

Jane Doe

vs.

Joseph Ladapo

Taped Transcription

Tab 26 and 39



Med Def_001485

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAPO,

6 Defendant.

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TRANSCRIPTION OF AUDIO RECORDING

13

FLORIDA BOARD OF MEDICINE

14

TAB 26 AND 39

15

GENDER DYSPHORIA DISCUSSION AND

16

PETITION TO INITIATE RULEMAKING

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TRANSCRIBED AUDIO RECORDING BY:

23

Julie Thompson, CET

24

25

Job No.: 322529

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

4 *****

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 First, I want to welcome all of our guests

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

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

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

15 Dr. Carnes (phonetic)?

16 DR. CARNES: No.

17 CHAIRMAN DIAMOND: Dr. Ackerman?

18 CHAIRMAN ACKERMAN: No.

19 CHAIRMAN DIAMOND: Ms. Justice?

20 MS. JUSTICE: No.

21 CHAIRMAN DIAMOND: Dr. Wasylik?

22 DR. WASYLIK: No.

23 CHAIRMAN DIAMOND: Dr. Vila?

24 DR. VILA: No.

25 CHAIRMAN DIAMOND: Dr. Chandra?

1 DR. CHANDRA: No.

2 CHAIRMAN DIAMOND: Dr. Pimentel.

3 DR. PIMENTEL: No.

4 CHAIRMAN DIAMOND: Dr. Pages?

5 DR. PAGES: No.

6 CHAIRMAN DIAMOND: Dr. Derick?

7 DR. DERICK: No.

8 CHAIRMAN DIAMOND: Dr. Hunter?

9 DR. HUNTER: No.

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

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

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

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

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

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

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

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

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

8 At this point, I think we should commence.

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

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

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

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

21 UNIDENTIFIED FEMALE: We can't hear.

22 UNIDENTIFIED FEMALE: We can't hear you.

23 CHAIRMAN DIAMOND: Is the mic on, sir?

24 SURGEON GENERAL LADAPO: Okay. All right.

25 Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 CHAIRMAN DIAMOND: Thank you, Mr. Wilson.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 related care to any child or adult.

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

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

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

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

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

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

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

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

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

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

25 So while the State has used exceptional

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

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

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

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

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

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

25 In closing, I ask you to uphold the

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

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

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

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

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

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

17 CHAIRMAN DIAMOND: Mr. Tellechea says no.

18 UNIDENTIFIED MALE: Okay.

19 ATTORNEY TELLECHEA: Not yet.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 DR. VAN METER: That's correct.

2 CHAIRMAN DIAMOND: Just gender dysphoria,
3 correct?

4 DR. VAN METER: That's correct.

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

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

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

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

5 CHAIRMAN DIAMOND: Thank you so much.

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

15 CHAIR ACKERMAN: I resemble that.

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

23 DR. HALLER: Very much so.

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

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

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

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

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

1 DR. HALLER: Correct.

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

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

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

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

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

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

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

1 establish that age cutoff?

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

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

11 DR. HALLER: That is correct.

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

14 DR. HALLER: That's my understanding.

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

20 DR. HALLER: Correct.

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

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

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

3 CHAIRMAN DIAMOND: Okay.

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

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

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

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

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

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

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

25 CHAIRMAN DIAMOND: So will you --

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

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

8 DR. DAYTON: No, sir.

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

11 DR. DAYTON: Yes.

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

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

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

1 DR. DAYTON: Yeah.

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

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

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

13 DR. DAYTON: Assent, yeah.

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

18 DR. DAYTON: Yes. That is common.

19 CHAIRMAN DIAMOND: It is common?

20 DR. DAYTON: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 You were kind enough to share with me a

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

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

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

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

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

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

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

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

16 DR. DAYTON: Right.

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

20 DR. DAYTON: Yeah.

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

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

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

5 DR. HALLER: I agree. I concur.

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

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

12 Dr. Wasylik, please.

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

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

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

3 DR. HALLER: No, sir.

4 DR. WASYLIK: Okay.

5 DR. HALLER: Not me personally.

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

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

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

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

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

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

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

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

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

23 DR. WASYLIK: Thank you so much.

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

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

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

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

17 DR. DAYTON: You guys are the best.

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

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

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

17 Any other questions?

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

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

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

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

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

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

5 CHAIRMAN DIAMOND: Further discussions?

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

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

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

23 DR. HALLER: I don't.

24 DR. CAIRNS: Why?

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

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

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

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

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

19 DR. DAYTON: One of the issues.

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

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

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

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

21 DR. HALLER: Yeah --

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

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

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

18 Any other comments? Dr. Vila?

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

1 DR. DAYTON: Yes.

2 DR. HALLER: Yes.

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

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

9 DR. VILA: So it's retrospective.

10 DR. DAYTON: Yeah.

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

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

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

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

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

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

6 DR. VILA: I know that.

7 DR. HALLER: And I would think --

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

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

19 DR. DAYTON: Yeah.

20 DR. VILA: It's there.

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

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

25 DR. DAYTON: Yeah.

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

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

15 Thank you so much.

16 DR. HALLER: Thank you.

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

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

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

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

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

7 UNIDENTIFIED MALE: We'd like to go.

8 UNIDENTIFIED MALE: Here we go.

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

11 UNIDENTIFIED MALE: (Indiscernible)

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

15 Good afternoon.

16 RUTH VELINAIZO: I am support. Thank you.

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

20 NAKORA KATAKO: I'm in opposition.

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

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

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

3 CHAIRMAN DIAMOND: Thank you.

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

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

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

21 CHAIRMAN DIAMOND: Thank you.

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

24 UNIDENTIFIED MALE: Okay.

25 CHAIRMAN DIAMOND: Tywin (phonetic) from

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

3 Good afternoon.

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

12 CHAIRMAN DIAMOND: Thank you.

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

15 Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

11 CHAIRMAN DIAMOND: Thank you.

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

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

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

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

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

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

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

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

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

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

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

1 process.

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

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

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

1 Thank you.

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

4 REPRESENTATIVE ESKAMANI: Absolutely.

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

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

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

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

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

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

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

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

24 REPRESENTATIVE ESKAMANI: Correct.

25 CHAIRMAN DIAMOND: But again, my

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

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

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

14 REPRESENTATIVE ESKAMANI: Thank you.

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

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

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

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

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

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

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

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

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

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

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

16 CHAIRMAN DIAMOND: Thank you.

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

19 Next is Gianna Cook from Palm Beach
20 Gardens.

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

22 CHAIRMAN DIAMOND: That's fine back there.

23 Good afternoon.

24 GIANNA COOK: Can you hear me?

25 CHAIRMAN DIAMOND: Yes -- not really.

1 GIANNA COOK: Maybe up there. Yes.

2 CHAIRMAN DIAMOND: Good afternoon.

3 GIANNA COOK: Hello.

4 CHAIRMAN DIAMOND: Yes.

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

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

1 persistence in that is highly illogical.

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

8 CHAIRMAN DIAMOND: Thank you.

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

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

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

17 CHAIRMAN DIAMOND: Sure.

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

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

22 Hello.

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

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

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

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

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

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

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

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

5 CHAIRMAN DIAMOND: No, talk to me.

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

9 CHAIRMAN DIAMOND: Thank you.

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

13 Good afternoon.

14 KIRK HOBSON: Hi, afternoon. My name is
15 Kirk Hobson Garcia, and I am the proud parent of a
16 transgender male. I like to start with a quote
17 before I ease into my own words on the topic.

18 "Include everyone, no matter their gender, sexual
19 orientation, race, or religion. We are all human
20 beings. We are part of the society."

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

1 its deep pain and struggle.

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

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

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

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

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

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

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

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

18 CHAIRMAN DIAMOND: Thank you very much.

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

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

25 DENNIS CONKLIN: Thank you. Dennis

1 Conklin, 4581 Northwest Sixth Court Plantation.

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

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

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

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

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

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

1 a left knee?

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

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

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

17 CHAIRMAN DIAMOND: Thank you very much.

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

19 CHAIRMAN DIAMOND: Thank you very much.

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

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

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

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

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

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

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

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

25 And we know that if we provide people with

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

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

9 CHAIRMAN DIAMOND: Thank you very much.

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

15 So, Scott Powell, you are next.

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

20 Go ahead, sir.

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

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

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

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

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

25 If we look at the petition details, we

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

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

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

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

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

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

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

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

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

1 Christian Family Coalition Florida Bar Association.
2 That will then be followed by Jo Staziaki
3 (phonetic).

4 OSA FIGUERIS: Good afternoon.

5 CHAIRMAN DIAMOND: Good afternoon.

6 OSA FIGUERIS: I want to clarify that I am
7 a member of the Florida Bar Association, but I am
8 not here on behalf of the Florida Bar Association.
9 I want to be clear on that.

10 I have been practicing as an attorney for
11 about 25 years, and a portion of the years that I
12 practiced, I did medical malpractice defense work.
13 And frankly, if I had a client come to me with an
14 issue or a complaint was brought in this area, I
15 would be concerned right now, because at the
16 beginning of the statements that you all made, you
17 said that you were vociferously apolitical. And I
18 know that your oath says, as opposed to mine, it
19 says, "Do no harm." And doctor --

20 CHAIRMAN DIAMOND: We're vociferously
21 apolitical as a board. We each have our own
22 (indiscernible), of course.

23 OSA FIGUERIS: Understood. Understood. And
24 then in listening to Dr. Haller, he himself
25 admitted, during one of the statements that he made,

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

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

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

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

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

7 JO STAZIAKI: Can you hear me? Okay.

8 CHAIRMAN DIAMOND: Go ahead, please.

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

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

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

17 CHAIRMAN DIAMOND: (Indiscernible)

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

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

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

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

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

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

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

8 CHAIRMAN DIAMOND: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 BETHEL FARGO: Could I please finish --

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

1 Thank you.

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

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

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

21 CHAIRMAN DIAMOND: Thank you very much.

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

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

1 going to take some more public comments.

