No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME V OF XXI
PART 1 OF 2

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INDEX TO APPENDIX

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

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Florida Medicaid Project: Treatment for Transgender Children

Medical Experimentation without Informed Consent:

An Ethicist's View of Transgender Treatment for Children

G. Kevin Donovan, MD, MA
5-12-2022

Florida Medicaid Project: Treatment for Transgender Children

Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children

I. The Issue

Growing controversy attends the diagnosis and treatment of individuals identifying as transgender, particularly those who are still children or adolescents. As was recently pointed out, leading medical, mental health, and public health organizations support understanding gender-diverse youth and providing gender-affirming medical (hormonal) and other(surgical) care as the standard of care, including the American Academy of Pediatrics, American Psychological Association, Centers for Disease Control and Prevention, Society for Adolescent Health and Medicine, and the American Medical Association. Major nursing organizations—the American Nurses Association and the American Academy of Nursing— have made statements that young people's access to inclusive, safe, and competent health care is a human rights issue. (Wolfe, I., & Goepferd, A. "Child Abuse in Texas." *The Hastings Center*. 14 Mar. 2022) However, this widespread support is not going unchallenged, even by those who have been providing medical interventions for these children and adolescents.

Recently, questions have arisen about the appropriateness of both the diagnosis, and the safety and efficacy of these interventions that have been strongly encouraged up until now. Currently, less than half of state Medicaid programs provide gender affirming care. (Mallory, C., & Tentindo,W. "Medicaid coverage of gender-affirming care." Williams Institute, UCLA School of Law. Oct 2019). The Florida Surgeon General has said that minors should not undergo gender transition procedures, puberty blockers and hormone treatments. "Florida Department of Health Releases Guidance on Treatment of Gender Dysphoria for Children and Adolescents." 20220420-Gender-Dysphoria-Press-Release | Florida Department of Health.) In Texas, the state attorney general issued a decision that gender-affirming medical treatments such as puberty-suppressing hormones fall under the definition of child abuse in Texas state law. In fact, 34 states have introduced legislation to limit hormonal and surgical interventions for such transgender patients. This aligns with similar reassessments and limitations in the United Kingdom, Sweden, Finland, and France. A new position statement from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) stresses the importance of a mental health evaluation for people with gender dysphoria — in particular for children and adolescents — before any firm decisions are made on whether to prescribe hormonal treatments to transition or to perform surgeries, often referred to as "gender-affirming care." "There is a paucity of quality evidence on the outcomes of those presenting with gender dysphoria. In particular, there is a need for better evidence in relation to outcomes for children and young people," the guidance states.

Given the legitimate concerns about the diagnosis, treatment, and the paucity of supportive, scientific studies in regard to the interventions being offered to minors who identify as transgender, I will offer a view of these from the perspective of an ethicist and pediatrician. This will be done in the face of strong and sometimes heated opposition to any variance from the currently prevailing recommendations. Each category of currently recommended or potential treatments will be briefly considered within this framework. The evidence base for these will be reviewed, and an overall argument made that such interventions must be considered as medical experimentation, subject to the requirements of research in childhood with informed consent. Finally, I will conclude with an examination of the fundamental flaw of the transgender project in childhood, and how it is leading to inevitable and controversial challenges.

In order to do this, we must review the ethical requirements for medical research in childhood and the elements of **informed consent**. Because of numerous abuses in the past, a strong system of regulations and oversight has been developed for the protection of human subjects in the United States. This began with the Belmont Report: (https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html) The report not only described the ethical principles listed below, but led to guidelines for research protections that are now codified in Federal regulations (Code of Federal Regulations, or 'CFR') and monitored by the U.S. Department of Health and Human Services (DHHS). These led to the establishment of IRBs (Institutional Review Boards) which are responsible for the protection of human subjects in federally funded research—IRBs are the Federally mandated committees that review research activities for the protection of human subjects. The Office for Human Research Protections (OHRP) provides leadership in the protection of the rights, welfare, and wellbeing of subjects involved in research conducted or supported by the DHHS. The OHRP helps ensure this by providing clarification and guidance, developing educational programs and materials, maintaining regulatory oversight, and providing advice on ethical and regulatory issues in biomedical and social-behavioral research. These measures have laid the ground rules for human research, in adults and children including the need for informed consent.

Although adults may be included in research, this should only be done with *fully informed consent*, and the requirements will differ for children and other vulnerable subjects. The bedrock of these protections lies in obtaining the informed consent from the participant. Informed consent to medical treatment and research involvement is fundamental to both ethics and law. The process requires that a *fully autonomous patient* have the ability to *understand relevant medical information* about the proposed interventions, including the *risks, benefits if any, and alternatives* (including doing nothing/non-participation). and consent *voluntarily* without *coercion*. This is rooted in respect for the **ethical principles** of **autonomy**, **beneficence**, and **justice**.

Autonomy is derived from respect for persons, which requires that we not only respect those who are fully autonomous but protect those individuals that are not fully autonomous. Vulnerable subjects such as children cannot legally or ethically participate in the consent process due to their age and maturity level. The rules for their involvement are set out by the Code of Federal Regulations (46 CFR 401-409). While consent cannot be given for another person, parents or guardians can give "permission" and children can give assent to the extent that they are able. The process of obtaining assent should be appropriate to the age, maturity, and psychological development of the child. The consent process must contain three ethically required components: *information*, *comprehension*, and *voluntariness*. Deficiencies in any of these categories would invalidate the process. The main contention here is that deficiencies in *all* these categories can be found in the current approach to minors who identify as transgender, and current attempts at treatment should not proceed as they are now practiced.

Beneficence is reflected in the complementary expressions of (1) do no harm and (2) maximize possible benefits and minimize possible harms. An assessment of risks and benefits will depend heavily on the delivery of accurate and complete information as described above. An assessment of risk will include both the probability and the severity of envisioned harms, both physical and psychological.

Finally, ***justice*** requires fairness in distribution of risks and benefits. It suggests that not only should like cases be treated alike, but different approaches are appropriate for different circumstances. This is highly relevant in the selection process for those being subjected to the various interventions while still minors.

Thus the process of informed consent must proceed with a correct diagnosis, the nature and purpose of recommended interventions, the known burdens and benefits of all options, including doing nothing or forgoing the intervention. While not able to do an exhaustive review of these elements as they apply to the main treatment approaches recommended for transgender minors, we can briefly examine each category to assess for obvious deficiencies. The issue of deficient information will be significant in each category, and questions of comprehension and voluntariness will be addressed at the end.

II. The Interventions

Surgery

A variety of surgeries have been performed on transgender adults. These range from removal of both breasts (bilateral mastectomy) and associated chest reconstruction, nipple repositioning, dermal implant and tattooing, to gender surgery for trans men which includes construction of a penis (phalloplasty or metoidioplasty), construction of a scrotum (scrotoplasty) and testicular implants, or a penile implant. Removal of the womb (hysterectomy) and the ovaries and fallopian tubes (salpingo-oophorectomy) may also be considered. Surgery for trans women includes removal of the testes (orchidectomy), removal of the penis (penectomy), construction of a vagina (vaginoplasty), construction of a vulva (vulvoplasty), construction of a clitoris (clitoroplasty), as well as breast implants for trans women, facial feminisation surgery and hair transplants. Certainly there are multiple known risks to this long list of surgeries. These used to be described as "sex-change" operations: they are now termed "gender affirming surgeries." The semantic shift is important, as we will see.

Most, but not all, practitioners would delay undertaking these permanent alterations in minor children and adolescents. This may be as much for legal reasons as for medical considerations. However, the lack of sexual maturity in younger patients, especially if previously delayed by puberty blocking agents, makes the sparse tissue more difficult to work with and outcomes less favorable, with problems such as wound rupture more likely. These are not challenges that are routinely described to minors at the beginning of their treatment progression with puberty blocking agents or hormones. This deficit of information would be a major failing.

Hormonal Treatment

Treatment with cross-sex hormones is a mainstay of gender affirming care. These result in the changes in body habitus, facies, voice tone, and hair development that transgender patients seek. They are described as "gender affirming", "life-saving" and "a human right" by their proponents. They have been prescribed by Planned Parenthood clinics and others after a first visit for gender dysphoria (https://www.plannedparenthood.org/planned-parenthood-greater-texas/patient-resources/transgender-healthcare). Surely no one would argue that such a precipitous practice has been accompanied by a full psychological evaluation, or disclosure of medical risks. Chief among these is the fact that the resulting bodily changes will not disappear, even if the initial desire for them changes. And this change is no unlikely development – upwards of 80% of minors who identify as transgender will reverse this identity by the time they reach their mid-20's if left untreated, and revert to their previous identification, albeit possibly with a same-sex attraction. It is more than simply changes in one's body that are at risk; sex hormones have an important and lasting effect on brain development and adolescent psychology. To not fully appreciate this fact, or to not have it delineated in the first place, is an egregious failure of informed consent.

Puberty Blockers

Perhaps the greatest failure of informed consent, and non-disclosure of human experimentation outcomes, is found in the supposedly benign use of puberty blocking agents in minors. They are routinely and widely prescribed with the thought that this will "buy time" for those questioning their gender as minors. Children and their supportive parents are assured that they are a benign intervention whose effects are easily reversible, just in case the child decides not to transition. Some potential effect on the development of bone density may be mentioned. The extent of this danger is just now being appreciated, with severe and disabling osteoporosis described in at least one child in Sweden. This led to new guidelines for gender-affirming care issued in February by the National Board of Health and Welfare. It stated that, based on current knowledge: "the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases." However, the effect of puberty blocking agents (started in early adolescent development) on long-term sexual function seems to be largely unstudied. Current guidelines recommend starting puberty blockers at the earliest stage of sexual maturation in children (Tanner two). These will not only prevent the enlargement of penile tissue, it will desensitize the orgasmic potential for tissues later exposed to cross-sex hormones. Simply put, transgender adults treated in early adolescence with puberty blockers may never experience orgasm. When children with gender dysphoria are given these powerful hormones (around age 11) they are too young to appreciate the implications of what will happen.

It is not simply a matter of chronology. As children mature into adolescents and adults, their brains are also being formed and reformed under the influence of sex hormones. There is evidence for structural changes, and these are likely to be demonstrated in cognitive and behavioral changes. In fact, the development of the adolescent brain and the maturation of its rational and executive functions does not typically complete until one's early 20s. Although the deleterious effects on sexual development and function in adulthood from puberty blockers may be predicted, no one is entirely certain of the effects on other critical areas such as brain development and bone density. Carefully constructed and monitored studies have not been done. *Until they are, these off-label treatments with puberty blockers and cross sex hormones can only be considered experimental.* Experimental interventions should be done as carefully as any other research, and fully informed consent is the only ethical way to enter into such studies. Clearly, this is not the current practice.

III. The Fundamental Flaw

There appears to have been a headlong rush in the past decade towards the process of gender affirming care described above. After close scrutiny, it can only be seen as off label experimentation, despite the fact that informed consent practices do not conform to this reality. Given this, we must ask ourselves: how can experienced and ethical physicians so mislead others or be so misled themselves? In 2013, the American Psychiatric Association published their update of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5. In it the diagnosis of "gender identity disorder" was replaced with "gender dysphoria." This was done to "avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender" other than the one to which they were born. The APA stated that "it is important to note the gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition." Dysphoria is a state of uneasiness, unhappiness, or dissatisfaction. With this change in terminology there was also a shift from seeking or correcting the underlying cause of the dysphoria, and a focus on transitioning to the preferred gender.

This revision has probably done more harm than good by accepting a self-diagnosis characterized by the belief that the patient (or their essence) is "trapped in the wrong body." This concept relies on the Cartesian duality, a body-self dichotomy. It reverts to the fallacious "ghost in the machine" concept. In reality, we cannot be trapped in the wrong body; we **are** our bodies, which are an integral and inseparable part of ourselves. To assert that there is a female self inside a male body (or the reverse), is to fail to achieve a full understanding that we are embodied persons, unified body and mind, if you will. A generation ago, sex and gender were taken to be synonyms for the same phenomena. Even now, a transgender female, no matter how much or how long of a hormonal therapeutic regimen they undergo, is still genetically male. Ignoring this fact has led to a contradiction, where sympathetic practitioners recommend "holistic care" while insisting on a fragmented concept of the self. This approach has been warmly embraced, even insisted upon, by many practitioners while viewed as nonsensical and even ludicrous by many laypersons.

Inevitably this has led to added difficulties. Even young patients are encouraged to begin puberty blockers and then hormones based on a self-diagnosis. Self-diagnosing psychiatric conditions is always fraught with the possibility of error. In this case, there can be no confirmatory lab tests, radiologic exams, or genetic findings. Moreover, the dysphoria can only be diagnosed and opened to treatment if it is causing significant trauma to the individual. The clinically significant distress manifests itself in underlying psychiatric diagnoses such as depression and suicidality. It is argued that embarking on affirmative treatment as early as possible is urgently needed to prevent further psychiatric complications, a contested assertion. Studies have shown that adult transgender persons continue to have evidence of depression and suicidality following treatment. The rate of suicide among post-operative transgender adults in a study from Sweden found an incidence 20 times greater than that of the general population. Such treatment may not be urgently needed to protect adolescents; it may not even be effective protection for their adult counterparts.

The claim of urgency coupled with an impulse toward nonjudgmental empathy for the disturbed patients has led to a frantic insistence on a single approach that may seem almost cult like in its insularity and opposition to outside challenges. Both parents (Trinko, K.(Nov. 19, 2018 "What It's Like to Lose Your Children to the 'Transgender Cult,' From a Mom Who Knows." *The Daily Signal*, 30 Oct. 2019) and teachers (Manning, M. for The Mail on Sunday. "Whistleblower Teacher Makes Shocking Claim That 'Most Are Autistic'." *Daily Mail Online*, Associated Newspapers, 19 Nov. 2018, https://www.dailymail.co.uk/news/article-6401593/Whistleblower-teacher-makes-shocking-claim-autistic.html.) report that their children or students are being wrongly encouraged at school to think of themselves as transgender. Sometimes this is the result of overenthusiastic acceptance or "love bombing". Sometimes it appears to influence the susceptible, as in autistic children. Sometimes transgender counseling is taking place even without the parents' knowledge, and this troubling approach has been supported in the literature with statements that adolescents should be legally empowered to obtain puberty-blocking without parental consent (Priest, M. Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm. Am J Bioeth. 2019 Feb;19(2):45-59).

Inevitably, this has resulted in complications and conflicts. The media have been replete with reports of such things as contested accessibility of transgender females to such things as domestic abuse shelters, female prisons, and female sports competitions. Similar issues regarding bathroom accessibility in schools recently came to a boil in Virginia, when it came to light that a sexual assault by a self-described trans- female (with a penis) was repeated in another school after the perpetrator was transferred. (Poff, J. "Loudoun superintendent failed to inform state of school sexual assault." Washington Examiner, 4 May 2022.) These issues are far from any resolution by debate, discussion, or legislation. In fact, both sides of the debate have doubled down with insistence that the opposing viewpoint must not only be rejected but considered unethical and made illegal.

