As I
18 said in my opening remarks, I believe as lawmakers we
19 have to draw the line when there are drastic,
20 life-altering procedures that could be given to
21 children and take place. So we have to protect our
22 very young children.

23 So we need to let kids be kids. Our laws
24 need to reflect that. We need to set appropriate
25 boundaries.

1 And, lastly, I do agree with this sentiment,
2 too, that government should not be making medical
3 decisions for individuals. We had an issue over
4 the past three years that affected the globe, which is
5 one reason why I did not support anything that would
6 mandate individuals to have to receive a certain
7 treatment. Many other senators feel the same way
8 about that.

9 We don't say that parents can't embrace
10 their children as part of this debate. And I would
11 ask for your favorable support because this is
12 best for the children and families of our state.

13 Thank you, Mr. Chair.

14 CHAIR HUTSON: Thank you.

15 Closed on your bill.

16 Michele, please call the roll on CS for
17 SB 254.

18 THE CLERK: Senator Albritton?

19 SENATOR ALBRITTON: Yes.

20 THE CLERK: Senator Berman?

21 SENATOR BERMAN: No.

22 THE CLERK: Senator Boyd?

23 SENATOR BOYD: Yes.

24 THE CLERK: Senator Burton?

25 SENATOR BURTON: Yes.

1 THE CLERK: Senator Calatayud?
2 SENATOR CALATAYUD: Yes.
3 THE CLERK: Senator Collins?
4 SENATOR COLLINS: Yes.
5 THE CLERK: Senator DiCeglie?
6 SENATOR DICEGLIE: Yes.
7 THE CLERK: Senator Garcia?
8 Senator Jones?
9 SENATOR JONES: No.
10 THE CLERK: Senator Mayfield?
11 Senator Mayfield?
12 SENATOR MAYFIELD: Yes.
13 THE CLERK: Senator Osgood?
14 SENATOR OSGOOD: No.
15 THE CLERK: Senator Rodriguez?
16 SENATOR RODRIGUEZ: Yes.
17 THE CLERK: Senator Simon?
18 SENATOR SIMON: Yes.
19 THE CLERK: Senator Thompson?
20 SENATOR THOMPSON: No.
21 THE CLERK: Senator Torres?
22 SENATOR TORRES: No.
23 THE CLERK: Senator Trumbull?
24 SENATOR TRUMBULL: Yes.
25 THE CLERK: Senator Wright?

1 SENATOR WRIGHT: Yes.

2 THE CLERK: Senator Yarborough?

3 SENATOR YARBOROUGH: Yes.

4 THE CLERK: Vice Chair Stewart?

5 SENATOR STEWART: No.

6 THE CLERK: Chair Hutson?

7 CHAIR HUTSON: Yes.

8 By your votes CS for SB 254 is reported
9 favorably.

10 Does any senator wish to be recorded voting
11 on bills reporting before the committee today?

12 Seeing none, Senator Mayfield moves to allow
13 staff to make technical corrections and adjustments.

14 Without objection, show that motion approved.

15 Is there any other business before the
16 committee today?

17 Seeing none, Senator Mayfield moves we
18 adjourn.

19 Without objection, show that motion approved.

20 We are now adjourned.

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CERTIFICATE OF REPORTER

STATE OF IOWA)

COUNTY OF WARREN)

I, Terri L. Martin, Certified Shorthand Reporter, certify that I was authorized to and did stenographically transcribe the foregoing audio recording to the best of my ability and that the transcript is a complete record of my stenographic notes.

Dated this 18th of August, 2023.

/s/ Terri L. Martin
Terri L. Martin, CSR, RPR, CRR