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

5 (END OF AUDIO RECORDING)

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CERTIFICATE OF TRANSCRIPTIONIST

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

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

Julie Thompson

Julie Thompson, CET-1036

<hr/> 1 <hr/>	18-year-old 72:25	250 37:8	93:15
10 30:14,22 68:8	1970s 28:3	26 2:6,8	60 62:11
100 24:17,20 71:22	1980 29:6	<hr/> 3 <hr/>	60s 88:8
11 80:4	1990s 51:24	39 2:7,12	66 28:14
12 41:6 68:10	1993 29:8	<hr/> 4 <hr/>	67,000 32:18,21
120,000 30:25 32:8	<hr/> 2 <hr/>	40 93:22	<hr/> 7 <hr/>
13 41:6 44:8	2 2:10	42 26:25	70 90:15
14 39:17	20 21:8 30:16 57:25 64:17 73:8 93:14	4581 81:1	70s 88:8
15 39:18	200 20:10 27:21 58:6	47 66:20	75 37:7
150 7:10	2000 2:10	48 21:9	<hr/> 8 <hr/>
16 24:7,21 38:25 39:13 40:16, 22	2007 28:11,13 29:18	481 37:24	80 32:24 90:15 93:18
17 38:12,25 63:20	2013 79:12	4:45 7:12	80s 88:9
17-year-old 38:13	2018 66:23	<hr/> 5 <hr/>	82 93:19
177 37:23	2022 2:10	5 24:18	86 37:22
18 20:19 24:8, 10,19,24 38:4,24 72:23 74:9 91:2 93:15	21 91:3	50 37:6 39:9 87:25	<hr/> 9 <hr/>
	22 63:17	50s 88:8	90 23:7
	25 89:11	<hr/> 6 <hr/>	90s 88:9
		6	9:31 81:19

A	52:14 66:25 70:25 71:8 72:10 75:16	action 35:7 92:8	admitted 89:25
AAP 50:10	acceptable 26:8	actions 21:25 34:12 41:20 67:8	adolescent 54:9 79:4
AB 7:4	accepted 14:14,18 53:10 68:22 79:15	active 12:1	adolescents 2:11 22:1 23:17 24:14 54:11 86:13
ability 12:23 18:18 42:10	accepting 29:2 38:20	actively 44:3 63:22	adopt 15:4,18 55:15
abrogation 72:5	access 26:4 29:19 45:10,11,12 56:14,16 81:5 86:17	actual 30:9 81:9	adoption 15:12
abruptly 63:24	accessing 69:6	addicted 64:14	adrenal 34:22
absence 44:2	accurate 40:10	addition 12:8 23:24	adult 23:1 73:17 82:15 84:21
absolute 18:18 43:13	accurately 51:5	additional 9:10 28:15 55:16 60:11 87:2	adulthood 79:5
absolutely 29:22 41:2 70:4 93:2	Ackerman 5:17,18 36:11,15 76:13,18	address 4:24 7:15 81:3	adults 12:24 15:9 22:1 54:9 69:4 86:13 87:4
absurd 22:21 54:1	Ackerman's 38:17	addressed 87:7	advanced 52:1
abundant 65:13	acknowledge 9:10,12 13:10 21:23 45:7 53:19 54:2,18	adds 12:25	advances 36:18
abuse 65:21 74:6	acknowledged 68:1	Adeline 72:15,16,17	adverse 32:2 90:25
abyss 64:2 65:16	acne 79:4	adequate 55:23	advice 29:12
academician 31:18	Act 15:21	adequately 21:5	advisors 22:20
Academy 20:20 25:15 32:17		Administration 10:4 14:12	advocate 85:12 86:2,6, 18 88:3
accent 73:7		Administrative 15:21	affect
accept 7:14,16,21 19:10 26:15		admit 21:24	

12:2	18:15 86:18	31:6	appearance
affiliated	agency	AMA	3:23 30:8
82:22 88:25	10:3 14:11,12	49:8	apply
affiliation	18:6 86:1	America	3:15 29:21
61:19 62:7	agenda	73:8	appointed
63:1,14 80:22	3:18 68:7	American	3:5 21:19
affirm	ages	20:20,21	appreciative
28:5 75:6	41:20	25:12,15,21	27:11
affirmation	agree	32:17 53:7	approach
32:19,20	48:5 50:10	73:13	5:7 19:9
affirmed	58:19 59:9,21	Americans	38:16,17 90:8
63:25 64:7	75:7 76:24	73:19 81:8	approached
affirming	agreement	amount	44:16
21:11 24:5	17:7 19:5	65:6	approaching
25:5 68:25	42:17 43:21	analogy	7:7 44:19
92:14	agriculture	25:8 53:13,15	appropriately
affliction	85:14,22,24	analysis	24:14 47:3
64:1	AHCA	20:15	approved
Africa	14:16 22:3,8	analyzing	33:7
52:4	69:19	58:8	April
afternoon	ahead	anatomic	14:6
2:18 13:24	13:21 17:1	42:3	area
61:15 63:3,4,	50:18 82:23	ancestry.com	12:13 43:18
15,16 72:19,	85:20 91:8	73:20	45:6 89:14
20 73:24	Alan	Anna	argue
74:23 75:2	80:23 82:20,	66:13,19	34:8
78:13,14	24,25	anti-	assent
82:24 85:21	alarmingly	69:11	42:12,13
89:4,5 93:11	76:25	anti-trans	81:17
age	Alejandro	22:19 68:12	assertion
24:7,8,10,21,	46:2	anxiety	21:4 22:11
24 30:19 38:4	Alexander	91:10	assess
39:1,4,5,13,	72:16,17	apolitical	52:11
16 40:22	alive	5:4 21:18	assessed
41:3,14,23,24	66:4 93:21	89:17,21	51:5
65:10 73:18	allowed	apologize	assessment
74:9 80:4	29:19	91:9,19	13:15 42:9
91:2	allowing		
agencies			

assessments 84:3	attempting 71:15 92:5	12,22 79:8 82:18	bathroom 47:25
assiduously 56:24	attempts 85:3	background 5:2 20:12 23:10 27:4	bathrooms 46:6
assignment 23:7 59:10 78:24 90:2	attend 57:13	backgrounds 25:7 84:23	Beach 74:19
assimilate 74:1	attendees 33:7	bands 46:7	bear 73:3
assimilated 73:18	attention 17:10	banned 31:11	beautiful 79:10
associate 48:14	attitude 90:11	banning 71:14	began 14:12 30:23 63:20,23 65:13
association 16:20 20:22, 23 83:2 85:19 89:1,7,8	attorney 13:23 26:19 47:2 70:18 89:10	Bar 85:19 89:1,7, 8	begin 2:15 7:23 16:9 73:10
association's 20:24 25:17	attribute 53:8	barbaric 77:3,10	beginning 81:18 89:16
associations 48:18	attributed 65:20	Barsky 80:24 82:20, 24,25	behalf 4:9 83:3 86:6 89:8
assume 39:22 56:9	audience 4:17	Barsoum 25:13	behavior 8:6
assumed 30:6	audio 2:3	based 4:5 10:17 12:16,20 40:23 41:16 42:7 45:2,21 48:22 49:9 56:14 76:4 88:14,17 90:19 93:6	behoove 19:3 57:1
assurance 57:15	author 46:4	basic 7:13	beings 78:20
assure 57:7 88:1	authority 18:15	basically 49:8 81:14 82:11	belie 34:17 36:25
Atlanta 26:24	authorized 7:15	basis 27:12 28:1	beliefs 52:12
attached 14:19	aware 25:2 77:12 91:22		believes 16:25
attacks 21:16 87:8	<hr/> B <hr/>		bell 67:25
attempt 93:4	back 33:3 51:24 52:25 74:7,		Belle 66:22

beneficial 32:4	12:10 77:14	Bob 47:5,6	breast 24:18 52:1
benefit 11:7 31:6 56:9	bless 74:15	bodies 77:2,23	breathing 66:4
benefits 56:15 60:5,6	blind 77:21	body 12:3 18:17 34:2 70:18 72:3 73:1,13 74:2 77:7 86:10 90:12	brightest 18:2
Bennett 62:6,9	blocked 28:19	body's 27:24	bring 35:23 64:9
Bethel 93:10	blockers 11:19 14:8 15:5 20:18 23:23 24:1 37:6,21 77:19	boldness 66:6	bringing 50:7
bias 68:12	blood 77:15	bone 52:1	broad 43:2
biased 22:5	board 2:20,21,24 3:12,14,18 5:3,6,10,11 6:20 7:15,21 9:2,6,24 13:12,24 14:22 15:4,19 16:6,10,13,16 17:1,5,20,22 18:1,10,14,21 19:2,23 21:18 23:11 25:3 27:9 31:15,22 32:12 35:7,20 36:3,8 46:11 48:10 55:3,5 56:7,20,25 66:9,19 69:13 71:14 72:20 81:7 87:2,6 89:21 93:12	born 63:17 79:13 86:4 87:20	broken 77:5
big 58:24		bottom 34:13 38:5 51:22 67:25 87:8	Broomer 85:11,12,16, 17,21 88:22
bigotry 87:11		bound 16:10	brought 16:23 17:15 18:19 33:1 35:13,20 56:20 81:22 89:14
bill 69:22 70:12 71:14		boy 29:8,9 79:14	building 8:7
biologic 27:12,25 29:9 30:9		brain 12:2 27:15 77:19 84:16	burden 57:3
biology 45:17		brand 69:15	bureaucrats 18:6
birth 62:13		brave 80:4	burgeoning 28:22
bit 4:23 5:2 19:1 34:17 37:2,4 40:14 52:15 54:19 88:23 93:21		Brazil 91:16	buried 33:10
blanket 43:24	Board's 18:18	Brazilian 35:11	busy 9:3
bleeding	board-certified 26:23 29:5		butchered 91:13

butt 35:11	cards 7:3 60:24	48:20	2:5 4:22
<hr/> C <hr/>	care 2:13 5:8	Carla 91:6 93:9,11, 12	5:17,18,19, 21,23,25 6:2, 4,6,8,10
Cairns 52:18 53:13 54:16,24 55:8 60:23	9:21,22 10:1 12:12,15,21 14:4 15:4 18:16,23 20:25 21:1,4, 5,11,15,17,22 22:14,15,18, 21,24 23:1, 12,18 24:11 25:1,5,10,14, 21 26:4 29:16 32:11,15 33:14,19 34:5 35:19 36:10, 17,18,20 38:14 42:25 44:11 45:12, 20 46:3,5,9, 11 47:3,18 48:24 49:25 53:21 54:14 56:2,3,14,16 57:24 60:9 68:12,23,25 69:16 70:13 71:15 83:5,6, 9,17,20 85:1 86:11,13,21 87:12,13 88:18 91:25 92:7,14	Carnes 5:15,16	8:16,23 13:17 18:25 26:6, 17,20 33:16 35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
call 47:5,7 48:22 76:14,15	called 21:10 27:1,2 31:3 64:5	carry 78:6	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
calling 47:6	calling 47:6	case 44:4	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
calm 4:18	calm 4:18	cases 16:19 22:24 25:1 35:12, 13,18 36:3	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
cancer 36:12 52:1 84:16	cancer 36:12 52:1 84:16	causation 92:6	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
canvassed 29:12	canvassed 29:12	causing 33:22 62:20	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
capacities 16:17	capacities 16:17	cease 61:4	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
capacity 33:24 42:4 52:11 73:2 84:19	capacity 33:24 42:4 52:11 73:2 84:19	cell 34:23	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
capricious 87:10	capricious 87:10	center 24:20	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
capture 3:2	capture 3:2	centers 24:23 28:15 45:12 55:12	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
card 4:2	card 4:2	Central 69:3	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
Cardiology 25:22	Cardiology 25:22	chair 3:3 4:5 13:23 15:16 17:23 35:21 36:15 60:23 76:13 83:1 90:14	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
	careful 79:9,22	chaired 90:6	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
	carefully 31:13	Chairman	35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11
	caring 15:10 46:19		35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11 70:2,5,10,16 71:22,25 72:12,15 74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8, 11