Some disturbing trends have developed resulting not only from this dichotomy of opinion about the proper treatment approach, but ultimately based in the acceptance of the mind-body dichotomy. There has been a change in the diagnosed population. As Abigail Schrier pointed out:

> For the nearly 100-year diagnostic history of gender dysphoria, it overwhelmingly afflicted boys and men, and it began in early childhood (ages two to four). According to the DSM-V, the latest edition of the historical rate of incidence was 0.01 percent of males (roughly one in 10,000).
>
> For decades, psychologists treated it with "watchful waiting" — that is, a method of psychotherapy that seeks to understand the source of a child's gender dysphoria, lessen its intensity, and ultimately help a child grow more comfortable in her own body. Now such an approach is disdained by the term "conversion therapy", and labelled as unethical, and even made illegal.

She continues:

> Since nearly seven in 10 children initially diagnosed with gender dysphoria eventually outgrew it, the conventional wisdom held that, with a little patience, most kids would come to accept their bodies. The underlying assumption was children didn't always know best. But in the last decade, watchful waiting has been supplanted by "affirmative care," which assumes children do know what's best. Affirmative care proponents urge doctors to corroborate their patients' belief that they are trapped in the wrong body. The family is pressured to help the child transition to a new gender identity — sometimes having been told by doctors or activists that, if they don't, their child may eventually commit suicide. From there, pressures build on parents to begin concrete medical steps to help children on their path to transitioning to the "right" body. That includes puberty blockers as a preliminary step. Typically, cross-sex hormones follow and then, if desired, gender surgery. (Shrier, A. "Top Trans Doctors Blow the Whistle on 'Sloppy' Care." Emmaus Road Ministries, 5 Oct. 2021)

These pressures apply not only to parents, but to the children themselves because of the strong emphasis on affirmative support for anyone declaring themselves transgender. As one mother described: "A lot of these kids have concurrent mental health issues, and they find a place to fit in because as soon as you say that you're trans, you get love-bombed," she reflects. "You get love-bombed online, you get love-bombed on at school … As soon as you say you're trans, you turn into a star. And kids are thirsty for that kind of affirmation." (Trinko, 2019)

Two phenomena may be associated with this. Strong affirmation for the diagnosis and hormonal treatment may be altering the natural course of the phenomenon in childhood. It may not only be easier to identify as transgender in today's environment; it may be more difficult to turn ones back on the diagnosis. This may help explain a recent report that found that an average of 5 years after their initial social transition, 7.3% of youth had retransitioned (changed gender identity) at least once. At the end of this period, most youth identified as binary transgender youth (94%), including 1.3% who retransitioned to another identity before returning to their binary transgender identity. 2.5% of youth identified as cisgender and 3.5% as nonbinary. Later cisgender identities were more common amongst youth whose initial social transition occurred before age 6 years; the retransition often occurred before age 10. Unlike previous studies of transgender youth, males were not predominant, but were outnumbered by 2 to 1. Moreover, this is a direct contradiction of previous data showing a high rate of reversion towards a sex/gender coherence in children as they mature. (Olson, Kristina R., Durwood, Lily, Horton, Rachel, Gallagher, Natalie M., & Devor, Aaron; Gender Identity 5 Years

After Social Transition. Pediatrics 2022; 10.1542/peds.2021-056082) We must ask if this represents a shift towards being trapped in a wrong diagnosis, rather than a child being trapped in a wrong body.

In fact, there has been another shift. Unlike in the past, we now see increased numbers of females identifying as transgender, and later in their adolescence. Sometimes this occurs in large cohorts within a single school or peer group, a phenomenon labelled "rapid onset gender dysphoria." Both these phenomena call into question the underlying cause for the concept of gender dysphoria. Rather than approaching it as an accurate self-diagnosis that must be affirmed and treated to change the outward sexual appearance, isn't there a better model? We may be making a fundamental mistake in approaching transgender phenomena, not as a disease or disorder, but at most a dysphoria that is a cause for affirmation. This contrasts with our approach to similar conditions claiming a mind- body divergence, such as anorexia nervosa or body integrity identity disorder. The former is familiar to most Americans. The latter is a rare mental disorder characterized by a desire to have a physical disability, claiming discomfort with being able-bodied and often resulting in a request for amputation of the body part that makes them uncomfortable. People with this condition may refer to themselves as "trans abled."

In all three of these conditions there is a claim for a mismatch between one's mental bodily image and physical body. All tend to find an onset in prepubescence and are frequently associated with other mental disturbances. "Affirmative care" is the only recommended standard for transgender patients. It is horribly disturbing to contemplate amputation of a healthy limb because of a mental disorder (although this has been done). No one would seriously consider surgery to limit caloric intake or weight gain for a patient with anorexia nervosa, in order to support and affirm her distorted body image. Nevertheless, sex change operations have been recast as "gender affirming surgeries". The change in language reflects the change in attitude that distorts the approach to treatment for a psychiatric, not medical/surgical, disorder.

Finally, what are we to make of this situation, as a medical profession, and as a society? This question cannot be answered until both the affected people and profession can overcome our collective hubris. It is not enough to admit we don't know all the answers. We must see that we are not yet certain of all the questions that must be answered. In such a situation, competing interests must not pretend to take the moral high ground when no one can be certain where it will be located. First and foremost, we must back off from our current approaches until questions can be answered with proper studies, done with sufficient patients, and sufficient controls, over a sufficient period of time. Any insistence on a single course of therapy without this information could prove to be the same type of morally unacceptable interventions that caused formal research protections to be created in the first place.

In the meantime, we must adopt a more respectful tone with those whom we disagree. As John Milton said, "Where there is much desire to learn, there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making." Most important of all, in order to protect the current and future well-being of these affected children, we must rely on the ancient principal of medical ethics "In the first place, do no harm." Until we can demonstrate the efficacy and safety of any proposed treatment or intervention, its usage must properly be considered a medical experimentation and require fully informed consent. Anything less is a betrayal of both our principles and our progeny.

About the author: *Dr. Donovan's observations flow from his professional experience. He has been a Board-certified pediatrician for over 40 years, as an academic physician who rose to Vice-chair of the Department of Pediatrics and ultimately interim Chair at the University of Oklahoma in Tulsa. His professional role and interests expanded in the 1990's after he took a sabbatical in medical ethics at*

Georgetown University under the world-famous Dr. Edmund Pellegrino, a founding father of modern bioethics. He subsequently went on to earn a master's degree in Bioethics and founded the first bioethics center in his home university, where he was responsible for ethics training and education for students and physicians. He also served as clinical ethics consultant for three teaching hospitals. He was chair of the Section on Bioethics for the American Academy of Pediatrics (AAP) for three years and then their first liaison member of the AAP Committee on Bioethics. He has also served as the chair for a hospital Intuitional Review Board for 17 years. Finally, he was asked to become Director for the Center for Clinical Bioethics at Georgetown University School of Medicine, where he served from 2012-2020. His duties included teaching, consultation, publishing papers and speaking on bioethics extensively at the local, national, and international level on four continents. He has been interviewed and quoted on National Broadcasting Company (NBC), National Public Radio (NPR), Eternal Word Television Network (EWTN), and Al Jazeera, as well as the New York Times and the Washington Post, among others. He was awarded the Humanism in Medicine award from the Gold Foundation, which recognizes physicians to have successfully integrated humanism into the delivery of care to their patients and families. He has also offered formal testimony on bioethical issues before state legislatures and the U.S. Congress.

Appendix Attachment

2

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

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Gender Dysphoria

In this chapter, there is one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents and adults. The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines. An additional source of confusion is that in English "sex" connotes both male/female and sexuality. This chapter employs constructs and terms as they are widely used by clinicians from various disciplines with specialization in this area. In this chapter, *sex* and *sexual* refer to the biological indicators of male and female (understood in the context of reproductive capacity), such as in sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia. Disorders of sex development denote conditions of inborn somatic deviations of the reproductive tract from the norm and/or discrepancies among the biological indicators of male and female. *Cross-sex* hormone treatment denotes the use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth.

The need to introduce the term *gender* arose with the realization that for individuals with conflicting or ambiguous biological indicators of sex (i.e., "intersex"), the lived role in society and/or the identification as male or female could not be uniformly associated with or predicted from the biological indicators and, later, that some individuals develop an identity as female or male at variance with their uniform set of classical biological indicators. Thus, *gender* is used to denote the public (and usually legally recognized) lived role as boy or girl, man or woman, but, in contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. *Gender assignment* refers to the initial assignment as male or female. This occurs usually at birth and, thereby, yields the "natal gender." *Gender-atypical* refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era; for behavior, *gender-nonconforming* is an alternative descriptive term. *Gender reassignment* denotes an official (and usually legal) change of gender. *Gender identity* is a category of social identity and refers to an individual's identification as male, female, or, occasionally, some category other than male or female. *Gender dysphoria* as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. *Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender. *Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).

Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

Gender Dysphoria

Diagnostic Criteria

Gender Dysphoria in Children — 302.6 (F64.2)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults — 302.85 (F64.1)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Specifiers

The posttransition specifier may be used in the context of continuing treatment procedures that serve to support the new gender assignment.

Diagnostic Features

Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence. Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.

Gender dysphoria manifests itself differently in different age groups. Prepubertal natal girls with gender dysphoria may express the wish to be a boy, assert they are a boy, or assert they will grow up to be a man. They prefer boys' clothing and hairstyles, are often perceived by strangers as boys, and may ask to be called by a boy's name. Usually, they display intense negative reactions to parental attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes are required. These girls may demonstrate marked cross-gender identification in role-playing, dreams, and fantasies. Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates are most often preferred. They show little interest in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play). Occasionally, they refuse to urinate in a sitting position. Some natal girls may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate.

Prepubertal natal boys with gender dysphoria may express the wish to be a girl or assert they are a girl or that they will grow up to be a woman. They have a preference for dressing in girls' or women's clothes or may improvise clothing from available materials (e.g., using towels, aprons, and scarves for long hair or skirts). These children may role-play female figures (e.g., playing "mother") and often are intensely interested in female fantasy figures. Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) are most often preferred. Stereotypical female-type dolls (e.g., Barbie) are often favorite toys, and girls are their preferred playmates. They avoid rough-and-tumble play and competitive sports and have little interest in stereotypically masculine toys (e.g., cars, trucks). Some may pretend not to have a penis and insist on sitting to urinate. More

rarely, they may state that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina.

In young adolescents with gender dysphoria, clinical features may resemble those of children or adults with the condition, depending on developmental level. As secondary sex characteristics of young adolescents are not yet fully developed, these individuals may not state dislike of them, but they are concerned about imminent physical changes.

In adults with gender dysphoria, the discrepancy between experienced gender and physical sex characteristics is often, but not always, accompanied by a desire to be rid of primary and/or secondary sex characteristics and/or a strong desire to acquire some primary and/or secondary sex characteristics of the other gender. To varying degrees, adults with gender dysphoria may adopt the behavior, clothing, and mannerisms of the experienced gender. They feel uncomfortable being regarded by others, or functioning in society, as members of their assigned gender. Some adults may have a strong desire to be of a different gender and treated as such, and they may have an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics. They may find other ways to resolve the incongruence between experienced/expressed and assigned gender by partially living in the desired role or by adopting a gender role neither conventionally male nor conventionally female.

Associated Features Supporting Diagnosis

When visible signs of puberty develop, natal boys may shave their legs at the first signs of hair growth. They sometimes bind their genitals to make erections less visible. Girls may bind their breasts, walk with a stoop, or use loose sweaters to make breasts less visible. Increasingly, adolescents request, or may obtain without medical prescription and supervision, hormonal suppressors ("blockers") of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] analog, spironolactone). Clinically referred adolescents often want hormone treatment and many also wish for gender reassignment surgery. Adolescents living in an accepting environment may openly express the desire to be and be treated as the experienced gender and dress partly or completely as the experienced gender, have a hairstyle typical of the experienced gender, preferentially seek friendships with peers of the other gender, and/or adopt a new first name consistent with the experienced gender. Older adolescents, when sexually active, usually do not show or allow partners to touch their sexual organs. For adults with an aversion toward their genitals, sexual activity is constrained by the preference that their genitals not be seen or touched by their partners. Some adults may seek hormone treatment (sometimes without medical prescription and supervision) and gender reassignment surgery. Others are satisfied with either hormone treatment or surgery alone.

Adolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides. After gender reassignment, adjustment may vary, and suicide risk may persist.

Prevaience

For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. Since not all adults seeking hormone treatment and surgical reassignment attend specialty clinics, these rates are likely modest underestimates. Sex differences in rate of referrals to specialty clinics vary by age group. In children, sex ratios of natal boys to girls range from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the sex ratio favors natal males, with ratios ranging from 1:1 to 6.1:1. In two countries, the sex ratio appears to favor natal females (Japan: 2.2:1; Poland: 3.4:1).

Development and Course

Because expression of gender dysphoria varies with age, there are separate criteria sets for children versus adolescents and adults. Criteria for children are defined in a more con-

crete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls. Young children are less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is "really" not a member of the other gender but only "desires" to be. Distress may not be manifest in social environments supportive of the child's desire to live in the role of the other gender and may emerge only if the desire is interfered with. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence. Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria.

Gender dysphoria without a disorder of sex development. For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years. This corresponds to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests. For some preschool-age children, both pervasive cross-gender behaviors and the expressed desire to be the other gender may be present, or, more rarely, labeling oneself as a member of the other gender may occur. In some cases, the expressed desire to be the other gender appears later, usually at entry into elementary school. A small minority of children express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to the experienced gender ("anatomic dysphoria"). Expressions of anatomic dysphoria become more common as children with gender dysphoria approach and anticipate puberty.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%. Persistence of gender dysphoria is modestly correlated with dimensional measures of severity ascertained at the time of a childhood baseline assessment. In one sample of natal males, lower socioeconomic background was also modestly correlated with persistence. It is unclear if particular therapeutic approaches to gender dysphoria in children are related to rates of long-term persistence. Extant follow-up samples consisted of children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types, ranging from active efforts to reduce gender dysphoria to a more neutral, "watchful waiting" approach. It is unclear if children "encouraged" or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner. For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex. For natal male children whose gender dysphoria does not persist, the majority are *androphilic* (sexually attracted to males) and often self-identify as gay or homosexual (ranging from 63% to 100%). In natal female children whose gender dysphoria does not persist, the percentage who are *gynephilic* (sexually attracted to females) and self-identify as lesbian is lower (ranging from 32% to 50%).

In both adolescent and adult natal males, there are two broad trajectories for development of gender dysphoria: early onset and late onset. *Early-onset gender dysphoria* starts in childhood and continues into adolescence and adulthood; or, there is an intermittent period in which the gender dysphoria desists and these individuals self-identify as gay or homosexual, followed by recurrence of gender dysphoria. *Late-onset gender dysphoria* occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender

dysphoria during childhood. Expressions of anatomic dysphoria are more common and salient in adolescents and adults once secondary sex characteristics have developed.

Adolescent and adult natal males with early-onset gender dysphoria are almost always sexually attracted to men (androphilic). Adolescents and adults with late-onset gender dysphoria frequently engage in transvestic behavior with sexual excitement. The majority of these individuals are gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria. A substantial percentage of adult males with late-onset gender dysphoria cohabit with or are married to natal females. After gender transition, many self-identify as lesbian. Among adult natal males with gender dysphoria, the early-onset group seeks out clinical care for hormone treatment and reassignment surgery at an earlier age than does the late-onset group. The late-onset group may have more fluctuations in the degree of gender dysphoria and be more ambivalent about and less likely satisfied after gender reassignment surgery.