Chandra 5:25 6:1	16 91:4 93:15	clear 2:25 7:20	Code 81:15
change 12:17 48:25 53:19 67:17 74:3 86:11	Children's 37:19	10:23 19:2,18 34:20 43:19 55:24 67:6,24 68:12 69:5, 10,20 89:9	coherent 64:15
changing 12:1 30:8	choose 53:18	chooses 22:16	coined 27:6 28:3
charged 34:2 70:6,18 72:3	chose 44:21	client 89:13	colleague 52:19
chief 6:17 19:15 20:5 36:1 85:24	Christ 65:13,24 66:5	climate 67:17,18	colleagues 29:12 45:6 46:1
child 23:1 30:4,6, 18 42:24 43:10,12,14 62:13 74:6 79:19 81:16 83:12 84:5 87:15	Christ-based 65:25	clinic 28:11 40:9 58:7	collecting 58:18
childhood 65:20 79:4	Christian 85:18 89:1	clinical 14:21 20:4 31:17,19	collective 63:2
children 2:11 14:10 15:7 17:9 20:9 22:15 23:3,5,24 24:16 28:6 31:1,6 32:8 33:25 37:6, 14,21 38:9 42:15 44:1 46:9 54:9 59:18 74:8 81:14,24 82:14 87:10, 14 90:2,9,11,	circumstances 42:15 74:2	clinician 59:9	college 19:25 25:21 64:13
	circumvent 69:21	clinicians 9:20,25 13:1	combine 12:11
	circumventing 70:15	clinics 23:18 24:15 28:22 51:10	comfortable 54:13
	cisgender 84:23	closed 31:10	commence 8:8
	citations 68:10	closing 25:25	comment 3:3,17 4:4 15:22 37:25 60:22 61:22
	citizen's 17:9	clots 77:15	commentary 22:10
	citizens 17:8 18:12	Club 63:22	commenters 14:22
	civil 4:14	co-morbid 23:18	comments 3:14,15,19 7:12 8:4,10 10:14,16 15:15 17:23 21:9 57:18
	claims 22:4	Coalition 85:19 89:1	
	clarify 56:22 89:6	coast 29:13	
	classmates 53:6		

74:18 86:9	complexity	confident	consistent
Commissioner	12:24	13:3	14:14
85:13	complications	confirming	consistently
commit	77:13 78:2	23:19	68:6
80:9	comport	conflict	constituents
commitment	37:24	20:20 25:11	67:2
59:5	concept	conform	construct
committed	27:7,8 28:2	14:17	27:13
93:23	29:20 30:3	confounding	constructing
committee	32:13 54:20	11:6	58:25
32:1,23 83:1	concern	confusing	consumed
common	67:1	11:23	93:20
18:10 42:18,	concerned	congenital	consumer
19 49:19	89:15	34:22	85:12,22
74:12,14	concerns	Conklin	86:1,6,7 88:3
communities	68:20 90:16	78:11 80:21,	consumers
88:6	concisely	25 81:1,4	86:2,8
community	34:4	82:18	contacted
50:1 87:9	conclude	connect	5:11
compared	11:7	62:20	contagion
79:12	concluded	Connections	52:24 53:25
compelled	14:16	62:7	contend
79:8	conclusion	consensus	33:24
competently	13:8 30:16	32:15	contends
12:25	43:4 93:6	consent	33:18
complaint	conclusions	12:23,25 13:5	contention
25:3 66:8	45:20 68:14	15:8 24:21	45:1 70:7
89:14	concur	30:20 31:23	contentious
complaints	48:5	39:5 42:12	5:7 67:6
28:24	condition	43:7,8 68:25	context
completely	35:16	69:7 81:14,16	9:10,11,12
11:1 12:4	conduct	84:20 92:16,	13:10
33:11 68:16	4:21 12:14	23,24	continue
75:19,21,25	46:13 56:24	consequences	26:3 74:9
completions	conducted	41:19 78:7	92:13,14 93:3
85:4	5:13	90:25	continues
complex	confidence	considered	24:3
43:1	13:13	24:6,10 84:10	

continuously 52:10	91:23 92:1	cruel 46:25 77:10	93:5
contrary 56:1	cosmetically 77:11	Cruzita 76:11	data-driven 21:5
contributing 52:21	cost 86:16	CTF 62:7	database 51:7
control 49:22 86:17	counsel 13:20 14:2 70:6	culture 73:15,16,18 74:1	date 11:3
controlled 49:11	counter 68:17	curious 35:17 57:23	dated 2:10
controlling 4:17	countries 45:18 73:16	cutoff 39:1,4 41:14	Davie 61:18 63:1
controversy 17:13 18:4	country 28:12 51:7,11 74:11	cutoffs 41:24	day 14:24 18:13 29:19 74:7 90:8
conversation 55:2	couple 16:12 34:14 36:6 53:14,15	cutting 45:15 60:2	days 8:20 9:3
conversations 3:7 21:22 56:9	court 2:23 3:1 81:1	<hr/> D <hr/>	Dayton 40:8,11,13,23 41:1,8,11,15 42:1,6,13,18, 20 43:1,18 44:12 47:10, 16,20 48:3 50:19 51:6,17 55:11,19 58:1,5,10,13 59:8,19,25
convince 73:9	coverage 21:25	daily 52:8	deal 17:3,7 18:18 78:1 84:17
Cook 74:19,21,24 75:1,3,5	COVID 29:24 30:4 52:22	damage 74:5	dealing 26:25 30:11, 12 81:13 82:14
Coral 61:14	create 58:15 71:20	dangerous 67:4 68:24 87:5	deals 82:6
core 49:22	created 18:1	data 10:10,18 12:17 13:9 21:3 23:5 28:7 30:16 31:5 35:23 37:18 45:14, 16 49:20 50:3,5 52:4, 14 55:23 58:8 59:12,13,15, 17 60:5 68:6 87:24 88:1,19	dealt 62:16
correct 34:25 35:1,3, 4 37:12 38:1, 7,8 39:10,11, 13,19,20 41:10 43:17 70:24 71:24	criticize 50:12		
correctly 41:22 81:17	critique 49:15,16		
correlation			

death 12:10	64:2 67:1 77:1 79:1,3	25 18:10,14, 17 20:16	77:11
deaths 35:10,14	80:4 90:20	35:24 68:5,9, 15 70:14	desire 90:12
debate 34:7	defense 89:12	71:17,19 85:13,22 86:9	desires 3:25
decades 53:16	define 90:6	Department's 14:3,24 18:22	detail 90:22,23
decide 57:15 75:14 76:6 83:13	defined 25:21	departure 10:5	details 86:25 87:1
decided 6:12 18:5 64:17	definitively 60:4	dependence 77:25	determine 14:13 72:25 87:12
decider 67:20	degree 20:3 58:24,25 91:20	dependent 36:19	determined 14:17
decides 7:21 56:25	delegated 17:24 18:17	depending 93:18	determines 73:7
deciding 64:22	delivered 45:21	depends 43:20	detransition 64:22
decision 18:9 43:5 45:1,5 57:2 65:18 72:9 88:13	delivery 45:9 60:7	depression 74:5 80:6	detransitioner 66:6
decisions 34:1 42:4 43:9 76:4 78:3,6 84:3, 5,13 87:12 88:16	demonstrated 22:12	depth 44:20	detransitioners 65:24
deck 76:16	demonstrates 33:5 77:1	Derick 6:6,7	detransitioning 63:18
decline 57:4 62:1	denials 67:18	Desantis 10:3	develop 49:2,8,21 66:1
decorum 4:19	denied 86:23	descent 73:21	developed 28:2 34:6 48:16,18,19 50:7
deep	Dennis 78:11 80:21, 25 81:4 82:18	descriptive 50:3	developing 49:7
	denying 87:12	deserve 22:9 53:21	development 12:2 20:7 34:22
	Department 10:2 13:21 14:2,6 15:3, 24 16:23,25 17:11,15,17,	deserving 79:23	devices 3:10
		design 31:24	
		designed 34:15 69:21	

diagnosed 23:19	74:16,22,25 75:2,4 76:8, 17,20 78:5,9 80:10,18,21 81:2 82:17,19 85:9 88:19,24 89:5,20 91:5, 8,12,17 93:8	disciplined 48:1	disqualified 22:23
diagnoses 21:3 49:20		discomfort 78:23	distance 8:14
diagnosis 49:19		discourse 4:15	distinct 18:15
diagnostics 84:3		Discovery 82:22	distinguished 72:20
dialogue 16:19 57:20	Diaz 46:2	discredit 22:21	distress 78:23,25 79:2
Diamond 2:5 4:22 5:17,19,21, 23,25 6:2,4, 6,8,10 8:16, 23 13:13,17 15:16 17:23 18:25 25:9 26:6,13,14, 17,20 33:16 35:2,5 36:5, 16,24 37:17 38:2,10,18,23 39:7,12,15,21 40:3,6,11,21, 25 41:5,9,12, 21 42:2,10, 14,19,21 43:11 44:6,14 45:22 47:7,8, 14,17,21 48:6 50:24 51:14, 18 54:5 56:18,22 60:13,17 61:9,12,17,21 62:3,21,25 63:12 66:11, 17 70:2,5,9, 16 71:22,25 72:12,15	differ 78:24	discredited 22:6	district 66:14,20
	difficult 52:2 91:10,13	discrimination 86:3	divided 60:24
	dig 80:4 90:23	discriminatory 21:7 86:24	divorce 43:21
	dignity 68:3	discuss 7:25	doctor 47:8 65:1 76:6 81:20 89:19
	diligence 18:7	discussed 79:15	doctor's 92:24
	direct 20:19	discussing 10:24 11:12 16:14	doctor-patient 26:1
	directly 16:23	discussion 2:8 6:23 10:18 17:5 26:16 43:3 54:3 57:6 69:8 83:13	doctors 21:10 25:13 26:3 43:6 51:1 67:9 84:14,15,17, 22 90:10
	director 2:17,20 40:9	discussions 54:5	document 56:6
	disadvantage 8:14	disorder 34:24	DOH 69:19 70:11 71:6
	disagree 43:19,24,25 50:9	disorders 34:21	double 21:6 64:12
	disagreeing 44:3 72:7	display 90:12	doubt
	disagreement 17:4 42:17 69:9		
	disciplinary 16:19 35:13		

56:10	Eastern	elects	13:1
drink	73:21	19:2 46:22	enrolled
91:2	economy	encourage	58:4
drugs	85:24	21:15 51:15	enter
64:3,15	edge	57:12 59:16	19:3 34:3
DSM-5	45:16 60:2	encouraged	35:25 56:25
90:6,15	Edgewood	90:13	57:7
due	66:22	encourages	enters
18:7 64:1	edict	3:13	87:5
67:7	31:11	encouraging	entire
duly	educate	40:19	31:19
2:21	86:1	end	entities
duty	educating	7:11 14:24	44:23
9:20 17:24	88:5	17:6 18:13	entitled
50:4	education	56:11 82:3	2:8
dysphoria	62:10 79:9,22	endocrine	entry
2:11,14 14:5,	effective	20:21 51:9	15:12
10 15:2,7	11:2 15:1	57:9	epidemic
16:4 18:24	effectiveness	endocrinologist	30:12 35:8
22:2 23:4,20,	10:24 11:1,15	26:24 29:6	66:2
21 35:2,20	effects	endocrinologist	Ernie
52:21 53:9	12:3,7 23:25	s	72:18,19
63:21 64:6	64:20	23:22	73:12
65:19 78:21	efficacious	endocrinology	err
82:9 90:7,11	33:5	6:18 19:15	91:1
dysphoric	efficacy	20:3,5,14	erring
20:19	22:13 28:9	23:15 29:5,13	92:13
<hr/>	31:16	ends	erupted
E	effort	48:6	28:14
<hr/>	69:15 70:14	energy	escorted
earlier	elaborate	9:7	8:7
65:16 67:5	11:23 19:1	engage	Eskamani
68:4 75:9	Elaine	16:21	66:13,16,20
earliest	62:4	engineer	70:4,9 71:4,
92:7	elected	79:10	24 72:6,14
ease	66:22 67:8	engineering	espoused
78:17	electronic	68:16	33:19 42:15
easily	3:10	enormous	
73:9			

esquire 72:16	event 32:2	existing 86:11	14:23 27:9 65:1 93:22
essential 7:6 19:17	evidence 10:10,17 14:25 16:3	exists 11:13	explanation 27:17 54:7
essentially 7:1 33:8	21:1 22:17 48:23	expand 15:15 57:19	explicitly 44:13
establish 20:13 21:2 39:1 91:23 92:1,5	evolved 10:13	expect 17:3,6 78:8 84:17	express 23:6
established 20:25 23:11 29:16 49:25	exact 18:1 39:24	expectation 4:14	extended 4:5
establishing 60:9	examinations 84:2	experience 11:10 26:25 30:21 45:14 48:20,23 49:7 52:6 57:21 63:20 66:18 67:11 68:21 90:14	extent 4:18
establishment 71:10	examined 27:22		external 9:18 22:20 65:21
Esteemed 19:23	examples 83:10		eye 10:23
estradiol 37:7,23	exceptional 24:25	experienced 78:25 79:3	<hr/> F <hr/>
ethical 13:1	excuse 21:8 70:2	experiences 63:19 66:7,9	facade 33:12
ethics 83:1,4	executive 2:17,20	experiencing 64:25	facilitate 3:24
euphoria 82:10	exercise 18:7	experiment 32:7	fact 24:1 50:14 68:7,10 72:7 73:11 82:14 92:13
Europe 30:13,15 31:2	exhumed 27:22	experimental 14:25	factors 45:2 52:21,22
European 30:21 73:20, 21	exist 33:12 53:18 54:14 67:16, 20	expert 20:13	faculty 27:5
evaluated 31:4	existed 53:17	expertise 23:14 48:21	fad 67:24
evaluates 9:21	existence 28:12	experts 7:25 22:6,20, 22 48:19 50:7 56:5	fair 36:22 41:7 42:5 49:15 56:25 61:5
evaluation 10:18 23:13	existentialism 75:12	explain	

fairly 7:4	feeling 64:6 78:22	36:7	10:4
faith 18:18	feelings 5:6 9:14	fitting 82:16	focusing 5:7
faithfully 19:11	Fellowship 20:3	flabbergasted 29:10	folks 48:21 50:12
fall 12:13	female 8:21,22 54:6	flaws 22:7 33:20	53:20 68:2
falls 12:20	fertility 12:7	floor 6:23 15:14	90:9
false 22:4,13	fight 79:8	Florida 2:20 3:12 5:5	follow 51:21 54:7
falsehoods 21:14	Figueris 85:18 88:25	7:7 13:20	force 17:14
familiar 12:9	89:4,6,23	14:2,5 16:5	forces 49:21
families 43:3 87:9	Figueroa 85:18	17:1,8 18:12, 24 19:16,25	forefront 16:13
88:16	filing 66:8	20:1,2 21:22	foreigner 79:5
family 84:4 85:19	fill 4:1 6:25	24:16 25:2,4, 10 37:5 38:3, 12 44:7 46:19	forgive 78:22
89:1	65:16	54:17 56:5	form 31:23 77:10
fat 35:11	find 15:10 28:17	57:2,25 61:18	formal 40:2 51:3
faults 79:24	53:14 56:4	62:6 63:1	66:8
favor 47:6	62:11 64:23	66:7,9 67:3	formally 58:15
favoritism 10:8	65:24	68:8,11 69:3, 11,21 80:22	forms 3:23
FDA 77:18	findings 27:18	81:6 85:13, 19,22,25 86:4	Fort 62:4 93:10
fear 80:13	fine 74:22 81:5	87:5 89:1,7,8	forum 32:25
feel 13:3 39:4	Finland 31:9 44:18	Florida's 68:15 85:24	forward 29:6 31:12,25
54:25 77:2	45:6	86:5	32:1,10 55:9
	fire 65:2	Floridian 87:23	69:9 82:13
	firstly	Floridians 76:5 86:8,19	found 27:20,21 29:6
		88:14	
		focus 8:2 87:1	
		focused	

31:5 68:10		29:21 30:4	12:14 14:14, 18
Fourth	<hr/> G <hr/>	32:9 35:2	genetic
24:3	gained	45:12 46:7	27:15
frankly	64:18	52:21 53:9	genital
22:21 47:1	gallery	54:12 56:2	24:9,23 77:10
89:13	74:18	62:13 63:8,20	genuinely
fraud	Galvin	65:19 78:18, 21,24 79:24	63:5
86:2	63:13,14,16, 17	83:21 84:7	Georgia
free	gamble	90:2,7,11	26:25 52:20
74:10	77:20	gender-	gestalt
freedom	game	21:10 22:25	40:1
26:4	57:13,14	24:4 25:4	Gianna
frequent	80:12	68:24	74:19,21,24
77:16	GAPMS'	gender-	75:1,3,5,19, 24
friend	22:8 56:6	affirming	giant
73:11	Garcia	20:25 21:4,5, 15,17 22:12, 15,18,24	32:7
friendship	76:21 78:10, 15	37:15 56:2	girl
80:7	Gardens	63:23 68:11	79:13
front	74:20	70:13 71:15	give
13:4 26:12	gather	83:5,15,17, 18,20 85:1	4:23 15:21
48:11 56:20	18:2	86:12 91:25	39:21 42:12
fulfillment	Gators	92:7	56:9 80:16
64:10	19:21	gender-neutral	81:16,17
full	gave	46:6	giving
13:12 18:18	21:9 79:7	general	19:19 49:10
19:19 20:12	gay	2:9 6:12	53:23 57:15
24:21 35:22	53:4	8:12,18,24	86:8
39:5 42:11	gender	13:20 14:1	gluteal
84:2	2:11,14 14:5, 10 15:2,7	21:13 37:16	35:11
fully	16:4 18:24	43:11 55:22	goal
32:19 45:4	20:19 21:22	56:3 63:6	18:11
51:11	22:1,4 23:4, 7,17,20,21	72:21 90:19	God
function	24:3,15 27:7, 12,24 28:1,6	91:23	65:9 74:15
85:25		general-neutral	good
future		47:25	2:18 13:24
12:8,17		generally	61:15 63:3,4,

15,16 72:19 74:23 75:2 76:10,18 78:13 82:24 85:21 89:4,5 93:11	grievance 81:20,22	16,17,25 49:7,9,13,21 50:6,12 54:17,19,21 55:10,14 71:13	28:10 29:1 32:22
governed 31:14	groomers 69:16	gun 82:10	happiness 91:24
government 31:8,9,11	gross 23:4	guys 9:3,14 51:17	happy 75:5 85:2 88:2
governor 10:2 21:9,20 69:24	group 4:8,9 18:6 50:11	<hr/> H <hr/>	hard 9:4 43:2 56:8 61:13 90:21
grabbed 80:6	groups 23:14	half 57:13	harm 31:5 33:22,23 66:25 82:4,7 89:19 90:18 91:2
grades 80:7	growing 66:2	Haller 6:17 19:12, 15,20,22,24 36:6,23 37:12 38:1,8,15,19 39:2,11,14, 20,24 40:4,8 45:3 46:25 48:5,13,17 49:3,5,14,18 52:19 53:12 54:10,16,23, 25 55:17,20 56:18,21 58:2 59:4,7,21 60:1,16 89:24	Hatred 87:11
graduate 19:25	guardian 84:21	handed 7:3 53:15	heal 65:22
grandmother 93:13	guess 52:5 57:19 59:2 90:5	handling 2:7	healing 65:24
grant 18:21	guests 4:25 48:11 74:17	happen 7:2,11,22 11:4,25 31:13 80:20 81:11	health 10:2 13:21 14:2 16:25 18:11,14 20:23 23:18 35:24 41:18 44:18 45:21 62:2 67:2 68:5,9,15,20 71:17 83:25 86:16
granted 15:19	guidance 14:7 15:9	happened	Health's 20:16 86:10
grants 20:10	guide 40:5		health-based 91:21
great 8:18 17:3,6 58:20 67:3 90:21,22	guideline 32:24 40:23 55:16		healthcare 10:3 14:12 17:8 45:8,10,
greatest 80:13	guideline- making 42:8		
Greg 76:20,21,23 78:6	guidelines 3:15 20:8,20, 24 32:16 39:3 40:24 41:10, 13,22 48:14,		
grew 53:1 87:18			