In both adolescent and adult natal females, the most common course is the early-onset form of gender dysphoria. The late-onset form is much less common in natal females compared with natal males. As in natal males with gender dysphoria, there may have been a period in which the gender dysphoria desisted and these individuals self-identified as lesbian; however, with recurrence of gender dysphoria, clinical consultation is sought, often with the desire for hormone treatment and reassignment surgery. Parents of natal adolescent females with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident. Expressions of anatomic dysphoria are much more common and salient in adolescents and adults than in children.

Adolescent and adult natal females with early-onset gender dysphoria are almost always gynephilic. Adolescents and adults with the late-onset form of gender dysphoria are usually androphilic and after gender transition self-identify as gay men. Natal females with the late-onset form do not have co-occurring transvestic behavior with sexual excitement.

Gender dysphoria in association with a disorder of sex development. Most individuals with a disorder of sex development who develop gender dysphoria have already come to medical attention at an early age. For many, starting at birth, issues of gender assignment were raised by physicians and parents. Moreover, as infertility is quite common for this group, physicians are more willing to perform cross-sex hormone treatments and genital surgery before adulthood.

Disorders of sex development in general are frequently associated with gender-atypical behavior starting in early childhood. However, in the majority of cases, this does not lead to gender dysphoria. As individuals with a disorder of sex development become aware of their medical history and condition, many experience uncertainty about their gender, as opposed to developing a firm conviction that they are another gender. However, most do not progress to gender transition. Gender dysphoria and gender transition may vary considerably as a function of a disorder of sex development, its severity, and assigned gender.

Risk and Prognostic Factors

Temperamental. For individuals with gender dysphoria without a disorder of sex development, atypical gender behavior among individuals with early-onset gender dysphoria develops in early preschool age, and it is possible that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely.

Environmental. Among individuals with gender dysphoria without a disorder of sex development, males with gender dysphoria (in both childhood and adolescence) more commonly have older brothers than do males without the condition. Additional predisposing

factors under consideration, especially in individuals with late-onset gender dysphoria (adolescence, adulthood), include habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems.

Genetic and physiological. For individuals with gender dysphoria without a disorder of sex development, some genetic contribution is suggested by evidence for (weak) familiality of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria. As to endocrine findings, no endogenous systemic abnormalities in sex-hormone levels have been found in 46,XY individuals, whereas there appear to be increased androgen levels (in the range found in hirsute women but far below normal male levels) in 46,XX individuals. Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system.

In gender dysphoria associated with a disorder of sex development, the likelihood of later gender dysphoria is increased if prenatal production and utilization (via receptor sensitivity) of androgens are grossly atypical relative to what is usually seen in individuals with the same assigned gender. Examples include 46,XY individuals with a history of normal male prenatal hormone milieu but inborn nonhormonal genital defects (as in cloacal bladder exstrophy or penile agenesis) and who have been assigned to the female gender. The likelihood of gender dysphoria is further enhanced by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization as may occur in female-raised and noncastrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid replacement therapy. However, the prenatal androgen milieu is more closely related to gendered behavior than to gender identity. Many individuals with disorders of sex development and markedly gender-atypical behavior do not develop gender dysphoria. Thus, gender-atypical behavior by itself should not be interpreted as an indicator of current or future gender dysphoria. There appears to be a higher rate of gender dysphoria and patient-initiated gender change from assigned female to male than from assigned male to female in 46,XY individuals with a disorder of sex development.

Culture-Related Diagnostic Issues

Individuals with gender dysphoria have been reported across many countries and cultures. The equivalent of gender dysphoria has also been reported in individuals living in cultures with institutionalized gender categories other than male or female. It is unclear whether with these individuals the diagnostic criteria for gender dysphoria would be met.

Diagnostic Markers

Individuals with a somatic disorder of sex development show some correlation of final gender identity outcome with the degree of prenatal androgen production and utilization. However, the correlation is not robust enough for the biological factor, where ascertainable, to replace a detailed and comprehensive diagnostic interview evaluation for gender dysphoria.

Functional Consequences of Gender Dysphoria

Preoccupation with cross-gender wishes may develop at all ages after the first 2–3 years of childhood and often interfere with daily activities. In older children, failure to develop age-typical same-sex peer relationships and skills may lead to isolation from peer groups and to distress. Some children may refuse to attend school because of teasing and harass-

ment or pressure to dress in attire associated with their assigned sex. Also in adolescents and adults, preoccupation with cross-gender wishes often interferes with daily activities. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired. Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals' access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.

Differential Diagnosis

Nonconformity to gender roles. Gender dysphoria should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests. The diagnosis is not meant to merely describe nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men). Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specified criteria.

Transvestic disorder. Transvestic disorder occurs in heterosexual (or bisexual) adolescent and adult males (rarely in females) for whom cross-dressing behavior generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question. It is occasionally accompanied by gender dysphoria. An individual with transvestic disorder who also has clinically significant gender dysphoria can be given both diagnoses. In many cases of late-onset gender dysphoria in gynephilic natal males, transvestic behavior with sexual excitement is a precursor.

Body dysmorphic disorder. An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When an individual's presentation meets criteria for both gender dysphoria and body dysmorphic disorder, both diagnoses can be given. Individuals wishing to have a healthy limb amputated (termed by some *body integrity identity disorder*) because it makes them feel more "complete" usually do not wish to change gender, but rather desire to live as an amputee or a disabled person.

Schizophrenia and other psychotic disorders. In schizophrenia, there may rarely be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur.

Other clinical presentations. Some individuals with an emasculinization desire who develop an alternative, nonmale/nonfemale gender identity do have a presentation that meets criteria for gender dysphoria. However, some males seek castration and/or penectomy for aesthetic reasons or to remove psychological effects of androgens without changing male identity; in these cases, the criteria for gender dysphoria are not met.

Comorbidity

Clinically referred children with gender dysphoria show elevated levels of emotional and behavioral problems—most commonly, anxiety, disruptive and impulse-control, and de-

pressive disorders. In prepubertal children, increasing age is associated with having more behavioral or emotional problems; this is related to the increasing non-acceptance of gender-variant behavior by others. In older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral problems. The prevalence of mental health problems differs among cultures; these differences may also be related to differences in attitudes toward gender variance in children. However, also in some non-Western cultures, anxiety has been found to be relatively common in individuals with gender dysphoria, even in cultures with accepting attitudes toward gender-variant behavior. Autism spectrum disorder is more prevalent in clinically referred children with gender dysphoria than in the general population. Clinically referred adolescents with gender dysphoria appear to have comorbid mental disorders, with anxiety and depressive disorders being the most common. As in children, autism spectrum disorder is more prevalent in clinically referred adolescents with gender dysphoria than in the general population. Clinically referred adults with gender dysphoria may have coexisting mental health problems, most commonly anxiety and depressive disorders.

Other Specified Gender Dysphoria

302.6 (F64.8)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The other specified gender dysphoria category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for gender dysphoria. This is done by recording "other specified gender dysphoria" followed by the specific reason (e.g., "brief gender dysphoria").

An example of a presentation that can be specified using the "other specified" designation is the following:

The current disturbance meets symptom criteria for gender dysphoria, but the duration is iess than 6 months.

Unspecified Gender Dysphoria

302.6 (F64.9)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

Appendix Attachment

3

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

AUGUST DEKKER, et al.,

Plaintiffs,

v. Case No. 4:22-cv-00325-RH-MAF

SIMONE MARSTILLER, et al.,

Defendants.
_____/

DECLARATION OF MATTHEW BRACKETT

I, Matthew Brackett, hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this declaration and would testify completely to those facts if called to do so.

2. I am a program consultant for the Agency for Health Care Administration. While working for the agency, I prepared approximately ten reports supporting determinations of generally accepted professional medical standards.

3. I was responsible for preparing the report, Florida Medicaid Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria ("the GAPMS Report"), which was published in June 2022.

4. The GAPMS Report was created after "the Florida Department of Health released guidance on the treatment of gender dysphoria for children and adolescents."

GAPMS Report Att. A. Because the "Florida Medicaid program" did "not have a policy on whether to cover such treatments for Medicaid recipients diagnosed with gender dysphoria," *id.*, Secretary Marstiller requested the Division of Florida Medicaid to review "sex reassignment treatments" of gender dysphoria for a coverage determination under Rule 59G-1.035, Florida Administrative Code. Secretary Marstiller's request to the Division of Florida Medicaid is Attachment A to the GAPMS Report.

5. "Sex reassignment treatments" refer to "medical services used to obtain primary and/or secondary physical sexual characteristics of a male or female." GAPMS Report at 2. The following sex reassignment treatments were discussed in the GAPMS Report: puberty blockers, cross-sex hormones, and sex reassignment surgery.

6. As a condition for coverage, under Rule 59G-1.035, Florida Administrative Code, the treatments must be consistent with generally accepted professional medical standards and must not be experimental or investigational. That rule is Attachment B to the GAPMS Report. The Deputy Secretary for Medicaid makes the final determination as to whether treatments are consistent with generally accepted professional medical standards.

7. The GAPMS Report included assessments from six subject-matter experts: Romina Brignardello-Petersen, Wojtek Wiercioch, James Cantor, Quentin Van Meter, Patrick Lappert, and G. Kevin Donovan. Those experts discussed the following subject matters concerning gender dysphoria: health care research, clinical psychology,

plastic surgery, pediatric endocrinology, and bioethics. Their reports are Attachments C through G to the GAPMS Report.

8. Specifically, for health care research, Dr. Brignardello-Petersen and Dr. Wiercioch "performed a systematic review that graded a multitude of studies. They conclude[d] that evidence supporting sex reassignment treatments is low or very low quality." GAPMS Report at 2-3.

9. For clinical psychology, Dr. Cantor "provided a review of literature on all aspects of the subject, covering therapies, lack of research on suicidality, practice guidelines, and Western European coverage requirements." *Id.* at 3.

10. For plastic surgery, Dr. Lappert "provided an evaluation explaining how surgical interventions are cosmetic with little to no supporting evidence to improve mental health, particularly those altering the chest." *Id.*

11. For pediatric endocrinology, Dr. Van Meter "explain[ed] how children and adolescent brains are in continuous phases of development and how puberty suppression and cross-sex hormones can potentially affect appropriate neural maturation." *Id.*

12. And for bioethics, Dr. Donovan "provide[d] additional insight on the bioethics of administering these treatments, asserting that children and adolescents cannot provide truly informed consent." *Id.*

13. The GAPMS Report concluded that "[a]vailable medical literature provides insufficient evidence that sex reassignment through medical intervention is

safe and effective treatment for gender dysphoria. Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased. Rather, the available evidence demonstrates that these treatments cause irreversible physical changes and side effects that can affect long-term health." *Id.* at 2.

14. Specifically, for puberty blockers, "[e]vidence does not prove that puberty blockers are safe for treatment of gender dysphoria. Evidence that they improve mental health and reduce suicidality is low or very low quality." *Id.* at 38.

15. For cross-sex hormones, "[e]vidence suggesting that cross-sex hormones provide benefits to mental health and prevents suicidality is low or very low quality. Rather, evidence shows that cross-sex hormones cause multiple irreversible physical consequences as well as infertility." *Id.*

16. And for sex reassignment surgery, "[e]vidence of improvement in mental health and reduction in suicidality is low or very low quality. Sex reassignment surgery results in irreversible physical changes, including sterility." *Id.*

17. The GAPMS Report also noted the emerging international consensus on treatments for gender dysphoria. Attachment D to the GAPMS Report provides more information on the consensus.

18. In Sweden, for example, "the Swedish National Board of Health stated that 'the risks of hormonal interventions for gender dysphoric youth outweigh the

potential benefits.' With the exception of youths who exhibited 'classic' signs of gender identity issues, adolescents who present with the condition will receive behavioral health services and gender-exploratory therapy." *Id.* at 35.

19. "In Finland, the Palveluvalikoima issued guidelines in 2020 stating that sex reassignment in minors 'is an experimental practice' and that 'no irreversible treatment should be initiated.' The guidelines further assert that youths diagnosed with gender dysphoria often have co-occurring psychiatric disorders that must be stabilized prior to prescribing any cross-sex hormones or undergoing sex reassignment surgery." *Id.*

20. And in the United Kingdom, the government "is also reassessing the use of irreversible treatments for gender dysphoria due the long-term effects on mental and physical health. In 2022, an independent interim report commissioned by the U.K.'s National Health Service (NHS) indicates that additional research and systematic changes are necessary to ensure the safe treatment of gender dysphoric youths. These include reinforcing the diagnosis process to assess all areas of physical and behavioral health, additional training for pediatric endocrinologists, and informing parents about the uncertainties regarding puberty blockers. The interim report is serving as a benchmark until the research is completed for final guidelines." *Id.*

21. As a result, the GAPMS Report did "not recommend sex reassignment treatment as a health service that is consistent with generally accepted professional medical standards. Available evidence indicates that the services are not proven safe or effective treatments for gender dysphoria." *Id.*

22. On July 8, 2022, the agency held an in-person hearing to receive public comments on the proposed changes to Rule 59G-1.050, Florida Administrative Code. I served as a panelist during the hearing. Attendees included physicians, attorneys, individuals who had detransitioned, and other interested parties. A true and correct copy of the transcript of the hearing is attached to this declaration.

23. Some attendees voiced opposition to the proposed rule change, but the overwhelming majority spoke in favor of the changes that will prohibit Medicaid coverage of puberty blockers, cross-sex hormones, and sex reassignment surgery when used to treat gender dysphoria.

24. Several attendees' comments were notable. The first attendee who spoke was Chloe Cole, a 17-year-old detransitioner, and said:

> I was medically transitioned from ages 13 to 16. My parents took me to a therapist to affirm my male identity. The therapist did not care about causality or encourage me to learn to be comfortable in my body because of—partially due to California's conversion therapy bans. He brushed off my parents' concerns about that because he had hormones, puberty blockers, and surgeries. My parents were given a suicide threat as a reason to move me forward in my transition. My endocrinologist, after two or three appointments, put me on puberty blockers and injectable testosterone. At age 15, I asked to remove my breasts. My therapist continued to affirm my transition. I went to a top surgery class that was filled with around 12 girls that thought they were men—I thought that they were men. Most were my age or younger. None of us were going to be men. We were just fleeing from the uncomfortable feeling of becoming women. I was unknowingly physically cutting off my true self from my body, irreversibly and painfully. Our transidentities were not questioned. I went through with the surgery. Despite having therapists and attending the top surgery class, I really didn't understand all of the ramifications of

> any of the medical decisions I was making. I wasn't capable of understanding it, and it was downplayed consistently. My parents, on the other hand, were pressured to continue my so-called gender journey with the suicide threat. I have been forced to realize that I will never be able to breastfeed a child, despite my increasing desire to as I mature. I have blood clots in my urine. I am unable to fully empty my bladder. I do not yet know if I am capable of carrying a child to full term. In fact, even the doctors who put me on puberty blockers and testosterone do not know. No child should have to experience what I have. My consent was not informed . . . .

Tr. 2:2 – 3:22.