11,19 60:7	high-level	53:2	human
63:6,11 74:6	87:1	honestly	12:3 41:17
83:24 85:6	highlight	72:24 76:3	78:19
86:7,8,15,20	87:7	honored	humbling
87:16 88:17	highlighted	86:5	66:18
93:25	16:8	hope	humility
healthy	highly	56:23	20:13
85:5	4:18 21:23	hopeful	hundred
hear	22:5 76:1	32:4	53:14
8:15,21,22	Hippocratic	hoping	Hunter
44:14 62:12	82:4	65:10	6:8,9
71:7,20 74:24	Hispanic	Hopkins	hurt
91:7	73:6,7,10,12,	27:4 37:19	79:3
heard	13,21,22,23,	Hopson	hyperplasia
82:9 88:18	25 74:1	76:21	34:23
hearing	history	hormonal	hypoplasia
71:21 82:25	29:3 36:4	11:22 30:18	34:23
heart	64:1 69:11	77:25	<hr/>
64:2 65:15	hit	hormone	I
73:23 77:5	30:4	11:18,19 14:8	<hr/>
88:10	Hobson	15:5,11 20:18	idea
heartless	78:10,14,15	28:18 29:9	29:15 39:21
47:1	80:12,19	64:11	56:13 76:18
held	hold	hormones	ideation
29:24	20:3,9 34:16	12:1 24:5	68:21 85:3
hell	80:6	37:15 92:18	identification
65:2	holding	hospital	46:7,16
helpful	81:6	27:5 93:16	identified
51:3	Hollywood	host	28:16
helps	62:6	28:15	identify
48:8	home	hours	4:8,12 73:25
hesitation	30:5 52:23	21:9 47:19	identifying
28:1	79:6	house	67:24
high	homes	80:14	identities
4:19 53:3	29:25	HRT	23:6
63:21 76:25	homosexual	69:4	identity
high-	53:17	huge	23:8,9,20
49:10	homosexuality	12:5	24:3 27:7,13,
			24 28:2 29:21

54:12 68:1 78:24 79:25	21:1 24:12	increasing 33:22	influenced 10:7
idioms 73:17	impossible 11:6 45:4 50:1	incredible 28:23 29:22	information 3:2 36:8 37:4 49:10 68:18
idiot 72:24 84:12	improperly 5:11	incumbent 7:17	informed 13:5 15:8 68:25 69:7 79:13 81:14, 16 91:19
idiots 84:14	improvement 86:17	indefinitely 23:9	ingenuous 55:1
ignore 22:17	improving 86:17	independent 31:22 32:1	inhibit 61:25
illegal 47:1	inappropriate 8:6 47:22	independently 63:18	initiate 2:12 14:4 15:18 16:6 18:22 35:16
illness 74:6	incidents 52:20	indiscernible 61:11 89:22 91:16,17	initiating 54:21
illogical 76:1	include 34:21,22 77:14 78:18	individual 4:9 11:19 38:4	input 56:25
immediately 63:24	included 66:1	individual's 11:10	insinuating 52:24
impacts 67:21	includes 66:21	individuals 10:19 11:25 28:16 29:2 32:13 34:9,21 35:19 37:7,8 38:13 41:17 46:5 51:1 62:2	insist 74:9
impartially 7:5	including 52:9 83:24 84:23 87:3	incongruent 28:6 32:9	Institute 82:22
implication 23:2	incongruent 28:6 32:9	incontrovertible 11:17	institution 38:11,25 39:19
implore 74:13	incorrect 69:17 70:8,24 72:2	indulgences 48:7	institutional 31:15
imply 39:17	increase 28:23 29:22 31:3 53:8 54:8 62:1	infection 12:9	insurance 86:16
important 2:25 9:11,12, 17,23 17:7 18:8 31:22 33:25 51:8 54:2 59:9 60:11 67:19 73:1 75:13 86:15 88:4	increased 30:12 52:20	infections 77:15,17	intellectual 84:18
Importantly		infinite 65:16	intelligent
		influence 9:19	

73:11	introduced	56:19 62:18	judges
intent	3:18	67:7 74:14	22:25
55:24	introduction	89:14 90:15	judgment
interest	13:25	92:10 93:1	79:24
3:24 76:5	investigation	issued	June
interested	15:23 20:4	14:7	2:10
3:13,16,19	investigational	issues	Justice
4:3,7,11	50:22	4:24 5:7 7:16	5:19,20
interesting	investigator	9:4 11:6 13:3	
50:25 75:9	50:16	22:9 23:19	<hr/>
interests	invite	33:24 35:9	K
56:12	7:24,25 19:20	44:19 46:12	<hr/>
interject	invited	54:12 55:19	K-A-T-A-K-O
50:24	6:16,24 19:14	64:25 69:16	61:18
internal	57:8,11	item	Karolinska
27:7	invites	3:18	44:19
international	3:12		Katakoto
20:8 40:24	inviting	<hr/>	61:18,20,23
55:14	57:9,10	J	keen
internet	involved	jeans	14:21
29:19,25	31:19 34:12	67:25	keenly
52:23	56:6 81:21	Jesus	18:6
interprofession	involvement	65:12,14 66:5	Ken
al	69:7	Jo	90:4,5
83:9	IRBS	89:2 91:5,7,	Kenotis
intervene	31:21	9,15,18	76:11,12
63:10	irreversible	job	kick
intervention	15:1 33:23	19:9	15:19
30:19 84:9	74:4 77:2	John	kid
interventions	Island	13:20 14:1	53:4
11:20	66:22	27:5	kids
intimate	issue	Johns	32:8 52:22
67:10	3:21 7:18	27:4 37:19	53:25 80:22,
intricately	9:14 10:4,11,	join	23 92:23
44:5	14,20 13:1,15	17:16	kind
introduce	17:1,7,14,20	Jones	29:16 30:18,
26:21	18:19 36:3,20	62:4,5	22 31:7 36:8
	44:15 55:18	Joseph	37:3 43:24
		2:9	45:25 47:6
			58:13 59:2

62:14 75:16	largest	84:20	licensure
81:23 82:11	24:15	Legislature	86:16
91:21	late	17:23 18:1,16	life
kinds	17:19	57:2 66:21	29:25 31:20
31:12,21	Latin	69:22 70:12,	52:9,10
Kingdom	73:8	15 71:10,11,	57:13,14 65:3
44:18	latitude	17	75:10 77:23
Kirk	19:9	Legislature's	80:7 87:13
76:21 78:10,	Lauderdale	16:21	lifetime
14,15 80:12,	62:4 93:10	lesbian	77:25
19	law	53:5	lifts
Klinefelter	70:22 87:22	letter	35:12
34:23	lawmakers	2:8 81:12	limit
knee	69:22	82:5	8:3 61:1,4
81:20,21,25	lead	letters	limited
82:1	17:12 37:11	40:19 82:3	4:3 27:14,18
knew	77:24	letting	45:14 49:20
53:16	leadership	76:7	listen
knowing	32:23,25 33:9	level	6:13 52:13
65:8	learn	10:10 11:17	87:23
	29:20 44:6	41:18,19	listening
<hr/> L <hr/>	learned	49:8,11	65:11 89:24
lack	73:17,18	Leydig	literal
42:7	Leave	34:23	65:2
Ladapo	88:15	LGBT	literature
2:9 6:12 8:9,	led	63:1,22	11:14 20:15
12,18,24	37:13 64:8	LGBTQ	22:5 48:22
13:18,25	leeway	68:20 69:12,	live
60:19	19:9	17 85:12	61:24 74:10
Ladapo's	left	86:6,7	79:14 80:8
6:14	64:12 81:20	license	85:5
language	82:1	47:12 48:2	lived
4:16 73:16	left-	licensed	29:25 73:8,
large	53:14	46:19	14,15
35:10,13	legal	licensee	lives
larger	43:19	46:22 47:23	29:21 52:8
4:7 51:7	legally	licensees	67:21 85:2
	16:10 18:14	46:5,13	92:9

living 52:10	92:10	makers 43:5	Mary 76:20,21,23 78:6
locally 51:25	lots 84:14	makes 22:4	mastectomy 24:6 39:8,18 40:16 44:9 64:12
location 36:19	love 65:13 75:6 88:20	making 3:25 10:14,16 19:18 41:13 45:5 53:22 75:13	master's 20:3 58:25
logical 64:15	loved 80:15	Maldonado 62:22,23	materials 14:20
logically 64:19 74:14	<hr/> M <hr/>	male 26:14,18 61:7,8,11 62:24 78:16	matter 32:3 52:8 73:10 78:18
loneliness 77:5	made 10:16 15:24 25:3 36:3 37:25 55:5 65:5,18 67:5 69:5 77:12,23 89:16,25	malpractice 89:12	matters 3:14,17 7:25
long 90:20	main 52:22	man 59:23 88:1	maturing 41:16
long- 58:15	mainstream 53:6	managed 44:5	maturity 64:19
long-term 28:7 58:11 59:18,21 60:5	major 22:14 58:22 75:12	mandated 16:21	Mauritania 36:21
longer 25:16 69:19 78:7	majority 23:3,5,25 24:19 33:7,8 50:10,13 90:1	maneuver 55:3	MD 2:9 93:10
longitudinal 51:4 60:4	make 4:1 33:25 42:4 43:9 48:22 52:15 57:2 61:21 67:18 72:9 73:25 76:4 80:19 83:10 84:3,5,13 88:13	manifest 90:16	meaning 75:13
looked 58:23 65:4		manner 84:5	meaningful 21:21
lose 48:1		marginalized 67:11	means 62:14
loss 77:20		mark 12:5	meant 80:17
lost 64:13		markers 27:16	Medicaid 21:25
lot 9:7,18 10:12 44:20 51:12 52:25 53:5 77:7 84:6 87:1 88:1		marrow 52:1	medical 12:15 14:14, 18 18:3 20:7 22:14 28:17