25. Sophia Galvin, another detransitioner, also spoke and stated:

> I began detransitioning at 17 and a half socially. At 18 was when I began detrans—I mean transitioning medically. I had a history of mental illness. I had suicidal ideation and I would self-harm. And my wanting to transition was all in an effort to escape the fear of being a woman in this society and because of traumas that I had been through in my life. So I continued down the process, and then ended up removing my breasts at 19 years old because I was trapped, afraid to go back to my original ideo—to my original sex, and basically look crazy to the people around me. When I detransitioned—after I detransitioned, it was very difficult because I didn't have any support. The doctor basically just told me to stop the hormones. I didn't have any one to speak to about it, I didn't go to a mental health counselor, and I didn't prepare anything. I just really want to say that this is not good for children. I was harmed by this, and it should not be covered under Medicaid.

Id. at 4:2-25.

26. Katie Caterbury, a mother, spoke and stated:

> At the age of 14, my once healthy and happy daughter was convinced by the Gay-Straight Alliance at school that she was my son. At the age of 16, a physician injected her with testosterone without my consent and without my knowledge. At the age of 17, Medicaid paid surgeons to perform a double mastectomy and a hysterectomy as an outpatient. At age 19,

> Medicaid paid for her to undergo a phalloplasty. She had and still has private insurance that was bypassed. I fought against what happened to my daughter every step of the way, but to no avail. How can any rational adult, much less a physician, not know that it is impossible to change one's biological sex? Why are there doctors convincing trusting parents to affirm the lie that biological sex is changeable? They prescribe irreversible puberty-blocking drugs and powerful wrong-sex hormones and amputate healthy breasts and remove reproductive organs from children against the protests of their parents. . . . Why is this being funded with taxpayer dollars? This must be stopped. . . .

Id. at 5:3 – 6:18.

27. The agency also received comments concerning the proposed rule change. Several stakeholder and advocacy groups, including the Endocrine Society, the American Academy of Pediatrics, and Yale University, raised concerns about the proposed rule change. The agency reviewed the comments and ultimately determined that the comments were not persuasive.

28. It should also be noted that the agency offers coverage of services for gender dysphoria. Those services are community-based health services; psychiatric services; emergency services and inpatient services in hospital settings; and behavioral services provided in schools and by school districts. Documents evidencing these treatments are attached to this declaration.

"I declare under penalty of perjury under 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my current knowledge and belief." Executed this 3rd day of October 2022.

Respectfully submitted,

/s/ Matthew Brackett

Matthew Brackett

TAPED PROCEEDINGS
IN RE: PROPOSED RULE 59G-1.050
HELD ON JULY 8, 2022

Transcribed by:

CLARA C. ROTRUCK

Court Reporter

TAPED PROCEEDINGS

MS. COLE: My name is Chloe Cole, and I am a 17-year-old detransitioner from the Central Valley of California. I was medically transitioned from ages 13 to 16. My parents took me to a therapist to affirm my male identity. The therapist did not care about causality or encourage me to learn to be comfortable in my body because of -- partially due to California's conversion therapy bans. He brushed off my parents' concerns about that because he had hormones, puberty blockers, and surgeries. My parents were given a suicide threat as a reason to move me forward in my transition.

My endocrinologist, after two or three appointments, put me on puberty blockers and injectable testosterone. At age 15, I asked to remove my breasts.

My therapist continued to affirm my transition. I went to a top surgery class that was filled with around 12 girls that thought they were men -- I thought that they were men. Most were my age or younger. None of us were going to be men. We were just fleeing from the uncomfortable feeling of becoming women.

I was unknowingly physically cutting off my

true self from my body, irreversibly and painfully. Our transidentities were not questioned.

I went through with the surgery. Despite having therapists and attending the top surgery class, I really didn't understand all of the ramifications of any of the medical decisions I was making. I wasn't capable of understanding it, and it was downplayed consistently.

My parents, on the other hand, were pressured to continue my so-called gender journey with the suicide threat.

I have been forced to realize that I will never be able to breastfeed a child, despite my increasing desire to as I mature. I have blood clots in my urine. I am unable to fully empty my bladder. I do not yet know if I am capable of carrying a child to full term. In fact, even the doctors who put me on puberty blockers and testosterone do not know.

No child should have to experience what I have. My consent was not informed and I was filled by (inaudible).

A VOICE: Thank you for your comment.

(Applause.)

A VOICE: The next speaker will be Sophia

Galvin.

MS. GALVIN: My name is Sophia Galvin. I am a detransitioner. I began detransitioning at 17 and a half socially. At 18 was when I began detrans- -- I mean transitioning medically.

I had a history of mental illness. I had suicidal ideation and I would self-harm. And my wanting to transition was all in an effort to escape the fear of being a woman in this society and because of traumas that I had been through in my life.

So I continued down the process, and then I ended up removing my breasts at 19 years old because I was trapped, afraid to go back to my original ideo- -- to my original sex, and basically look crazy to the people around me.

When I detransitioned -- after I detransitioned, it was very difficult because I didn't have any support. The doctor basically just told me to stop the hormones. I didn't have anyone to speak to about it, I didn't go to a mental health counselor, and I didn't prepare anything. I just really want to say that this is not good for children. I was harmed by this, and it should not be covered under Medicaid.

A VOICE: Thank you for your comments.

(Applause.)

A VOICE: The next speaker is Katie Caterbury.

MS. CATERBURY: At the age of 14, my once healthy and happy daughter was convinced by the Gay-Straight Alliance at school that she was my son. At the age of 16, a physician injected her with testosterone without my consent and without my knowledge. At the age of 17, Medicaid paid surgeons to perform a double mastectomy and a hysterectomy as an outpatient. At age 19, Medicaid paid for her to undergo a phalloplasty.

She had and still has private insurance that was bypassed. I fought against what happened to my daughter every step of the way, but to no avail.

How can any rational adult, much less a physician, not know that it is impossible to change one's biological sex? Why are there doctors convincing trusting parents to affirm the lie that biological sex is changeable? They prescribe irreversible puberty-blocking drugs and powerful wrong-sex hormones and amputate healthy breasts and remove reproductive organs from children against the protests of their parents.

Affirming the false notion to a child that it

is possible to change one's sex is child abuse. Administering powerful hormones that cause irreversible changes to their bodies and their brains is child abuse. Amputating the healthy body parts of a child whose brain has not reached full decision-making maturity is simply criminal.

Why are these doctors not criminally charged? Why is this being funded with taxpayer dollars? This must be stopped.

Three years ago, I traveled to Washington, DC -- Washington, DC, to speak to federal lawmakers. I begged their staff to do something. Democrats and Republicans, no one seemed to care. But I will not give up trying until this medical experiment on children is over.

To every single person fighting for the health and lives of our children, I am profoundly grateful. Thank you.

(Applause.)

A VOICE: Just so we get through all the speakers, we'd ask that you hold your applause until the end of the program.

Next speaker will be Jeanette Cooper.

MS. COOPER: My name is Jeanette Cooper, and I am here on behalf of Partners for Ethical Care, a

nonpartisan, nonprofit organization that has no paid staff.

No therapy is better than bad therapy, and children are suffering because parents cannot find professionals to serve the psychological needs of their families and children, and they are being met with a medical treatment for a psychological condition. We need to make space in the public sphere for ethical therapists by removing the medical treatment option.

Nearly every therapist who publicly speaks is a cheerleader for gender identity affirmation, gluing that poisoned bandage on the skin of children, causing permanent psychological and physical harm by solidifying an idea that maybe you were born in the wrong body.

We are here to state the obvious. No child can or ever will be born in the wrong body. Everyone knows what a woman is, but some people are afraid to say it. We are not afraid.

Our organization was founded by a handful of mothers who realized that no one was coming to protect these children. We could not wait any longer for help to arrive.

Families are desperate to find actual support.

They do not want a poisoned bandage that cosmetically covers a wound that grows deeper when covered and left untreated. Affirmation is a poisoned bandage that does not help to heal, but hides a deep need that will not be helped by injections and surgeries.

The state has no business using taxpayer funding to turn children into permanent medical patients. The state has no business assisting doctors in selling disabilities to vulnerable, suffering children by prescribing puberty blockers, cross-sex hormones, and extreme cosmetic body modification. These so-called treatments are not real health care.

The state should, however, fund legitimate and proven care. For many children, a transidentity is a crutch. It is a placeholder that stands in for real suffering that hasn't been named. If they can find a pediatrician, family therapist, or other professionals who will address their actual needs, children discard their transidentity and move forward with self-actualization, rather than staying in a state of stunted psychological and physical growth, surviving with superficial, short-term validation like a street drug that needs

to be injected every day. Our job is to protect children, and we have to step in because the medical field is failing these families.

Thank you for stepping in now before it costs the State of Florida much more than dollars. Thank you for this proposed rule. We support you.

(Applause.)

A VOICE: Thank you for your comments.

Next speaker, Donna Lambart.

MS. LAMBART: Hello. My name is Donna Lambart. I am here on behalf of concerned parents to speak in support of the rule to stop allowing Medicaid to pay medical transition of children in Florida.

Today I appeal to you on behalf of over 2,600 parents in our group. As parents, we know our kids. As people, we know right from wrong. But the health care professionals are presenting many of us with a false and painful choice: Accept what we know will permanently harm our children or lose them to suicide. These false ideas are being stated in the presence of children. This is not only cruel, it's simply not true. There is no data to prove that medically transitioning minors prevents suicide.

Society, the Internet, media, schools, and government convince kids that their parents que- -- if their parents question -- if their parents question their identity, it is because their parents hate them. Parents who are unwilling to drop all rational thinking and surrender to the affirmation-only model of care pay a social, emotional, and custodial price no parent should ever have to pay.

Parents lose their children every day to people who help them transition, leading them down a dangerous medical path that permanently -- permanently harming their healthy bodies with off-label drugs and experimental surgeries.

I interact with parents on a -- every day whose children are instantly derailed as a result of adopting a transgender identity. These children become angry and hostile and resentful. They begin lashing out at anyone who will not agree with their new-found identity. Parents are left -- have been forced to rely on each other to figure out how best to navigate this destructive social phenomenon.

The current one-size-fits-all affirmation model cuts parents out of the equation, charging forward with a rigid, transition-only course of

action.

A VOICE: Ma'am, excuse me, your time is up. Could you please wrap it up?

MS. LAMBART: Yes.

I would just like to say that on behalf of thousands of loving parents, we ask Florida -- the health -- to stand up for the protection of children and teens who are under -- who are being offered a magic fix. Parents deserve support and children deserve sound care.

Thank you for your support and your time.

(Applause.)

A VOICE: Thank you for your comments.

The next speaker is Gerald Buston.

MR. BUSTON: Ladies and gentlemen, I am here as a Christian pastor. 71 years ago, I gave my life to Jesus Christ and chose to live my life according to the Word of God, the Bible. The Bible teaches that God makes people male and female, and it says that repeatedly. Jesus said that himself. And for us to try to transition people away from what God did should be -- well, it definitely is a sin, but it should be a criminal abuse of children, especially when they're not at the age where they can properly process what they're doing to

themselves or allowing to be done to themselves.

I urge Medicaid don't support this. I urge the State of Florida to pass laws against it and not allow our children to be abused the way they are being abused by people that have one goal in mind, and that is depopulating the world by cutting back on the birth rate and by cutting back on the population we have in our world right now.

So I support the bill that we do not pay for this kind of stuff, and I would say let's go further and pass laws against it and make that extreme child abuse to do that to children that don't have the right to know.

(Applause.)

A VOICE: The next speaker is -- I believe it's Brady or perhaps Brandy Andrews.

MS. ANDREWS: Hey there, Brandy Andrews. I'm here to speak in support of banning Medicaid funding for transgender surgeries and treatments.

Transgender surgeries, puberty blockers, and cross-sex hormone treatments have been shown to be extremely harmful, especially to minors, causing sterility and irreversible physical and psychological damage.

Physically healthy, gender-confused girls are

being given double mastectomies at 13 and hysterectomies at 16, while males are referred for surgical castration and penectomies at 16 and 17, respectively.

How have we reached this point in life where we're allowing this at such a young age, but yet you have to be 16 to drive a car, 18 to buy a pack of cigarettes, where we're allowing children to change their genders before they've even reached puberty or shortly after?

Pharmaceutical companies are unethically enriching themselves off the destruction of countless young lives that are being fed puberty blockers, which these companies are advertising children. It's just straight-up child abuse, and it's preying on our society's most vulnerable youth.

Let kids be kids. I am asking Medicaid to stop funding experimental medical treatments on minors. Thank you.

(Applause.)

A VOICE: If I could remind folks to please state your name before you start your comments.

Next speaker is Sabrina Hartsfield.

MS. HARTSFIELD: Good afternoon. My name is

Sabrina Hartsfield, and I am speaking just from my own opinions. I am an alumni of Florida State University and I am a born-again Christian.

Because of this conviction, I believe we as human beings have an obligation to ensure poor and marginalized people of all ages have adequate medical care through the Medicaid program.

Without gender-affirming health care, transgender and gender nonconforming individuals will die. According to every major legitimate medical organization, gender affirming care is the treatment for gender dysphoria.

I am here today to speak against Rule 59G-1.050, the Florida Medicaid trans and medical care ban, from being put into place.

Gender-affirming care is medically necessary and life-saving treatment that should be decided between a patient, their caregivers, and a health care professional, not big government.

Florida is about freedom from big government overreach. Medicaid should cover all medically-necessary treatment, and under the right to privacy found in Florida's constitution, this is, again, a decision that should be hands -- in the hands of the patient and their health care

providers.

This rule also violates the nondiscrimination protections for people of all gender identities found in the Affordable Care Act and the Medicaid Act.

Transgender and gender nonconforming people who have gender dysphoria are already at increased risk for negative health outcomes, such as being diagnosed with anxiety or depression, battling a substance use disorder, and attempting suicide. Denying medical care that has been determined to be the best practice by every major medical association from the American Psychological Association to the American Medical Association to the Endocrine Society will be life-threatening. Denying transgender and gender nonconforming people medical care can lead to depression, self-harming, social rejection, and suicidal behavior.

If the trans medical care ban is enacted, it will be putting the lives of over 9,000 transgender Floridians in danger.

Please block proposed Rule 59G-1.050.

(Applause.)

A VOICE: The next speaker is Simone Chris.

MS. CHRIS: Good afternoon. My name is Simone

Chris and I'm an attorney. I'm the director of the Transgender Rights Initiative Southern Legal Council. We are a statewide, not-for-profit, public interest civil rights law firm that utilizes federal impact litigation policy reform and individual advocacy to ensure communities that we serve have access to justice and freedom from discrimination.

We vehemently oppose the proposed rule based both on the science and evidence supporting the medical necessity of treatment for gender dysphoria and our own extensive experience working with hundreds of transgender adults and minors and witnessing the tremendous benefits that access to such care provides.

In effect, the proposed rule creates a blanket exclusion for coverage of medically-necessary health care for one of the most vulnerable populations in our state, eliminating the right of all transgender Floridians with Medicaid to even have their health care needs subjected to a medical-necessity analysis. The insidiousness of this rule is exacerbated by the fact that it places in its cross-hairs the individuals in our state who are already disproportionately likely to experience

poverty, homelessness, unemployment, poor mental and physical health outcomes, and to have the least access to resources in health care as it is.

We urge AHCA to reject these proposed changes to the rule excluding the coverage for all medically-necessary gender-affirming care because it directly contravenes the widely accepted, authoritative standards of care and the consensus of every major medical association in our country. It will cause significant harm to the individuals that we serve by depriving them of critical, life-saving medical care. It interferes with and substitutes the state's judgment in place of the doctor/patient relationship, the rights of the individual, and the fundamental rights of a parent to determine appropriate medical treatment for their own child, and it is a shameful waste of state resources.