31:7 32:19,20 36:18 43:5,9 49:20 64:25 68:17 77:25 81:9 86:13,21 87:12,13 88:15,16 89:12 92:18, 22	men 13:11 24:7 74:7 mental 23:18 41:18 45:11 62:2, 15,17,18 64:1 68:19 83:25 mention 9:7 mentioned 32:17 52:20 65:16 75:9 81:17 Meter 26:10,22,23 34:19 35:1,4 44:17 50:9 methodical 7:8 Miami 37:20 46:2 63:13 mic 8:17,23 Michael 6:16 19:24 Mike 19:15 mimic 77:11 mind 9:16 19:10 minded 18:7 minds 14:21 16:14 18:3	mine 73:11 89:18 minimum 51:15 minor 12:23 30:18 43:12 minors 31:13 33:21 42:12 69:6 minutes 4:4 8:4 80:11 mirage 33:14 mirror 15:15 19:7 65:4 misinterpreted 68:13 misinterpreting 68:6 misrepresentati on 23:4 misrepresented 40:15 missing 32:5 mission 85:23 misstated 68:9 mistakes 65:5 misusing 68:6 modified 44:25	mom 87:18 moment 31:2 73:4 Money 27:5 28:3 monitoring 4:20 months 10:15 monumental 30:12 morbidity 28:25 morning 81:19 mother 88:7 93:13 motion 14:19 26:15 motivate 87:11 motivated 22:2 69:24 87:10 mouth 65:4 move 65:3 69:9 76:18 moving 31:12 32:9 55:9 MRI 27:14 multi-specialty 60:2
medically 28:5 86:12 medication 84:9 92:20 medicine 2:20 3:12 5:3 6:21 9:24 13:12 17:22 19:24 20:1 22:4 25:3,24 38:22 45:16 48:2 66:9,19 71:14 81:7 meeting 2:21,22,23 3:5,6,11,20 4:1,19,21 5:13 81:7 member 5:10,11,12 89:7 members 5:5 6:24 9:1, 20,23 13:24 17:5 19:23 32:21 48:10 72:20 members' 16:14 membership 33:9			

multidisciplinary 23:14	69:13 77:22 navigate 13:2	notably 65:20	79:7
multiple 49:9 64:14	neatly 17:13	note 39:16 87:17	occur 78:23
mutilating 65:21 74:2 77:2	necessarily 17:25 19:7 57:5 58:17	noticed 2:21 46:14	occurred 35:10,16
mutilation 73:1 77:11	needed 79:13 80:17	number 2:6,8 4:6 9:4 16:4 28:21,23 30:24 33:20 35:10,13 37:20,22,23 39:22,23 65:23 81:19	occurs 24:7
<hr/> N <hr/>	needing 58:14	numbers 27:17 34:9 37:9 39:25 40:1	odd 56:4
Nakora 61:18,20,23	neutral 46:7	nurse 93:14,15	offensive 69:17
name's 75:19	newer 51:20 52:14	<hr/> O <hr/>	offer 23:23
names 7:2 46:8,16	News 68:7,10	numerous 20:10 22:4,7	offered 24:4
narrow 46:3	nice 59:14	Nuremberg 81:15	office 69:2 83:11 85:13
nasopharyngeal 36:12	Nicholas 37:20	nurse 93:14,15	officially 28:13
Nathan 85:11,16,17, 21 88:22	NIH 20:10		officials 67:8
national 20:8 40:24 44:17 49:7 55:13 69:15 83:1,2	no-go 43:14,16		oftentimes 71:13
nationalized 45:9	Noah 62:22,23		olds 41:7 44:8
natural 77:22	non-discriminatory 86:20	oath 82:4 89:18 90:18	oncologist 51:16
naturally 17:13	normal 15:20	object 56:13	oncology 25:12 51:24
nature 21:23 50:4	north 29:13 73:20	objective 10:6,9 69:13	one's 27:12,24
	Northwest 81:1	observational 11:5 50:3	ongoing 16:19 23:2 43:3 50:19 57:23
		obvious 11:21	online 28:18 64:24
		occasion	

81:12	opposition	overwhelming	part
open	7:1 34:5	23:3,25 50:13	3:7,22 4:7
6:20,22 19:10	61:20 86:9	Ovo	12:14 14:19
29:1	orchiectomy	34:24	15:20 42:8
opened	38:6	_____	43:4 51:3
65:4	order	P	66:24 75:7
openly	7:4 21:21	_____	78:20 80:12
5:7 53:4,10,	55:6	p.m.	81:21
16 61:25	organization	7:12	participated
79:15	22:14	Pages	20:7
operational	organized	6:4,5	parties
51:11	3:12	pain	3:13,16,19
operative	orientation	79:1	4:3,11 6:19
46:14	78:19	painful	partners
opinion	original	77:16	18:13
44:10 46:23	23:7	Palm	parts
47:23	originally	74:19	12:2 66:21
opinions	27:1	paper	party
19:19 37:1	Orlando	46:4,14	4:7
44:25	66:21	papers	pass
opioid	Orthopedic	20:11	69:22 70:12
35:8	25:15	parent	71:14
opportunities	Osa	42:16 43:9,	passed
84:2	85:17 88:24	14,15 44:2	27:21
opportunity	89:4,6,23	63:7 78:15	passes
3:17 19:22	outbursts	79:16	71:11
27:11,23	8:5	parent's	passing
72:21 81:8	outcome	92:24	61:25
oppose	10:9 16:11	parental	past
63:5,9,10	28:7	24:21 43:7	8:19 9:2
71:5 75:8	outcomes	Parenthood	28:21 29:23
76:3 83:20	53:23 58:12,	28:17 69:3	35:7 39:9
opposed	16 59:18	parents	patently
38:24 71:2	outreach	30:5 43:5,13,	22:13
89:18	88:5	19,23,25 69:8	patient
opposite	oversight	83:12 92:22	13:4 15:10
77:12 82:10	81:9	Park	23:22 24:22
83:20		66:22	25:4 29:7,8
			30:1,10 38:17

43:6 63:7	38:6	persistence	72:11 75:8
76:7 88:10	penmanship	76:1	82:6,13
91:24	76:10	persists	86:10,25
patient's	people	23:21	petitioner
15:12	5:4 7:6 29:24	person	16:5
patients	37:10 47:22	5:14 27:6,20	petitions
20:19 21:16	50:7 53:15,17	36:11 46:20	70:11
24:4,17 26:3	61:23 62:11	48:1 52:13	phase
27:1,2 28:24	67:3,11,13,	75:22 76:14	67:23 79:17
29:7,20 30:24	14,16,20,22	80:2,17 82:2,	Phd
32:5 40:16,17	68:20,24	15 83:22	2:9
41:4 47:4	69:15 73:9	person's	phenomenal
48:15,20	75:6,14 78:4,	84:7	31:3
49:12 50:6,	23 81:10	personal	philosophy
17,18,20,21	83:10 84:1,	5:6 21:16	75:11,12
56:12,16	17,18,24,25	37:1 57:15	phonetic
58:3,6,18	92:9,15	65:12 67:11	5:15 61:13
59:3 67:9	people's	87:17	62:25 76:9,11
77:12 84:22	54:19 61:25	personally	80:24 85:11,
88:16	percent	49:5 66:3	18 89:3
pattern	23:7 24:20	persons	phoria
77:22,23	32:24 71:22	4:8	82:9
Paul	90:15 93:19,	perspective	physical
2:19	22	10:6,7,9,13	64:20 74:5
pediatric	perform	11:24	physician
6:17 19:15	25:17	perspectives	46:19 63:6
20:1,2,5,14	performed	10:19	83:13 87:19
26:23 29:4,5,	81:25	Petersburg	physicians
13 51:9	period	37:19	15:9 18:5,7
pediatricians	60:23	petition	21:16 25:6
32:18 50:13	permanent	2:12 6:15	41:18 46:12
pediatrics	77:19	7:2,14,17,21	51:12 83:7,24
20:21 23:15	permits	10:25 13:22	87:19
32:18 46:3	4:5	14:3 16:14,23	physiological
peer-reviewed	permitted	17:15 18:22	62:17,19
20:11	38:4	20:17 21:24	physiology
peers	persist	26:2,15 34:20	12:3 42:3
63:25 68:22	23:9	67:1,14,23	pick
penectomy		69:21,25 71:5	

38:24 75:11	political	potentially	prerogative
Pimentel	21:7,23 45:4	12:10 17:4	6:19
6:2,3	55:3 67:7	33:23 52:15	present
pioneers	68:7 76:4	57:20	6:15 10:25
30:22	93:2	Powell	13:22 14:3
place	politically	82:21 85:10,	23:17 28:13
29:11 59:1	22:2 69:24	11,15	29:19 37:5
places	87:10	power	56:7 84:8
28:16	politicians	79:7	presented
plan	18:5	practice	10:18 19:8,11
86:21	politicized	25:20,24	72:8
Planned	21:2 92:11	26:24 29:7	presenting
28:17 69:3	politics	31:20 38:22	28:24 44:3
Plantation	93:6	40:17 46:12,	presents
78:11 80:22	poor	13,24 47:18	18:4 68:11
81:1	25:1	48:2,14,16	71:6,19
pleased	population	71:12 87:13	president
6:11	54:9 55:7	88:8 92:18	63:22
pleasure	86:7	practiced	press
21:19	portion	89:12	21:12,13
plenty	89:11	practices	pressure
15:22	Portuguese	55:22 68:17	9:18 53:11
point	91:15	practicing	pressured
2:6 6:16 8:8	position	25:6 29:4	5:12
13:19 17:11	3:21 14:24	89:10	pretended
29:10 34:14	32:8 34:5,18	pray	33:11
35:15 37:9,11	42:16 52:15	65:10	pretty
41:1 44:22	positions	prayed	9:5 54:1 92:1
48:9 50:25	25:2 33:18	65:8	previous
52:7 67:5	34:16 48:8	pre-print	84:11
70:11 71:5,9	possession	46:1	previously
points	35:23	pre-pubertal	56:8
57:5	possibility	23:5,24	primary
policies	19:4	predicated	22:11 59:10
69:12	possibly	42:2,4	83:7 85:5
policy	64:6	preferred	private
38:3 67:18,21	post-operative	46:8,16	26:24 31:20
68:16 71:10	76:25		problem

28:4 29:17	program	protect	pseudonyms
30:3,7 32:21	37:18	5:4 67:10	4:11
62:20 65:22	programs	86:2	psychiatric
problems	57:21,22	protection	64:3 93:14
30:4 62:16	progress	86:1	psychiatrist
procedure	4:20	protocol	90:5
52:3	prohibition	31:14 32:10	psychological
procedures	20:17	proud	20:22 64:20
11:18 12:13	prohibits	66:20 78:15	74:4 78:25
15:21 16:3	15:5 91:3	87:25	psychology
28:4,20 42:8	project	prove	23:15
77:3	35:22	60:4	pubertal
proceed	promote	proves	20:18 23:23
42:24 44:21	21:14	28:8	24:1 37:6,21
proceeding	promulgate	provide	puberty
2:2 28:4	19:4,6	3:13,17,19	11:20,22 12:2
process	promulgated	4:4 5:1	14:8 15:5
3:24 10:21,22	32:16 54:21	12:23,25	23:8,22 28:19
15:8,19,20	pronoun	13:13 16:6	77:18 92:21
16:8,9,17	46:21,22	20:12 21:10,	public
18:23 19:3	47:24	17 40:10 46:6	2:22 3:3,6,15
41:17 44:5	pronouns	47:25 56:24	6:23,24 7:24
57:8 64:9,23	46:8,16	84:25 88:22	8:4 14:22
69:1	proper	provided	15:22 17:4
productive	93:25	3:23 22:25	21:9 36:2
85:2	proportions	25:1 37:18	37:13 60:22
profane	30:13	46:2 55:25	71:21 72:21
4:16	proposed	83:6 86:22	81:5 85:23
professional	4:6 16:7	providers	publicly
16:20 20:23	20:17 22:8	20:7 23:14	36:9
31:20 33:13,	67:4 71:16	56:2 83:24	publicly-
19 34:6 44:10	prosecuted	88:17	noticed
46:23,24 83:4	21:11	providing	7:23 8:2
professionals	prosecutor	13:5 47:3	published
41:18 83:25	36:2	prudent	11:3,8 20:10
professor	prospective	51:2 88:13	58:7
20:5	58:19	pseudo	pulled
professors		22:6,20	39:25
27:6			

punch 79:21	45:23 47:12 49:1,17,18	41:24	reason 10:2 19:17
purely 27:13 44:22 92:21	50:15 52:18, 19 53:7,13 54:6 60:10,12 64:5 70:3 73:4 87:6,24	raped 64:14	28:25 41:13, 23 43:19 74:12 90:9 92:22
purported 52:4	questioned 79:17	rashes 77:15	reasonable 56:1
purpose 18:2 80:7 85:5	questions 6:19,21 16:12 18:20 34:15 36:6,25 48:7, 10 51:4 52:17 60:13 85:8	rate 76:25 91:24	reasons 15:25 34:1 56:13 59:11
pursue 44:1 58:21 72:9	quote 75:9 78:16	rational 16:1	reassignment 14:9 15:6
pursuing 91:20	<hr/> R <hr/>	rationale 68:16	receive 21:17 31:7
purview 34:11	race 78:19	RCTS 50:2	received 4:2 40:17 64:22 65:14
Pushaw 21:12	Radiation 25:12	re-look 31:23 33:2	receiving 33:21 37:15, 21,22,23 51:1 68:23
pushed 55:2	radical 77:14	reach 14:22	recent 21:25 30:1 36:2,4
pushing 56:10	raised 86:4 87:20	read 61:13 76:24 81:12 91:14	recently 31:9 68:7 77:18
put 5:6 55:10	raises 50:25	reading 61:10	recognize 7:7 13:19 22:3
<hr/> Q <hr/>	ran 69:2	ready 76:15	recommend 29:14 41:6 81:13 90:20
quality 21:1 27:16 86:17	random 7:3	real 67:15	recommendation 14:7 15:24 16:2 25:18 40:19 41:14 55:25
Quentin 26:10,22	randomized 49:11,22	reality 69:14	
question 5:10 7:13 12:5,16 16:24 17:21 31:4 35:6 40:7,12, 14 43:25	range 36:10,14,17	realize 79:23 80:3,5 83:7	
	ranges	realized 80:14	
		realm 54:4	

recommendations 19:8 25:11	23 28:20 40:15 47:4	33:24 35:18 64:7 86:12	14
recommended 23:16	refined 52:16	relationship 26:1 65:12 88:9	representatives 32:25
recommending 14:7 38:12 41:2	reflect 33:8 56:15 63:1	release 14:11	represents 32:18
recommends 15:3 23:12 90:7	reflects 33:4	relies 22:5	request 4:8 16:8 17:16 18:21 33:10 46:20 71:7,9,20 82:5
reconcile 77:8	refrain 3:4 4:16	religion 78:19	requesting 72:10
record 3:2,8,20,22, 25 4:13 35:17	refuse 25:20	remains 27:20	requests 7:10 87:2
recorded 2:22 3:7	regard 4:15	remarks 6:14 69:20	require 9:6 16:5 47:12 53:24 60:3
recording 2:3	registered 93:13	remember 3:6 9:19 88:6	required 70:11 84:20
recurring 77:15	registries 50:21 51:21 59:21	remind 23:11	requirement 71:6,19
Redfern 21:14	registry 40:2 58:15	reminded 65:5	requires 15:7 59:5
redundancy 55:17,21	regret 77:1	remove 21:25 33:2	research 14:23 15:23 18:8 31:14, 17,19 35:22 66:1 68:9 90:3
redundant 55:15	regular 75:23 92:22	repeat 76:24	research-based 68:17
refer 38:9	regularly 21:14	repeated 78:1	researcher 59:8
reference 41:23 83:4	regulation 86:16	report 14:11,16,19 22:3,8	researcher's 68:13
referenced 36:9 44:16 46:4	reiterate 82:12	reporter 2:23 3:1	researchers
referrals 39:9	reject 69:25	represent 88:25	
referred 24:18,19,20,	rejecting 83:21	representative 66:13,16 70:3,4,9 71:4,24 72:6,	
	related 2:10 23:1		

68:8	responsibility	risk	rules
resemble	66:24 70:7,	11:17 12:8	55:5,10 60:9
36:15	19,20,25	77:13 92:9	76:4
reserved	72:3,8 83:8	risks	running
17:25	responsive	60:6	64:2
Residency	16:18	robbed	Ruth
20:2	restrict	80:6	61:12,14,16
resolution	56:14 60:9	robust	<hr/>
16:7 17:10	71:15	15:7	S
33:1,6,10	restrictions	role	<hr/>
42:23	29:23	86:14 88:3	S-A-U-V-E
resolve	result	roles	72:18
23:3 42:22	34:6 77:21	9:6,23,24	Sadly
43:15 90:17	resulting	rolled	21:8
resolved	78:2	69:4	safe
43:16	results	room	30:17 33:5
resources	92:4	50:8 67:13	safeguard
59:5,14 64:24	retrospective	root	85:23
65:25	58:5,9	65:20	safeguarding
respect	retrospectively	round	18:11 85:25
35:8,9 68:3	58:16	80:10	safety
84:18 90:9	return	routine	11:16 22:13
91:4	23:6 90:2	9:5 92:17	28:8 31:15
respected	reverse	rude	32:1
68:1	68:15	61:5	sanctioning
respectful	reversible	rule	33:13
34:8 75:22	24:2	15:4,12,18	sanctity
respectfully	review	19:4,6 22:8	26:1
17:16 18:21	10:17 20:14	56:1,11,15	satisfied
20:16	22:5 31:15,21	67:4 71:16	32:22
respond	46:3 56:6	rulemaking	save
5:14 25:9	reviewed	2:13 7:14,22	63:1
response	12:19 13:9	14:4 15:18	save.lgot.
46:17	reviewing	16:6,7,17,22	61:19
responsibilitie	48:21	18:22 19:3	saving
s	rhetorical	20:17 34:3	92:8
7:19 34:3	73:4	35:25 57:1,8	scary
72:5		86:11	68:24

scholarship 64:13	segregated 6:25	setting 2:13 14:4 40:18	23:25 52:14 91:1
school 29:24 53:3 63:22,25 87:21,22	select 41:4	sex 27:7,25 30:9 34:21 64:14 74:3 77:12	significant 65:23 80:5
science 5:8 8:2 33:3, 4 34:7 36:18 45:5 52:9 68:4 91:20, 21,22 92:12 93:3,6	selected 7:3	sexual 14:9 15:6 35:19 65:21 78:18,24	silence 3:10
scientific 11:2,7,14,24 13:14 20:15 34:7,9 44:22, 24 45:1 54:3	self-harm 64:3	share 13:7 18:10 36:8 37:3 45:25 72:22 87:17 88:2,20	silly 73:4
scientifically- based 88:15	senior 63:21	shared 13:14	similarly 21:12 24:22 47:7 53:15
scope 71:12	sense 32:12 35:18 44:23,24 74:13,14	shed 79:6	simple 5:10
Scott 82:21 85:10, 15	separate 45:4 60:10,12	shirk 7:18 70:20	simply 14:25 15:19 16:9
scrutinized 31:14	series 7:23 51:21	shocked 79:16	single 24:22 25:3 53:4
searching 79:9,22	serve 20:4 21:19 66:20 84:22 85:25 86:5,18 88:6	showing 57:14 92:6	sir 8:11,23 26:12,20 36:7 41:8 49:3 52:18 59:4 80:10 85:20
seat 40:12	served 16:15 36:1	shown 11:3 93:17	sister 14:11
secretary 21:12,13	service 13:11 44:18	shows 60:6	sits 87:22
seek 52:16 54:14	services 28:18 69:4,6	shred 35:23	sitting 48:11 52:25
seeking 22:20	Services' 85:23	shuffling 60:24	situations 9:17
	serving 84:1	siblings 92:17	sixth 24:9 81:1
	set 9:21 16:18 18:15,23 40:22 45:15 91:3	side 3:7 12:6	slur 69:18
			small

34:10 39:23	sort	22:9 25:24	14,21 29:16
50:11 55:6	41:16 43:20	50:22 56:19	32:11,15
smaller	71:12	70:13 86:22	33:14,19 34:5
30:24 37:10	sorts	specifically	35:19 36:9,
so-called	64:25	54:8 70:6	10,17,18,19
22:22 35:11	soul	spent	38:14 44:10
38:5 39:8	79:9,22	10:12	45:20 46:11
social	south	spirit	47:18 49:25
27:8,13 28:2	29:14 52:4	65:14	56:3 86:11
52:24 53:11,	Southwest	spironolactone	91:3
25 62:12,14	69:3	37:7,22	standards
83:2 84:8	Spalding	spoke	9:21,22 12:12
91:10	91:6 93:9,11,	65:11 68:7	14:15,18 21:2
socially	12	spoken	44:13 48:24
28:5 63:24	Spanish	10:15	50:14 88:17
societies	73:10	Springs	standpoint
33:20 34:6	Spargo	61:14	62:17,18
society	93:10	Spu	start
9:21 20:21	speak	76:9	5:9 78:16
25:12 29:1	2:24,25 4:9	Spur	started
51:9 53:7	6:12 7:9	76:9	30:13 64:24
57:9 78:20	19:23 27:11	St	75:18 87:3
Solen	59:23 63:19	37:19	starting
76:9	65:4 73:10	staff	41:1
solution	76:7	58:24 63:25	starts
66:1	speaker	stages	23:22
someday	6:25 7:3,10,	92:8	state
77:21	12 60:24	stakeholders	2:9 5:5,12
someone's	speaker's	49:9	6:11,14 7:7
47:12 63:11	4:2	stand	15:13 18:3
67:25	speakers	8:13,17	22:16 24:12,
son	4:6 84:11	standard	25 25:1,10,
78:25 79:13,	speaking	2:13 5:8 10:1	14,19 33:18
23 80:3 82:10	3:5,21,25	12:15,21 14:4	34:10,11 35:9
sons	67:1 83:3	15:4 18:16,23	38:13 44:7,13
88:12	specialized	20:25 21:6	54:22 55:15,
Sophia	45:12	22:21 23:11	24 56:5 66:7,
63:13,14,16,	specific	24:10 25:10,	13,21 67:3
17			70:3 86:5,18
			87:5,20 88:9