Similar exclusions have been enjoined or struck down by courts across the country as inconsistent with the rights guarantee to Medicaid recipients under the Medicaid Act, under the equal protection clause of the 14th Amendment, the Affordable Care Act. And this litigation that the state will certainly find itself embroiled in is

wasting valuable state resources that could be better utilized enhancing the lives of Floridians rather than attacking them.

Thank you.

(Applause.)

A VOICE: Matthew Benson.

DR. BENSON: My name is Matthew Benson. I'm a board-certified pediatrician and pediatric endocrinologist in the state, and I agree with this rule. I think the data on which the gender affirmative model is based is not scientific.

The National Board of Health and Welfare of Sweden has recently enacted in that country pretty significant restrictions. And if we're going to do this type of care, it needs to be under an IRB-approved protocol and it needs to be based on the best data.

I'm used to prescribing these medications in the sense of puberty blockers. And one of the largest studies that came from Sweden was published around 2016, and basically what they showed is that in those individuals who are transgender and receive these types of procedures, the rates of overall mortality compared to the general population was three times that of the general

population; completed suicide, 19 times that of the general population; five times suicide attempts of the general population. Similarly, in Denmark, out of a 20-year period, by the time a similar study was done, 10 percent of the population had died.

We need better data. We need long-term perspective trials where we can look at adverse effects. We need much more robust data to justify these kinds of very aggressive therapies. And we've already seen two individuals, Chloe and Sophia, testify here today about how they were harmed by these procedures.

Thank you for your time.

(Applause.)

A VOICE: Next speaker, Karen Shoen.

MS. SHOEN: My name is Karen Shoen. I'm with the Florida Citizens Alliance and I'm a former teacher.

I would like to know why .03 percent of the population is dictating to 99.97 percent of the population to accept and pay for an elective surgery. Kids change their minds. I can tell you as a teacher, one day they want to be a fireman, the next day they want to be an engineer, and then they go into being something else.

The problem is we are not explaining the wonders of what it is to be comfortable in your body with both our parents and in our biology and hygiene glasses. So kids become fearful. It's our job to take that fear away as a teacher, not to force them into something else.

The children may be afraid of maturing, they may be afraid of a lot of things, but we're not looking for the root cause, we are now suggesting and implanting in their brains that they're not comfortable in their body.

I'd like to leave you with this thought: Can I drive a car? No, you're 13. Can I have a drink? No, you're 13. Can I shoot a gun? No, you're 13. Can I change my gender? Yes, you're in charge. How is that possible?

(Applause.)

A VOICE: Next speaker, Bill Snyder.

MR. SNYDER: Thank you. Bill Snyder. I (inaudible) Monticello.

I want to talk about a disease that has infected society today called reality disease. Charlie had reality disease. He woke up one morning and wouldn't get out of bed and go to work. His wife said, "Charlie, you've got to get up,

you've got to go to work." He said, "I can't, I'm dead." His wife said, "You're not dead, you're talking to me. I can see you breathing." Charlie says, "I can't get up and go to work, I'm dead." The wife called in a psychologist. Psychologist gave Charlie a lengthy interview. At the end of the interview, the psychologist said, "Charlie, come on, we're going to go downtown." They went downtown to the morgue. The psychologist opened a locker, (inaudible) out a cadaver on a tray, pulled the sheet back over the feet of the cadaver, said, "Charlie, dead people's hearts don't beat, they don't have circulation, they do not bleed." He took the toe of the cadaver, stuck a pin in it. No blood came out. The psychologist said, "See, Charlie, dead people don't bleed. Now, give me your thumb." Took Charlie's thumb, stuck a pin in it, out came bright, red blood. The psychologist said, "See, Charlie, you're not dead. That's blood." Charlie said, "What do you know? Dead people do bleed."

The further we live from reality, the further we move from morality, the further we move from virtue, the more secular we become. The more secular we become, the less freedom we have.

Please approve this proposed rule change. Thank you.

(Applause.)

A VOICE: Next speaker, Ingrid Ford.

MS. FORD: Yes. Good afternoon. I'm Ingrid Ford. Thank you for the opportunity. I'm with Christian Family Coalition. I've been a college counselor 15 years, and I'm here in support -- I'm to speak in support of Rule 59G-1.050 to ban Medicaid funding from transgender surgeries and treatments.

This rule will protect Florida residents, especially minors, from harmful transgender surgeries, harmful blockers, and other unnatural therapies being promoted by radical gender ideals and with no basis in science.

This rule also will protect taxpayers from being forced to subsidize these highly unethical and dangerous procedures, which can cost upwards of $300,000.

Thank you.

(Applause.)

A VOICE: Next speaker, Richard Carlins.

MR. CARLINS: Hello, my name is Richard Carlins and I am in support of the rule and I'm

just going to speak from the heart a little bit. I feel like I'm walking in a house of mirrors or something or it's just -- it's surreal, the world that I live in today from the world that I grew up in.

I had a traditional family, a mother and father. We're saying the Pledge of Allegiance in schools and having prayer in schools. We were founded upon Biblical principles. Our constitution goes hand in hand with that. We're battling with each other right now, you know, over things that were clearly right and wrong before.

Seriously, a kid has no idea. They're being indoctrinated. They're being indoctrinated even through commercials, Disney World, Coca-Cola commercials, the restaurants they go to. And then when they want to be what it is that they were pushed to be, we mutilate their bodies and it's irreversible. It's horrendous. It's a horrendous evil.

And with that, I go. I just can't believe where we're at. And we're -- God raises up nations and he brings down nations, and we are in judgment right now. This is wrong, we need to be able to admit that it is wrong and to help the children to

have wholesome lives that history prior to us -- this is just recent this -- what we're battling with right now. I'm just -- you know, not well-studied or anything, but I think it's 1,500 years that we've been living in Judeo-Christian principles, you know, and it's just recently that we're throwing any mention of God, the Bible, under the bus. They're not allowed to hear it. They're not allowed to know it. If you feel like you want to have pleasure this way or that way, with this, with that, you can and we're going to support it and do whatever it is so that you can never change your mind again and give you nothing wholesome to hold onto. That's all.

(Applause.)

A VOICE: Amber Hand. Amber Hand.

MS. HAND: Hi, I'm Amber Hand and I am just with the body of Christ.

So I come today because I represent -- well, I come from a family, my mom was gay and my dad was gay. He struggled with his identity his whole life, but he fought against it because he was a Christian. And I was taught by my dad I was a little girl, and by mom, I was a little boy. And so I got real confused, you know what I mean, and

I'm 36 today and I just realized -- last year I was thinking about getting a sex change still. I've always thought about it. And when I was a kid, I was like, "When I get boobs, I'm going to cut them off with a butter knife," you know what I mean?

And when we're kids, we're so impressionable. I remember my sister going and seeing my dad use the bathroom, and she went to use the bathroom like him, but he corrected her, you know, because we have to teach these kids right from wrong. And it's wrong to take kids and teach them, "Hey, you can make whatever decision you want and you don't even know mentally what you're really going through as a child." We need to take Medicaid and treat people for psychiatric problems and depression and teach them like you can be a female, it's okay to be a female today and say that you're a woman, you know, like -- and I just realized now at 36 that I want to have a baby, and if I had done that, I would have never been able to have a child.

And I just have to say that the Bible says, "Beloved, I wish above all things that thou mayest prosper and be in health even as thy soul prospers." And when we struggle with identity, our souls are in turmoil. And if we just begin to

realize that we just need to teach these kids right from wrong and that it's not okay to change your identity when God made you a male or a female, and when a little boy puts on a high heel because he sees his mother wearing a high heel, it's just play, like it's okay, but that's not what you wear, and teach him what to wear. We just don't understand as kids what's going on until somebody teaches us. We have learned behavior. We're programming kids these days with everything --

A VOICE: Time's up. Please wrap it up.

MS. HAND: -- (inaudible) around us to be somebody we're not. God bless.

(Applause.)

A VOICE: Shauna Peace.

MS. PEACE: Hi, my name is Shauna Peace, and I am just am here to speak in support of Rule 59G-1.050 to ban Medicaid funding on transgender surgery and treatment.

Children are being pressured and socialized at a very young age to identify as transgender. Much of the pressure is coming from on-line social networking sites that celebrate and encourage transgenderism while denying normal heterosexual behaviors. It accounts for much of the metric rise

in the children's identifying as transgender in the recent years. It has doubled since 2017, according to the news sensors for the Centers for Disease Control and Prevention.

The most thorough followup of sex reassignment people, which was conducted in Sweden, documented that 10 to 15 years after surgical reassignment, the suicide rate is twenty times to comparable peers. The alarmingly high suicide rate among post-operative transgender demonstrates the deep regret that may feel after irreversible mutilating their bodies with these barbaric procedures.

I am here today because I have had children that have battled with identity and sexual identity, and that my stepson is now identified as female. He wanted to when he was younger in years, to change, but now that he has gotten into his 20s, he has now decided that he wants to have children, and if you mutilate these children's bodies at an early age, they don't understand that they will never be able to procreate ever again. Whether you go female or male or male or female, neither sex will be able to procreate ever again. And I just think it's mutilating and it's not right.

Thank you very much.

(Applause.)

A VOICE: The next speaker, Leonard Lord.

MR. LORD: My name is Leonard Lord. I am much in favor of the bill.

Even as a boy, I wasn't comfortable in my body because I didn't know why I was here. So when I got the age to say, "I want to find out why I'm here," I spent three days fasting, praying, seeking God. He brought me to his Word, and I found out that the only way I got comfortable in my body was to know what I was created for.

And so what I found, either we're playing games, or if we really believe there's a God and the Bible is true, we find out this whole problem happens because we do not retain the knowledge of God in our conscience and are given over onto our own deception.

And now I hear all of the mental problems we're having. Well, it's real simple. God's spirit is the answer to what's missing in our lives. We're only complete in Jesus Christ. And the scripture says in Timothy 1:7, God has not given us a spirit of fear, we ought to fear man or woman, but he's given us power, love, and a sound mind. You take the Bible out of school, you take

God out of school, you take prayer out of school, and what have you got? You have no power, you have no love, and you have no sound mind.

So I'm just saying let's go back to getting mentally right is the only way I can at 75 is to know God created me, his Word is true, live in supernatural peace and joy and know where you'll spend eternity and don't live confused.

A VOICE: Thirty seconds.

MR. LORD: The devil is the author of confusion. Get a pure heart and live in peace and joy and enjoy things. If you spend your life trying to find out if you're a man or a woman, you'll never know why you're here.

All I can say, God bless you, I'm in support of the bill, and hopefully America will wake up and be a shining city on a hill for all the nations one more time. Lord bless you.

(Applause.)

A VOICE: Pam Olsen. Pam Olsen.

A VOICE: Dan or Pam?

A VOICE: Pam.

MS. OLSEN: It's me, Pam Olsen.

Thank you for this proposal. I've read all the pages. It's excellent. I am for stopping

Medicaid from paying for children and teenagers to have sex changes.

I've talked to a lot of kids that are confused, and they are confused. That's what's going on today. There is so much onslaught against these kids, and you've got kids saying, "I'm a boy, I'm a girl; no, I'm a girl, I'm a boy." You have kids today saying, "I'm a furry animal." Are we going to start paying for them to have furry animal body parts put into them? I mean, where does this stop?

And I am so thankful that this has been proposed, that we will stop the madness in Florida and we will not do this. I hope that you guys do approve this today because it matters for the sake of the children. You know, I've got 12 grandkids and I'm going to fight tenaciously, not only for my grandkids, but for their friends and for all the children across our state, our nation. We need to say stop the nonsense and let's do what is right. There are boys, there are girls, there are men, there are women.

Thank you so much for approving this. I believe you will do that. Thank you.

(Applause.)

A VOICE: Jon Harris Maurer.

MR. MAURER: Good afternoon. My name is Jon Harris Maurer and I'm the public policy director for Equality Florida, the state's largest civil rights organization based on securing full equality for Florida's LGBTQ community.

The proposed change to Rule 59G-1.050 is without sound scientific basis, it is without legal basis, and it is clearly discriminatory. The agency should reject it.

The proposed rule is about politics, not public health. We urge you to listen to the numerous medical professionals opposed to the rule. Experts from the country's and the world's leading health organizations disagree with the fundamental premise of the proposed rule. They endorse gender-afforming [sic] care. These organizations represent millions of medical professionals, and they recommend gender-affirming care. We're talking about the American Academy of Pediatrics and its Florida chapter, the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Psychiatric Association, the American Psychological Association, the

American Academy of Family Physicians, the American Academy of Child and Adolescent Psychiatry, the Endocrine Society, the Society for Adolescent Health and Medicine, the Pediatric Endocrine Society, the World Professional Health Association for Transgender Health, and others; again, representing millions of medical professionals.

Furthermore, AHCA lacks the specific delegated rulemaking authority to adopt the proposed rule. The statutes that AHCA names as its authority to make this proposed rule --

A VOICE: Thirty seconds.

MR. MAURER: -- grant no authority for (inaudible) patient of the individual role for health care practitioners to make decisions with their patients.

The rule is simply discriminatory, it undeniably targets the transgender community. You may not understand what it's like to be transgender --

A VOICE: Fifteen seconds.

MR. MAURER: -- or to be a parent of a transgender kid just trying to find the best care for your kid, but transgender Floridians are here in this audience and they're telling you about how

harmful this rule would be to the more than 9,000 transgender Floridians on Medicaid. We know these therapies are safe because the agency is not opposing them for all Floridians.

A VOICE: Sir, please wrap it up. Your time is up.

MR. MAURER: In conjunction with the state willingly ignoring the body of scientific evidence that supports gender-affirming care, there's no question of the politically-calculated animus behind this proposed rule. Please reject the proposed rule.

(Applause.)

A VOICE: I appreciate your comments. I would just ask for decorum in the crowd. We want to give everybody equal opportunity to speak.

A VOICE: Next speaker, Anthony Verdugo.

MR. VERDUGO: Thank you. Good afternoon. I want to start off by thanking all of you for being here today and for your public service.

My name is Anthony Verdugo. I am the founder and executive director of the Christian Family Coalition. We are a leading human rights and social justice advocacy organization of Florida, and we're here to strongly support Rule 59G-1.050

to ban Medicaid funding for transgender surgeries and treatment.

They call it gender-affirming care. They don't care and it's not affirming. Let's get that straight. And we know that because of heroes who are among us here today, folks like Chloe Cole and Sophia Galvin. They are heroes because they've had the courage to come out and speak the truth in love.

And everyone needs to be respected and treated with dignity, but this is a war on children. These are crimes against humanity. Groomers are using their authority as adults to pressure children and ruin their lives.

I'm going to share with you about a brand, the No. 1 prescribed puberty blocker in America. It's called Lupron. And they themselves list on their package that "Emotional instability is a side effect and warrants prescribers to monitor for development or worsening of psychiatric symptoms during treatment."

These so-called medical organizations which were just listed --

A VOICE: Thirty seconds.

MR. VERDUGO: -- have been discredited.

World-renowned organizations such as the Royal College of General Practitioners in the United Kingdom, Australian College of Physicians, and the American College of Pediatricians -- and I will end with their quote -- say, "Americans are being led astray by a medical establishment driven by a dangerous ideology and economic opportunity, not science and the Hippocratic oath." The suppression of normal puberty, the use of disease-causing cross-sex hormones, and the surgical mutilation and sterilization of children constitute atrocities to be banned, not health care. Let kids be kids.

Thank you.

(Applause.)

A VOICE: Next speaker, Roberto Rodriguez.

MR. RODRIDGUEZ: Thank you very much for this opportunity. I love America as a veteran, ex-police officer, father, grandfather -- let me see what else, you know, and a father of a veteran who is serving in the Navy today as a pilot. And first of all, I wanted to thank you. You guys made me cry. Why? Because, you know, I have a question. Has -- you know, anybody can answer it. Has a doctor ever been wrong? You know, has a parent ever been wrong? Has teachers ever been

wrong? Have scientists ever been wrong? But, then, why are we listening and waiting for scientists and doctors to talk different to what we have evidence here today?

We have the evidence right here today. They came walking in this place and we're being blind to them, and I want to recognize you and I want you to let you know that the true dream is interwoven in every atom of your existence. God will fulfill his true dream to you, no matter what man try to do to you. You have a purpose, you have a reason, and today proves it.

And I'm here to tell you that this rule, we need to go ahead, I support it. We need to stop being ignorant to what faces us and listening to people.

I am from the Centers of God and I have multiple churches that will stand here today. So I'll tell you what, we're bigger than any organization there is right now and represent that we are for this rule.

God bless you and thank you. We love you guys for serving. Thank you.

(Applause.)

A VOICE: Next speaker, Michael Haller, M.D.

All right. Michael Haller, M.D.

DR. HALLER: Good afternoon, everyone. My name is Michael Haller and I am a graduate of the University of Florida's College of Medicine, pediatric residency, and the pediatric endocrinology fellowship. I hold a Master's in clinical investigation and I am the professor and chief of the Pediatric Endocrinology Division at the University of Florida. The views expressed here are, however, my own.

I have trained thousands of medical providers, participated in the development of national guidelines, and have treated tens of thousands of children, including many transgender youth.

I provide this background with full humility, but also to establish myself as an actual expert, both in the management of gender-diverse youth and as one who can review and analyze relevant literature.

The Gapums document and proposed rule change seeking to remove Medicare -- medical -- Medicaid coverage for gender dysphoria makes numerous false claims, uses a biased review of the literature, and relies on more so-called experts who actually lack actual expertise in the care of children with

dysphoria.

While there are a number of flaws, the state's plan following deserves specific commentary.

First, the state's primary assertion that gender-affirming therapy has not demonstrated efficacy and safety is patently false. Nearly every major medical organization that provides care for children, as you heard previously, have provided well-evidenced guidelines supporting gender-affirming care as the standard of care. The assertion from the state, the data included in those guidelines, are not as robust as the state would like them to be --

A VOICE: Thirty seconds.

DR. HALLER: -- is at best a double standard, and is at worst discriminary [sic] political fear. The state is either unwilling or willfully chooses to ignore the totality of evidence in support of gender-affirming care, and the latter seems most likely.

Second, the state's use of --

A VOICE: Fifteen seconds.

DR. HALLER: -- (inaudible) experts as (inaudible) advisers seeking to discredit evidence used (inaudible) of care is laughable. Several of

the state's own experts have been legally discredited from testifying as such in cases regarding gender-affirming care, while others have acknowledged publicly that they have never provided gender-related care to children.

A VOICE: Wrap it up.

DR. HALLER: The proposal to limit gender-affirming care to those dependent on Medicaid is poorly conceived, is likely to cause significant harm to Floridians dependent on Medicaid, and should be rejected. Thank you.

(Applause.)

A VOICE: Next speaker, Robert Yules.

Jason, did you want to comment?

A VOICE: I'm sorry, we have -- the panel has one comment to that. I'm going to refer this to Dr. Van.

DR. V: So just some insight into the support of gender-affirming care by the large societies, medical societies in the United States. The American Academy of Pediatrics has actually made a statement against this -- this, and the Florida chapter as well.

These are not standards of care. Standards of care by definition are an arduous process of

listening to all input from every side, every aspect, of a medical condition, and these individuals get together and they agree on someplace in the middle that they can all live with as a then standard of care.

These are merely guidelines. The guidelines from the Endocrine Society specifically state they are not standards of care. They're just guidelines. They are the opinions of the individuals who wrote the guidelines. The Endocrine Society guidelines were written by nine people in the first go-round and ten in the second go-round, all of which were ideologues from the World Professional Association of Transgender health.

That group -- that interest group excluded world renowned experts in the field and did not listen to their input, didn't include their input on purpose. And so it's not surprising that you come up with one view that does not really represent any kind of standards of care.

So we have to stop using the term "standards of care" when there are absolutely no standards of care in this instance that have been addressed.

(Applause.)

A VOICE: Mr. Yules. Mr. Yules.

DR. HALLER: I would also --

A VOICE: Sir, you've spoken already. If you have further comments, please submit them in writing.

A VOICE: No, I'm sorry, Dr. Haller. If you have further comments, you can -- you can refer them in writing. You can refer them in writing, Doctor.

A VOICE: Robert Yules.

MR. YULES: Yes, my name is Robert Yules. It's an honor and privilege to be here. I was born and raised in St. Petersburg, Florida, and my, how things have changed. Forty-three years ago, my senior high school class came here to view the legislature, and the topic of the day was about dog-catching rules in the state of Florida. My, how far we've come.

This was not even in the purview of anyone at that time. This was not in the purview of anyone ten years ago. This was not in the purview really of anyone five years ago to bring it to the state level, the city level, the classroom level, to be driven by the teachers' unions with all of their ideology, and really it begins and ends when man

proclaims himself as God. The truth begins with me and it ends with me. And our country is in a lot of trouble because people aren't willing to say "No, that's not your truth." There is a truth. That might be your perspective of the truth, but there is not your truth, your truth, your truth, my truth, his truth. It's not the way it works, and we're going down -- just even philosophically and morally, we're going down a very, very slippery road when we start delving into these things.

It's interesting to me also how a child cannot own this or own that or own this, and the thing we've been told for the last ten years, "Well, their brain's not fully developed until around 25." Everybody says that, right? Their brains aren't developed until they're 25, and now our governor caught such flack because he said don't teach kindergarteners --

A VOICE: Thirty seconds.

MR. YULES: -- about transgendering, leave it out till third grade. I think they should leave it out till 12th grade and let parents have those conversations with people. Put it back where parents talk to their own kids, and let's -- let's make school about science, technology,

engineering --

A VOICE: Fifteen seconds.

MR. YULES: -- and mathematics and get back where we need to be.

Thank you so much for your time. Thank you.

(Applause.)

A VOICE: At this time, we would like to remind everyone that they can submit comments in writing to medicaidrulecomments@ahca.myflorida.com. Information is provided on cards at the exit when we are finished, as well as up on the screen. We'll continue with the speakers.

A VOICE: Flaugh. Keith Flaugh.

MR. FLAUGH: Good afternoon. My name is Keith Flaugh. I am one of the founders of an organization called Florida Citizens Alliance, which is a not-for-profit organization of almost 200,000 parents and grandparents, and we focus on K through 12 education.

We have recently completed a detailed study in all 67 county school districts based on 58 novels that we found throughout. I've left a copy with Cole. I would encourage you to read it.

Twenty of those are LGBTQ and gender -- promoting gender dysphoria. Some of these

materials are actually designed for pre-K.

Children in our public schools are being purposefully confused, desensitized, and even pressured into abnormal sexual behavior. Gender idealogues are coaching kids to be into this dysphoria, and even telling them to threaten suicide.

There is a considerable debate in the psychiatric and medical circles about whether the transgender condition is biological or psychological. In numerous public schools, staffs and even teachers are aiding this dysphoria and purposely hiding what they're doing from the parents. Further, taxpayers shouldn't have to pay for this.

Florida Citizens Alliance strongly supports the rule of 59G-1.050, especially to protect minors from the harmful transgender surgeries, hormone blockers, and other unnatural therapies. Thank you.

(Applause.)

A VOICE: Robert Roper.

MR. ROPER: Hi, my name is Robert Roper. I'm here to speak in support of the rule to ban Medicaid funding for transgender surgeries and

treatments. The most important aspect of this rule is that it serves to protect the children of the state of Florida.

Gender confusion is the only disorder that comes with a false assertion that a child can actually be born in the wrong body. They are led to believe that some day they'll actually become a member of the opposite sex. That's impossible. Maybe that's why they call it "transgender." You never actually arrive at the desired outcome.

Gender confusion is the only disorder that the body is mangled to conform to the thoughts of the mind.

Gender confusion is the only disorder that the child actually dictates his or her medical care to medical and -- medical professionals and counselors, instead of the other way around.

Gender confusion is the only disorder that the parent can be completely excluded from determining what is best for their own child.

Gender confusion is the only disorder that the treatment takes the child down a dead-end road literally. What we are seeing in Florida and across the nation is a social media-driven epidemic manufactured by social media influencers making a

lot of money off the very vulnerable element of our society -- that's our children.

While most counselors somehow have been convinced that affirmation is the only way, even the APA would be the first to affirm that a child simply does not have the capacity to make these kinds of long-range decisions. In fact, you don't need to be a doctor --

A VOICE: Thirty seconds.

MR. ROPER: -- of psychology to know this. Ask any parent. They will tell you that a child wants what they want, and they want it now.

What some -- some will call on their faith, some will call on a counselor, but all do so to be delivered from the disorder, not to be sent deeper into it.

A VOICE: Fifteen seconds.

A VOICE: You don't give drugs to a drug addict, alcohol to an alcoholic, porn to someone addicted to pornography. This is not a form of treatment.

In closing, transgender regret is among the fastest-growing movements on social media today --

A VOICE: (Inaudible).

MR. ROPER: -- on Reddit this morning. I

found a thread with 35,600 entries of people regretting their transgenderism. It increased to a hundred more while I drove here today.

Watchful waiting from loving parents yields an exponentially higher success rate of resolving gender disorders than any prescription drugs or surgery, 90 plus percent. This rule will protect Florida residents.

(Applause.)

A VOICE: Carl Charles.

MR. CHARLES: Good afternoon. My name is Carl Charles and I'm a senior attorney in the Atlanta, Georgia, office of Lambda Legal, the nation's oldest and largest legal organization fighting for the rights of LGBT people and everyone living with HIV.

We are here today to share that we strongly oppose and are deeply disturbed by AHCA's notice of proposed rule, which if approved will remove coverage of medically-necessary care for transgender youth and adults from the Florida Medicaid program. This essential and in some cases life-saving care is clinically effective, evidence based, and widely accepted and used by medical professionals across the country to treat gender

dysphoria.

Unlawful exclusions of this kind cause significant harm to a state's most vulnerable residents. Indeed, should this proposed rule be adopted, it will cause serious, immediate, and irreparable harm to transgender Medicaid participants in Florida who already experience well-documented and pervasive stigma, discrimination in their day-to-day lives, including significant challenges, if not all-out barriers to accessing competent health care services.

We are especially concerned by the administration's characterization of this care as experimental and ineffective. This is contrary to all available medical evidence and relies on misrepresentations of the findings of various studies, as well as reports by so-called experts, one of whom is on this panel, who have been discredited and notably do not treat transgender people --

A VOICE: Thirty seconds.

MR. CHARLES: -- in their medical practice.

Finally, I would like to note for the record as to whether or not this was a negotiated rulemaking process and who on the panel is a

transgender Medicaid recipient in Florida. Okay, there's no one.

Finally, singling out transgender Medicaid participants for unequal treatment by denying them coverage for services that non-trans Medicaid participants access plainly violates the equal protection clause of the U.S. Constitution and federal law.

A VOICE: Time. Please wrap up your comment.

A VOICE: Furthermore, Section 15-57 of the Affordable Care Act prohibits discrimination on the basis of sex by any health program or activity receiving federal financial assistance.

Finally, shame on you all for proposing this rule.

(Applause.)

A VOICE: Jason, did you want to comment?

A VOICE: Just quickly, I would like to refer everyone to the Gapums report, in particular the numerous appendices that we attached to that report. There have been references to the numerous clinical organizations that have endorsed these procedures, and in particular, I would refer you to Dr. Canter's report, pages 27 through 28 -- I'm sorry, pages 32 through 42, which go through each

one of those organizations. Thank you.

A VOICE: Speaker Ed Wilson.

MR. WILSON: Ed Wilson. I've traveled here today to speak in support of Rule 59G-1.050 to ban Medicare funding from being used for transgender treatments and surgeries.

This rule will protect children who are not mature enough to be comfortable in their own body or to have sexual desires that they have not gone through puberty yet from making mistakes that will destroy their lives.

Children are being misguided into believing that they're transgender. Taxpayer money should never be used to destroy innocent lives.

Transgender treatments and surgeries never actually succeed in changing someone to the opposite sex, but do cause permanent harm to the people who undergo such treatments.

Health care professionals need to focus on healing the mind of confused and/or abused people, not mutilating their bodies. As Anthony already quoted, I'm going to skip part of the quote from the American College of Pediatrics, but it ends with, "The suppression of normal puberty, the use of disease-causing cross-sex hormones, and the

surgical mutilation and sterilization of children constitute atrocities to be banned, not health care.

Please take their advice. Ban these atrocities --

A VOICE: Thirty seconds.

MR. WILSON: -- and keep Medicaid about health care. Thank you very much.

(Applause.)

A VOICE: Speaker Suzanne Zimmerman.

MS. ZIMMERMAN: I'm Suzanne Zimmerman, and I am merely a mother, grandmother, great-grandmother, aunt, great-aunt, and specifically great great-aunt of a young child who is going through the throes of gender dysphoria from the age -- a young age. He is now 8 years old, and I pray that our state doesn't make it easy for her parents to be dissuaded toward gender change.

I listened to the young people here who have gone through this, and I think they speak volumes more than any of the rest of us could say because they've been through the difficulties and they've learned through the difficulties.

And my bottom line is God doesn't make mistakes. We're all created equal and different,

each in His image, and there are many, many different people in this world and we are to love them all. It's a commandment, it's God commandment, and He loves us all.

I urge you to support this ban to make it easy through Medicaid to have --

A VOICE: Thirty seconds.

MS. ZIMMERMAN: -- the surgery for children who are children with very young brains. Have a heart and please pass this ban. Thank you.

(Applause.)

A VOICE: Judy Hollerza, H-o-l-l-e-r-z-a.

MS. HOLLERIN: I'm Judy Hollerin, poor work -- poor penmanship apparently.

I support -- I support that we ban -- that we ban this. I -- every day, of course, we wake up seeing new things that we can't believe are happening to us today. And I support everything that's been said -- everything in support of that has been said today.

The idea that Medicaid should be doing -- should be supporting this or paying for it -- again, this expansion of us paying for these kinds of critical things without further thought. My, I -- I would like to look 20 years younger, but I

do not expect Medicaid to be paying for it. Enough said.

(Applause.)

A VOICE: Next speaker, Ezra Stone.

MR. STONE: Good afternoon. My name is Ezra Stone and I'm a licensed clinical social worker.

Social work is a profession with a long history of valuing human dignity and autonomy, and according to the values of my profession, I have an ethical obligation to support my clients in reaching their fullest potential, problem-solving barriers to treatment with them, and collaborating with other professionals.