State's 21:24,25 22:8,11,19,22 23:2 26:2 86:1,14	89:2 91:5,7, 9,15,18	27:14,15,16 31:17,21,24 49:11 57:23 58:25 59:1,4 60:4,11 92:3, 4	suicide 68:21 76:25 80:9 85:3 91:25 93:23
state-supported 22:3	step 58:20 64:8 83:16,17	sterility 12:7	summarize 33:17 34:4
stated 15:22	Stetson 87:21	study 14:13 31:25 32:3,5 50:16 51:4 53:24 57:20,24 58:4,6	super 91:19
statement 33:2,3 36:22 37:13 41:7,25 42:5 43:12	stigma 53:7	stutter 78:22 79:3 80:1	support 7:1 11:4 22:17 25:2,19 50:14 54:20 61:16 64:23 67:13,23 77:25 80:15 81:11 85:24 87:13
statements 2:16 6:25 89:16,25	stop 33:15 64:17	Suave 72:18,19	supported 63:23 87:16
States 28:7,10 30:15,23,25 31:1 32:7 36:20 79:6	stopping 32:3	subject 91:20	supporting 21:3
statistic 93:17	stories 88:7,11	substantial 10:5 64:24	supportive 22:15 83:25
statistical 27:18	strategic 84:5	substantively 33:21	supposed 30:25
statistically 65:23	strength 66:5	successfully 79:10 87:22	supposedly 32:8
statistics 68:23	strenuously 56:13	succinctly 33:17	Surgeon 2:9 6:12 8:12,18,24 90:19
statutes 16:5	stress 67:12,22 68:5,18	sued 21:11	surgeon's 21:13
statutorily 7:15 70:10	strong 9:13	suggest 50:1 53:24	Surgeons 25:16
statutory 71:6,18	strongly 57:12 92:2	suggested 25:10,14 50:11	surgeries 15:6 24:9,13 25:17 38:9 77:10,14,24
staying 52:22	struggle 79:1,2	suggestion 54:1	
Staziaki	struggles 79:11	suicidal 64:3 85:3 93:20	
	struggling 59:13		
	studies 11:2,5,8		

78:1 92:15	table	Ten	therapies
surgery	53:1	39:12	11:12,18,22
12:6,8 14:9	takes	tens	12:4,15 14:9
20:18 24:18,	77:4	20:9	15:5,8 51:20
23 38:5 39:6,	taking	term	60:3
8,18 44:8	9:4,9,14 46:5	27:6 58:16	therapy
78:2 83:15,16	80:1	82:8	13:5 15:11
84:4,9	talk	terms	20:18 22:12
surgical	54:14 78:4,5	3:11 8:14	29:9 37:15
11:20 12:15	79:20 83:4,5	9:23 10:1,23	64:4,11 65:6
28:20 30:19	84:15	12:4,7 27:16	thing
31:7 32:19	talked	39:7	34:19 55:4
surgically	48:14,15	terrible	65:15 75:9,11
28:5	53:2,10 68:4	35:8 52:6	80:20 92:21
surprised	talking	65:5	things
59:2	54:13 67:17	testicular	30:22 33:13
surrounding	81:24 83:6,8	34:24	47:22 50:21
10:10	tall	testify	51:19 54:18
surveys	8:14	66:7	57:4 58:18
58:18	tally	testifying	74:9 76:19
Sweden	37:17	22:23	84:15 88:4
31:8 44:19	Tampa	testing	thought
45:6	87:18	22:23 84:6	4:23,24 52:3
swelling	tangential	testosterone	64:16 79:16
77:19	45:24	37:8,24 64:18	90:22,23
syndrome	task	Texas	thoughtful
34:24	19:10	22:24	90:22
system	team	thankfully	thoughts
60:7 83:23	48:19 57:8	21:18 79:21	93:20
systematically	60:2	that'll	thousand
58:17	tears	93:9	24:16
systems	79:6	theater	thousands
45:9,19	technically	21:7	20:6,9 51:25
<hr/>	30:24	themselves	threatening
T	Tellechea	84:8	87:14
<hr/>	26:17,19	therapeutic	three-minute
tab	tells	65:25	61:1
2:6,7,12	13:2 75:15		thrive
81:18			87:15

thriving 87:22	93:12	trans 23:9 24:7	treat 16:4 30:18
thrown 80:14	Today's 78:3,6	53:17 67:14, 15,20,21,24	36:11 48:16
tied 17:13	token 75:15	transcribed 2:2	treated 20:9 23:19 34:10 68:2
time 3:4,6,9 4:5 6:22 9:8 10:12 11:23 15:11,22 17:10,19 19:12 28:13 29:10 31:2 41:6 44:11 48:25 53:1 56:19 60:14, 18 61:1 63:21 65:3 66:10 69:5 77:8 82:18	told 28:25 70:5, 18,23 72:4 73:11 80:8	transfers 35:11	treatment 2:14 14:10 15:2,6 18:23 28:17 31:7 32:10,13 42:24 44:1,4 51:2 63:23 86:21,22 90:8
timers 61:1	tomorrow 17:19	transform 90:12	treatments 14:13,17 15:1 28:19 30:14 31:10,13 32:4 33:21 64:21 87:4
times 33:6 43:23,25 64:14 68:21	top 12:22 39:8,18 44:8	transgender 20:23 23:6,8 24:13 27:2 28:11,15,16, 24 30:1 31:1 46:3,20 57:24 77:9,24 78:2, 16 79:15 84:24 87:9,14 88:1,14 92:19 93:19,24	trends 92:6
today 5:1 6:13 7:9, 13,22 9:9,15 10:14,16,24 11:12 12:20 15:17,25 16:8 17:15 18:19 19:23 26:11 60:6 66:4,13, 19 67:1,10 71:8,23 75:6 79:9 81:7 82:25 83:3,10 88:18 90:3	topic 78:17	transgenderers 77:1	trials 49:22 50:19, 22
	torment 65:1	transition 60:22 63:24 65:19 84:8	trouble 61:9
	total 37:20,22,23	transitioning 74:10	true 33:15 68:19 69:11 79:21
	totality 22:17 48:23 55:5	transparent 32:11	trust 84:13,22 88:5,10
	touch 17:21	transplant 52:2	truth 52:16 74:13
	touched 35:6	transsexual 27:1	tumor 84:16
	toxic 52:2	trapped 64:8 73:13	turn 2:15 8:9
	tract 77:16	travel 9:7	
	trade 16:19		
	trained 20:6		
	training 13:2 57:21,22		

15:14 45:23 48:9 78:3 Turner 34:24 type 18:2 69:6 84:9 typically 43:16 Tywin 62:25 63:4	13:6 38:5 undergoing 15:11 44:8 52:1 underlying 41:13 underpinning 44:24 understand 2:24 4:16,19 11:24 16:22 17:18 26:7,10 34:16 37:1 38:11,24 39:8 40:22 41:22 42:11 48:8 49:14 63:8,9 69:12 70:17 73:2 understandable 45:18 understanding 39:3,14 41:15,16,19 62:15 65:13 70:22,23 72:1,2 Understood 40:21 89:23 unemancipated 42:11 43:12 unemployed 64:14 unequivocally 18:16 unexamined 52:9 75:10 UNIDENTIFIED 8:21,22	26:14,18 54:6 61:7,8,11 62:24 United 28:7,10 30:15,23,25 31:1 32:7 36:20 44:18 79:5 university 19:16,25 20:1,2,6 31:18 37:5 38:3 40:18 46:1 54:17 57:24 58:23 university- based 28:14 unknown 12:4 unscientific 73:5 unusual 21:23 62:11 uphold 25:25 urgency 17:17 urinary 77:16 78:1 urination 77:16 USF 87:21 usual 12:8 16:17 utterly 33:11	<hr/> V <hr/> VA 93:16 vacuum 69:14 vaginectomy 38:6 Van 26:10,22,23 34:19 35:1,4 44:17 50:9 Vasquez 2:16,17,19 4:22 8:3 vast 33:7,8 veins 77:16 Velinaizo 61:12,14,16 vernacular 27:3 versus 38:16 54:9 veterans 93:16 vice 60:23 68:7,10 view 44:22 vigilant 51:18 vigorous 34:7 35:7 Vila 5:23,24 57:18,19
<hr/> U <hr/> UF 6:17 UK 31:10 ultimately 9:22 unable 64:4,15 unacceptable 25:16 unaware 22:16 unbiased 10:22 13:14 69:19 uncertain 11:1 uncertainty 90:24 unclear 70:21 uncommon 24:14 undergo			

58:3,9,11,22 59:6,12,20,23	weaker 21:3	women 51:25 74:7	worth 52:10 77:20
virtue 62:13	website 58:23 59:15	wondered 79:18,19	worthy 17:9
vision 77:20	week 31:10	word 46:15 83:18	wounds 64:1
vocal 50:11	welfare 18:12	words 6:18 19:16,21 59:10 78:17	WPATH 57:10
vociferously 5:3 89:17,20	well-documented 88:14	work 8:19 9:2 52:3,5 80:1 89:12	wrap 69:20
voice 19:19 79:8	well-established 24:4	workbook 90:6,15	wrinkles 42:7
voices 50:10	wellbeing 67:2	worked 69:2	wrist 46:7
vote 26:2 76:3	Wellness 62:7	Workers 83:2	writing 40:19 61:14
<hr/> W <hr/>	whatsoever 28:1	working 9:4 13:10 50:20 51:10 62:10 93:14	wrong 36:13 38:18, 20 52:12,13 75:25 79:18
wait 17:12,13 90:8,10,13	who've 32:14	works 34:8 51:23	wrote 32:23 39:16
waiting 91:2	wife 73:22 79:10, 17	workshopping 35:25	<hr/> Y <hr/>
waive 3:20	willfully 21:15 22:16	workshops 7:23 44:21	year 14:6 32:25 33:1 41:7 44:8
walk 57:4 71:2 83:11	William 62:6,9	world 20:22 33:13	year-olds 39:18
wanted 13:7 65:3 80:9,15,16	Wilson 10:25 13:20, 23 14:1 18:25 35:6,21	worldwide 28:8	years 16:16 24:18 27:21 28:21 29:23 30:5,6, 14,16,22 36:1 38:13,24 39:10 53:14 57:25 62:10,
warned 77:18	Winter 66:22	worse 64:12	
Wasylik 5:21,22 25:13 48:12,13 49:1,4,6,16 50:15,23	withhold 92:21	worst 21:6	
	withholding 92:15		

11 63:17,18
64:11,17
72:24 73:8,15
77:4 79:14,25
89:11 90:14
93:14,15

years'

26:25

yell

34:8

yesterday

30:2

yield

82:18

young

33:25 62:2,10
65:10 68:20,
24 80:4 92:15

youth

24:15 68:21
82:6

z

Zachariah

25:19

Zed

46:21

Zucker

90:4,5