Additionally, we have a professional obligation to provide evidence-based treatment, and there is significant research that medical transition is safe, effective at relieving symptoms of dysphoria, and improves mental health.

In my private therapy practice, my clients express tremendous relief at being able to access medical care, which decreases their anxiety and depression and increases their feelings of safety, comfort, and joy as their bodies and minds become more congruent. Understanding and being seen as their true selves creates a sense of belonging,

which is a fundamental human need.

On the other hand, the current political climate in the state is causing significant harm to transgender, nonbinary questioning and gender diverse Floridians. My clients report increases in anxiety with each proposed anti-LGBT measure the state takes, fear violence in their daily lives, and worry about their continued access to medical care.

These observations from my clinical practice support the research on the minority stress model, which demonstrates that expecting experiences of harm, marginalization, and rejection have a negative impact on people's mental health and overall well-being.

Passing this change to Medicaid --

A VOICE: Thirty seconds.

MR. STONE: -- will not only take away medically-necessary care from several thousand of the most vulnerable Floridians, but it will also further create a climate of fear for LGBT people and their health care providers across the state.

(Applause.)

A VOICE: Jason. Speaker Peggy Joseph.

MS. JOSEPH: Hello. I'm Peggy Joseph, and I

would just like to share some thoughts from an author and doctor, Ryan T. Anderson, who wrote about -- a book called, "When Harry Became Sally."

So in 2016, the Obama administration and the Center for Medicare and Medicaid Services revisited the question of whether sex reassignment surgery would have to be covered by Medicare plans. It refused on the grounds that we lack evidence that it benefits patients. They stated, "Based on a thorough review of the clinical evidence available, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes."

There were conflicting study results, and the quality and strength of evidence were low. Many studies that reported positive outcomes were exploratory-type studies with no confirming follow-up. The author says, "The lack -- the lost of follow-up could be pointing to suicide."

The largest and most robust study, a study from Sweden, found a 19 times greater likelihood of death by suicide and a host of other poor outcomes.

To provide the best possible care serving the patient's interest requires an understanding of human --

A VOICE: Thirty seconds.

MS. JOSEPH: -- wholeness and well-being. The minimal standard of care should be with a standard of normality. Our brains and senses are designed to bring us into contact with reality. Thoughts that distort --

A VOICE: Fifteen seconds.

MS. JOSEPH: -- (inaudible) are misguided and cause harm. Okay.

(Applause.)

A VOICE: Next speaker, Jack Barton.

A VOICE: Actually, I have one comment with respect to that, so as a partial addendum to my earlier answer focusing on some of the clinical organizations in the United States, but I wanted to also mention because it has come up a couple times here, that the Gamus report on pages 35 and 36 also talks about international consensus as also talked about in Dr. James Canter's report on pages 42 through 45. So I would encourage people to look at that as well.

A VOICE: Go ahead.

MR. BARTON: My name is Jack Barton. I'm here with the Christian Family Coalition. I'm an Assembly of God pastor. The 37 years I have

counseled, among them I've counseled lesbians, gays, and bisexuals. I believe in First Corinthians 6:9, that people can escape from that life. Unfortunately for the transgender, they suffer. These young people have made that clear.

I believe that gender dysphoria should be labeled as child abuse, it is not something that should be happening to our children, and with the doctors that will participate in this, it's not so unlike the doctor who tears a child apart in abortion and calls it health care.

These are the issues: The puberty blockers, the hormone manipulations, that's not science. The only name that was left out before was Anthony Fauci. I kept waiting to hear them to say that.

Every -- any procedure like this should be labeled criminal. You have a child that at that age doesn't know if they like vanilla ice cream or if they like chocolate ice cream, and yet they're going to let them march in and either make that decision to be led down that path. Nearly 90 percent of those that escape from that life do it by the time they reach the end of puberty because they come back to their senses that they were created male and female by God.

Suicide that we talk about so much comes when a person has followed up on these things, has done it, and now they are confused because they still don't find the completion that they thought they felt.

Among those that go through these processes, many of it comes from child abuse that happened when they were kids, some who have wanted to have acceptance by others and were rejected. One man, his grandmother wanted a granddaughter. She dressed him like that, and so he adopted that life.

A VOICE: Thirty seconds.

MR. BARTON: I'll close with this. There are two genders, male and female. Women bear children, women breastfeed, women have menstrual cycles. Men do not. I would not provide the anorexic with food and I would not say give money to do something that would harm a child.

A VOICE: Fifteen seconds.

MR. BARTON: It's a terrible thing to do and I ask you to stand your ground.

(Applause.)

A VOICE: Jose Martin.

MR. MARTIN: Good afternoon. Thank you for letting me speak. I'm also with the Christian

Coalition, and I'm here to speak in support of Rule 59G-1.050. I am a father and a grandfather, and I am here to stand against mutilation that we all are asked to fund. The people we are talking about need counseling, not promotion to a destructive choice.

I also want to remind that one day we will all stand before a living God and give account for where we stand on this and other issues. And I also want to thank you brave people, who I think are more qualified than all the other experts that came up, because you are living and you lived through it and you know the results of that, and I thank you. Thank you very much.

(Applause.)

A VOICE: Folks, we have a number of speakers coming up from the same organization. We just ask that you be respectful of others' time. We've got a number of speakers to get through before 5:00 p.m., so if you could just be brief and support comments of others, if possible. Thank you.

Next speaker, Bob Johnson.

MR. JOHNSON: Good afternoon, Bob Johnson. I am a retired and recovering attorney, but I am -- and I'll be very brief.

I say thank you to the Florida Division of Medicaid for putting together this report. I've read the whole report. It's not my area of expertise, but I've had significant experience working with the development of agency rules, statements of need, and reasonableness as we call them in the state that I come from, and I just want to compliment the agency. I've read through it. I think the case is compelling for the rule change. I strongly support the rule change.

There is specifics in there again that's not an area that I studied, but in reading the report and looking how thorough that it was put together, the case has been made for the need to adopt this rule change, the case has been made for the reasonableness of what you're proposing. I just found it compelling the fact that the FDA does not approve any medication as clinically indicated for gender dysphoria. The fact that there's no randomized, controlled trials for the use of these puberty suppression, that's the gold standard, I know, in medical studies, and there are no randomized, controlled trials, and the fact that there's no long-term data. I just think there is so much concrete, substantial evidence that totally

justifies it, and I would just echo many of the others that have testified here today. I urge you to go forward, adopt these rules, changes --

A VOICE: Thirty seconds.

MR. JOHNSON: -- (inaudible) we need them, we need them in the state of Florida. Thank you.

(Applause.)

A VOICE: Next speaker, Sandy Westad, W-e-s-t-a-d, I believe.

MS. WESTAD: My name is Sandy Westad and I'm also here with CFC, Christian Family Coalition.

I -- I want to speak from the heart. I'm a mother, I'm a grandmother, I'm a sister, whatever, and my heart is breaking for what these kids are going through. It just seems to me that if the parents -- the parents need to stay in control. They need to stay in the authority of their children. They need to be able to speak to their kids about the sex and the transgender.

Kids play house. They pretend. You know, they do things in a play world, but they don't want to be or understand or even know what it is to change from one sex to another. They pretend. I remember my sons playing and pretending they were girls and sometimes they would pretend they were

boys, but they were boys and they grew up to be boys. They didn't want to be girls. They felt that that was what they were supposed to be. Jesus made them boys, and they were going to stay boys. But the thing is we -- we need to understand that children cannot make those kinds of decisions. They cannot --

A VOICE: Thirty seconds.

A VOICE: -- decide who they are. The parents need to be their guide, and the parents -- God gave children parents for a reason.

So I just support this bill, this rule, and I thank you so much for everyone that's here.

(Applause.)

A VOICE: Gail Carlins.

MS. CARLINS: Good afternoon. I'm Gail Carlins and I'm with CFC also. And I am in favor, I support this rule change here with not having the funds -- the Medicaid funds go to supporting these.

My beliefs are based on the Bible, and the Bible, I believe, is the only truth that there is. And the Bible says, as was mentioned a couple times, God created male and female. If you want to bring science into it, females have two X chromosomes, males have an X and a Y chromosome.

It's an impossibility to change from one to the other. That cannot be done. And so no matter what kind of mutilation or anything is done to a person, they can't change it.

So, again, I am in support of this bill and I thank you for your time.

(Applause.)

A VOICE: Dorothy Berring.

MS. BERRING: Good afternoon. My name is Dorothy Berring, also with the Christian Family Coalition. I also live in The Villages, Florida.

First of all, I would like to thank our brave governor once again for bringing this to the forefront. We are -- Florida definitely is going to make change, and thank you to these brave people and to Amber for not going along with what you were trying to be brainwashed into believing.

Again, it's strange, you know, they're definitely targeting our -- our youngest. We can't seem to find baby formula anywhere, but yet Medicaid can fund this nonsense.

Again, this has to be left up to the parents. Whatever you choose to practice in the privacy of your own home is your business. I'm not discriminating against any genders or whatever. I

just -- it needs to be taken out of the schools, and this doctor that was from UF or USF or whatever, it's shameful, shameful what you are trying to teach our students, and that's why we are in this bloody mess right now. Okay? And this needs to be changed --

A VOICE: Thirty seconds.

MS. BERRING: -- and you all need to listen.

And thank you, doctors, for being here and for giving us this forum. Thank you.

(Applause.)

A VOICE: We would ask that the comments be focused on the rule and be respectful of other speakers, please.

Troy Peterson.

MR. PETERSON: Good afternoon, Troy Peterson. I come supporting Anthony and Christian Family Coalition. I'm also the President of Warriors of Faith here in Florida. We brought a few people with us from the Tampa Bay area, and really we come representing thousands that stand in agreement with this rule.

And I want to thank you, doctors. I read the 40-page report. I'm not a doctor, I'm a pastor. But when I saw the evidence, I could clearly see

that we need this rule.

In the book of Genesis, in the beginning God created man in his own image, male and female, and then he said, "Be fruitful and multiply the earth." So that's why I'm here is because I'm opposed to even that doctor back there. And I appreciate you said that because if I had any authority in the medical field, I would have his license revoked.

The most thorough follow-up of sex reassigning people, which was conducted in Sweden, documented that 10 to 15 years --

A VOICE: Thirty seconds.

MR. PETERSON: -- of surgical reassessment, that the suicide rate is 20 times that of the comparable peers.

I also read in the medical evidence that 50 percent --

A VOICE: Fifteen seconds.

MR. PETERSON: -- of the gender identity-confused children have thoughts of suicide.

Thank you for your time.

(Applause.)

A VOICE: Janet Rath.

MS. RATH: Hi, my name is Janet Rath. I'm a

mother, a grandmother, and a new great-grandmother. And I think 50 years ago as parents, we were smarter than what is going on today. Parents are left out of their children's lives. Some of it is the parents' fault, and some of it's the teachers' faults.

I have a granddaughter that's a teacher who has said that if she has a child that comes in and identifies as a cat, she must have a litter box there and a bowl of water.

We are as a country going absolutely insane, absolutely insane. We all bought into Dr. Fauci, who was nothing but a money-grabbing liar -- pardon my French -- and we have been hoodwinked ever since. We have got to stop this.

Chinese children in third grade are learning advanced calculus. Our third graders are learning which bathroom to use. I'm sorry, but I do not want my great granddaughter growing up in this world if this is what it's going to turn into. We have got to change, and we had best do it now. Thank you.

(Applause.)

A VOICE: Gerald Loomer, L-o-o-m-e-r, Gerald.

MR. LOOMER: Good afternoon. My name is

Gerald Loomer. I drove three and a half hours from Lady Lake, Florida, to be here because I want to support Rule 59G-1.050. Especially I want to support the best governor in the United States, Ron DeSantis who also supports this.

(Applause.)

MR. LOOMER: But I'd like to share three quick stories with you. The first is the little girl who saw her brothers go fishing with their dad, out in the backyard playing catch with a football, says, "You know, I'd like to spend more time with Dad. If I were a boy, I could spend more time with Dad."

Or the boy who said, "You know, those girls, they're in the kitchen cooking with Mom, they go shopping with Mom, they're doing makeup with Mom. I want to spend more time with Mom. I think I should be a girl, then I can spend more time with Mom." Well, those things passed.

Remember the child who said, "Can I drive the car?" "Of course not, you're 13 years old." "Well, can I drink a beer?" "Of course not, you're 13 years old." "Can I smoke a cigarette?"

A VOICE: Thirty seconds.

MR. LOOMER: "Of course not, you're 13 years old." "Can I take hormones to block puberty?"

"No, you're 13 years old. Of course, you can. You know what you want." "Can I take cross-sex hormones?"

A VOICE: Fifteen seconds.

MR. LOOMER: "You're 13 years old. Of course, you can. You know what you want." "Can I have gender sterilizing surgery?" "You're 13 years old. Of course, you can, you know what you want." "Can I have body-mutilating surgery" --

A VOICE: Time. Please wrap up your comment.

MR. LOOMER: -- "that's going to alter my sex?" "Of course, you can, you's are 13 years old, you know what you want."

A VOICE: Sir, your time is up. Please wrap it up.

MR. LOOMER: How absurd is all of this? Continue to keep this resolution.

Thank you.

(Applause.)

A VOICE: Pastor Marta Marcano.

MS. MARCANO: Good afternoon. I'm Pastor Marta Marcano from (inaudible) Jacksonville, Florida. I'm a director of Protect our Children Project, Duval County chapter, and an organizer of the Christian Family Coalition in Jacksonville too.

I'm here to let you know that I'm support of the Rule 59G-1.050 to ban Medicaid funding for transgenders, surgeries, (inaudible) blockers, and other unnatural therapies.

Also, this rule protect taxpayers from being forced to subsidize the (inaudible) is driving by unethical pharmaceutical companies enriching themselves with the puberty blockers. That is an atrocity of children abuse.

World-renowned Swedish psychiatric, Dr. Christopher Gilbert, has said that pediatric confusion is possibly one of the greater --

A VOICE: Thirty seconds.

MS. MARCANO: -- scandal in medical history and call for an immediate moratorium.

As a pastor --

A VOICE: Fifteen seconds.

MS. MARCANO: -- I want to remind you that doc do not been a stumbling block for the little one, because Hebrews 10:31 said --

A VOICE: Time. Please complete your comment.

MS. MARCANO: -- "It's a fearful thing to fall into the hands of the living God."

Please protect our children. Thank you very much for this time.

(Applause.)

A VOICE: Paul Arrans.

MR. ARRANS: Good afternoon. My name is Paul Arrans. I'm a physician. In practice, I've had transgender patients, and I have transgender personal friends with whom I discuss their medical care at length.

With profound respect for the young people who testified earlier, I still oppose this amendment (inaudible) the preponderance of medical science and practice when we do irreparable harm to the health and well-being of thousands of transgender Floridians of all ages and their families.

The American Academy of Pediatrics and its Florida chapter representing thousands of board-certified pediatricians have directly reviewed many controversial assertions in your publication on gender dysphoria, and the Florida Department of Health's statement responded.

Contrary to an earlier comment, the Endocrine Society has stated, "Both medical intervention for transgender youth and adults, including puberty suppression, hormone therapy, and medically-indicated surgery has been established as the standard of care. Federal and private

insurance should cover such interventions as prescribed by a physician," end quote.

Gender dysphoria is very real. You can learn this for yourselves by meeting with transgender people. You will then realize that denial of appropriate gender-affirming care at any age would be inhumane and a violation of human rights. These medically-necessary treatments are the generally accepted professional medical standards, (inaudible) authoritative opposition to the proposed rule.

A VOICE: Thirty seconds.

MR. ARRANS: (Inaudible) to just rush this through, thereby putting the health and lives of trans people in danger.

It feels like Medicaid is crossing into a political lane by seeking to preempt provider/patient/family decision-making here, and I urge you to withdraw this proposal.

A VOICE: Fifteen seconds.

MR. ARRANS: This represents knowledge and practice regarding gender-affirming care. If you are still determined to address this topic, at least convene (inaudible) panels of experts, including transgender community members, who inform

yourselves and the public about the overwhelming evidence --

A VOICE: Time.

MR. ARRANS -- against denying coverage for gender-affirming care.

Thank you for the opportunity to testify.

(Applause.)

A VOICE: Thank you for that comment. I'm going to refer for further comment to Dr. Van. VANMOLE, VANMO, VENMO?

DR. V: I would encourage everybody just to read the Gaplins report, and particularly the attachment to it. A great deal of attention has been put in there into evaluating the science. And some of the studies that have been brought up, both pro and con, are involved -- they're specifically the flaws that are in so many of these studies. Specifically --

A VOICE: Hold on.

A VOICE: (Inaudible) while Dr. Vanmo speaks.

DR. V: Yeah, and by the way, I like the idea that everybody lets everybody speak. So it kinds of bothers me when I'm hearing speakers shout it down because they're saying something you don't like. How we treat other people with whom we

disagree is a reflection of our own character, not theirs. So, please, let -- due decorum.

First of all, the Endocrine Society's 2017 guidelines are guidelines, just that. And it states specifically page 3895 that they do not guarantee an outcome and they do not establish a standard of care. It's in black and white there.

I would refer you also, as is mentioned in the Gaplins report, the histories in the United Kingdom, Sweden, Finland, France, four nations that were leading this from quite some time, they did national-level reviews involving scientific organizations, divisions of governments, medical professionals. And mind you, these are nations that were leading it. And after review, they all came to the same conclusion, this should not be going on in minors at all under 16, and only between 16 and 18 under tightly-regulated studies, the kind of which we really don't see happening.

And they also came to the conclusion that strong psychological support is what's needed when we talk about evaluating kids for this. We have four decades of literature showing the overwhelming probability of mental health problems, adverse childhood events, neuropsychological problems like

autism spectrum disorder, and other things that need to be addressed. And, in fact, also for these nations, somebody strongly demonstrating psychologic instability -- quite specifically, you say you're suicidal -- blocks you from the transition pathway. They insist that those things be taken care of first because transition simply won't fix them. The underlying problems of a transgender youth become the underlying problems of an adult who identifies as transgender. That's what is going on here.

So, again, I'd refer you to the report and some of the other letter, complaints, that I've seen come in in the past 24 hours from the AAP, as well as from the Endocrine Society, what they're complaining about is actually addressed here, including some of the studies they bring up, and there too, it's a very well-researched document. The State of Florida put a lot of effort into this.

You're free to disagree, but please make sure you've read it and understand it before you do.

A VOICE: Just to be a little bit more specific with respect to the report, I'd refer you to Dr. Rigner (inaudible) Peterson's report, which is Attachment C to the Gaplins report, and also a

doctor named Paul Hruz, H-r-u-z. Title of his publication is, "Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria." He did not provide an expert report for purposes of this report, but he is published in medically reviewed literature, and I would encourage you to read that as well.

Thank you.

(Applause.)

A VOICE: January Littlejohn.

MS. LITTLEJOHN: My name is January Littlejohn. I am a mother of three children and a licensed mental health counselor.

In the spring of 2020, our 13-year-old daughter told us that she was experiencing distress over her sex and that she didn't feel like a girl. She had expressed no previous signs of gender confusion, and three of her friends at school had recently started identifying as transgender.

As we tried to understand our own observations and seek professional help, we discovered that her middle school had socially transitioned her without our knowledge or consent. Her mental health spiraled. We worked with a psychologist to help our daughter explore and resolve co-occurring

issues, including low self-esteem and anxiety. We also gave her more one-on-one time, in-person activities away from trans influences, limited her Internet use, and declined to affirm her newly-chosen name and pronouns. We set appropriate boundaries and allowed her to choose her hair style and clothing, but denied harmful requests such as breast binders, puberty blockers, cross-sex hormones, and surgeries.

It was clear from our conversations that our daughter was uncomfortable with her developing body and had an intense fear of being sexualized. She was filled with self-loathing and was in true emotional pain, but had been led by peers and influencers to believe that gender was the source of her pain.

What she really needed was for us to help her make sense of her confusion and remind her that hormones and surgeries could never change her sex or resolve her issues.

A VOICE: Thirty seconds.

MS. LITTLEJOHN: I shudder to think what could have happened if we had affirmed her false identity and consented to medical treatment as opposed to what we did, which was to lovingly affirm her as

she is: Beautifully unique and irreplaceable and undeniably female.

A VOICE: Fifteen seconds.

MS. LITTLEJOHN: Our daughter has desisted and is on a path to self-love, but, unfortunately, gender-dysphoric children are being encouraged through activism and peer pressure to disassociate from their bodies and to believe their body parts can be simply removed --

A VOICE: Time. Please finish your comment.

MS. LITTLEJOHN: -- modified, or replaced.

The irreversible consequences of medically transitioning, including loss of sexual and reproductive function, cannot be fully understood by children or teens who lack the necessary maturity or experience. These children need love and therapy, not hormones or surgery.

Thank you.

(Applause.)

A VOICE: Next up, Kendra Paris.

MS. PARIS: Hi there, my name is Kendra Paris. I still suffer from being an attorney. I'm a mental health attorney, and I wanted to follow up on the comment about the lack of peer-reviewed standards of care, because as an attorney, the lack

of peer-reviewed standards of care mean that a lot of people who are harmed or experience bad outcomes from these surgeries or other interventions have no ability to sue, and I find that problematic as an attorney. They've had decades to create peer-reviewed standards of care, and they have not. And I suspect some people don't want those standards of care because it would open them up to lawsuits for bad outcomes, which is not happening right now and it really frustrates me.

You all are so brave. I'm so proud of you for coming and telling your stories.

We just don't know, and I want to talk about a particularized thing that we don't know yet. When you put a female on testosterone, within about five years, she's going to have to have a hysterectomy, though you passed most recent standards of care, recommend hormone -- cross-sex hormone therapy for females at 14. So we're talking about a potential hysterectomy before she turns 20. We have known for a very long time that hysterectomies correlated with negative mental health outcomes and cognitive decline. And we know that the earlier a hysterectomy is performed, the worse mental health and cognitive decline is. Essentially, the earlier

you do the hysterectomy, the earlier the onset of dementia.

And so what I am very concerned about is in, I don't know, 10, 20, 30 years, we're going to have an absolute wave of young females, 40, 50 years old, with early-onset cognitive decline --

A VOICE: Thirty seconds.

MS. PARIS: -- or dementia in our assisted living facilities.

And in surveys and anecdotal experience is starting to indicate that some individuals who are trans and have dementia forget that they're trans. In a state like Florida, we have substituted judgment.

A VOICE: Fifteen seconds.

MS. PARIS: So if they don't have written documentation allowing for their medical proxy to allow for detransition, they might be cut off. And I really worry that we have not considered all of the implications of this.

So I appreciate the rulemaking and I thank you --

A VOICE: Time.

MS. PARIS: -- for your time. Thank you.

(Applause.)

A VOICE: Nathan (inaudible).

MR. BRUMER: My name is Nathan Brumer. I am Florida's LGBTQ consumer advocate as appointed by Commissioner of Agriculture Nikki Fried. One of FDACS' many critical roles here in the state includes serving as Florida's consumer protection agency.

On behalf of health care consumers, I provide the following comments in opposition to the proposed changes to Rule 59G-1.050: As a state agency, FDACS encourages all consumers to remain aware, vigilant, and act when necessary, but to do so, we know consumers must be provided with accurate information, education, choice, safety, representation, and redress.

Documented, well-researched standards of care have been established, are based on a wide range of evidence, and conclude gender-affirming medical care is medically necessary and safe and effective. In other words, gender-affirming care is the standard of care, and the proposed rule as it stands would deny health care consumers in the state of Florida access to the standard of care.

State agencies must serve and advocate for all Floridians. We should not deny any Floridian the

ability to thrive. We serve the public good and we must defend the rights of every Floridian, including transgender Floridians, and this includes the right to nondiscriminatory health care coverage. We must work to increase access to health care, not lessen it or remove it all together.

A VOICE: Thirty seconds.

MR. BRUMER: On a personal note, Florida is my home state. I am one of thousands, tens of thousands of transgender Floridians here in our state who have had the privilege to have access to gender-affirming health care --

A VOICE: Fifteen seconds.

MR. BRUMER -- for decades who are happy and successful and thriving. I'm an attorney, I'm an advocate, and I work for and very hard and I'm proud to serve the State of Florida. We are part of the fabric of this nation --

A VOICE: Time. Please wrap up your comment.

MR. BRUMER -- and of this great state, and we deserve the rights and benefits afforded to all.

(Applause.)

A VOICE: Nathan Bremmer.

MR. NEWELL: Hi, I'm Nathan Newell. I think

we got the Nathans mixed up. Here (inaudible) for support. Tell you a little bit, I have a son, I have four children. My son, 15, is -- doing everything we can to keep him straight. He doesn't make good decisions. One of the things lately, you know those little things on the side of the road that flashes and tells you your speed? Well, we had one of those near our house. So he decides to take his dirt bike in pitch black and with his friends out there and go 80 miles per hour down the road. We know this because of the ring. He was bragging to his friends, so we watched the ring and saw that.

Then a couple days ago, he was upset with us and said he was leaving. So we said, "Where are you going to go, Hunter?" He goes, "I'm going to St. Teresa, I got friends down there." "How are you going to get there, Hunter?" "I'm going to ride my bike." I said, "It's going to take you forever," and he goes, "It's going to take me four hours."

So, anyways, this 15-year-old, he's not making good decisions. And to sit here and to even think that these kids can make a decision on what they want that's going to be with them for the rest of

life is child abuse. These doctors are despicable. They need to have their license taken away. They are a disgrace to the human race. It's just despicable to think that these people are taking care of us and taking care of our children, and I appreciate what y'all are doing.

(Applause.)

A VOICE: We'd ask that you please be respectful to the other speakers.

A VOICE: Thank you for your comments. We respect your comment, we respect everybody's comments, including the doctors that you referenced.

A VOICE: Nathan Brumer.

Dotty McPherson.

MS. MCPHERSON: Hi there, I'm Dotty McPherson. I'm speaking as the District 2 representative for the Florida Federation of Republican Women.

The age of majority is 18, but even at 18, children don't have the maturity to handle certain responsibilities given them, like driving, alcohol. Even older adults don't.

Your agency's safety net programs include programs for abused and neglected children, but not gender decisions. Please prevent funding the

destruction of children's genitalia and hormonal balance.

Please consider unintended consequences of, No. 1, is taxpayer money that will need to be used for lawsuits by those whose lives are ruined from surgeries that got -- that they got while they were immature or too young to understand, also by parents whose parental rights were denied to protect their children's future.

I grew up in a low-income neighborhood on the low-income side of town. When I got to junior high school, I saw how rich kids were, and a lot of them were just real brainiacs, and I felt so inadequate. I had a terrible inferiority complex, but I got over it. I graduated with honors from FSU. I had a good job and made a good life for myself and my four children. Life isn't fair. We've got to stop giving in to the poor, pitiful me syndrome. People need to get their brains right and --

A VOICE: Thirty seconds.

MS. MCPHERSON: -- get straight. Government has no business funding these things. Our elected governor has authority to make this rule, which should be upheld. Please support our governor's rule. Thank you.

(Applause.)

A VOICE: I'm going to get this first name wrong, but I think it's Marjorie Caulkins.

MS. CAULKINS: Hello, my name is (inaudible) Caulkins and I am from Milton, Florida, and I came in support of the ban of Medicaid funding for transgender surgeries and treatments.

I believe that Floridians do not need our taxpayers' money to be spent in this funding of surgeries that are both unnecessarily and tremendously harmful.

As a mother of two, I believe there is a war on our children and we need to stand on the right side of this war and protect our children, support our Governor DeSantis. We are blessed with our governor, and I think we should be on the right side and support this rule and ban Medicaid funding for transgender surgeries.

Thank you so much, and thank you for your service.

(Applause.)

A VOICE: James Caulkins.

MR. CAULKINS: Hi. I'm James Caulkins from Milton, Florida, and I just want to say we really need this rule passed to support Rule 59G-1.050 to

ban Medicaid funding for transgender surgery and treatment.

We are in a battle in this country, and I'd like to thank all the people who showed up today, because your voice matters. Our state -- the people have spoken. They elected the greatest governor in the United States, Ron DeSantis. They put Republicans in office in this state to stand for what's right, and this rule change is what's right.

We don't need this stuff, this evil, this Medicaid funding for transgender surgery. We don't need this in our state of Florida. We need to lead in Florida, we need to lead the other states in Florida against this evil transgender surgeries.

So please pass this rule. Thank you all so much for your public service and God bless the state of Florida. Thank you.

(Applause.)

A VOICE: Tuana Aman.

MS. AMAN: Thank you for the opportunity for us to be here. I am in support of the ban to the Medicaid funding for transgender surgeries and treatments. And let me say that years ago, I was told that I needed to go on hormone therapy, and I

had one doctor tell me that it was the right thing to do, but as I did more and more surg- -- more and more study and research, I saw the risks involved to hormonal therapy. And when someone tries to tell you there isn't any risk to these kinds of procedures and these kinds of things that are happening to young people, to young kids -- I mean, I'm an adult who's fully developed, right, as a human being now, right, and they say 25 generally, look at these kids and their development, the process.

And what I think is even more sad is that they're born like the young girl with a certain amount of eggs that will be released every month from the time she starts puberty, and here we're trying to prevent those natural things from occurring and expect it not to have any problems.

I was watching Bill Mayer, which he's not a favorite of conservatives, right? And he came out a couple of weeks ago and was slammed by the LGBT community because he said, "Isn't it interesting" -- and this is him, right -- "Isn't it interesting that if you look at Los Angeles and New York and Miami and all these different hubs, that's where this transgender service -- these surgeries

are going on, the focus," and he got slammed. They said they wanted him off the air, and, I mean, he had -- they had a campaign against him --

A VOICE: Thirty seconds.

MS. AMAN: -- because it was focused on the fact that he was just saying, "Isn't there something ironic about the fact that you look at the rest of the country and these things aren't going on, and then you look at these hubs where social engineering is happening and where people are being influenced that I" --

A VOICE: Fifteen seconds.

MS. AMAN: -- "can't go out into the media and say anything against transgender, because what will happen? I will be criticized and condemned." It isn't fair. I think it's right to be here and have the opportunity to give our voices, but I believe that the government should not be involved in supporting any --

A VOICE: Time. Please wrap up your comment.

MS. AMAN: -- kind of procedure for these young kids. Thank you. Amen.

(Applause.)

A VOICE: Jason, do you have a follow up?

A VOICE: Just very quickly. We appreciate

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil