Jane Doe

vs.

Joseph Ladapo

Taped Transcription

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Doe Pls' Trial Ex.
23

JANE DOE,
Plaintiff,
vs.
JOSEPH LADAPO,
Defendant.
_____

TRANSCRIPTION OF AUDIO RECORDING
FLORIDA BOARD OF MEDICINE
TAB 26 AND 39
GENDER DYSPHORIA DISCUSSION AND PETITION TO INITIATE RULEMAKING

TRANSCRIBED AUDIO RECORDING BY:
Julie Thompson, CET

Job No.: 322529

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

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

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

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

EXECUTIVE DIRECTOR VASQUEZ: Thank you. Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First, I want to welcome all of our guests

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

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

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

Dr. Carnes (phonetic)?

DR. CARNES: No.

CHAIRMAN DIAMOND: Dr. Ackerman?

CHAIRMAN ACKERMAN: No.

CHAIRMAN DIAMOND: Ms. Justice?

MS. JUSTICE: No.

CHAIRMAN DIAMOND: Dr. Wasylik?

DR. WASYLIK: No.

CHAIRMAN DIAMOND: Dr. Vila?

DR. VILA: No.

CHAIRMAN DIAMOND: Dr. Chandra?

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DR. CHANDRA: No.
CHAIRMAN DIAMOND: Dr. Pimentel.
DR. PIMENTEL: No.
CHAIRMAN DIAMOND: Dr. Pages?
DR. PAGES: No.
CHAIRMAN DIAMOND: Dr. Derick?
DR. DERICK: No.
CHAIRMAN DIAMOND: Dr. Hunter?
DR. HUNTER: No.
CHAIRMAN DIAMOND: Thank you. What we're going to do is we're very pleased that our State Surgeon General, Dr. Ladapo has decided to speak with us today. We're going to first listen to Dr. Ladapo's remarks. I believe then the State is going to present the petition.

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

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

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

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

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

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

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

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

At this point, I think we should commence.

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

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

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

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

UNIDENTIFIED FEMALE: We can't hear.

UNIDENTIFIED FEMALE: We can't hear you.

CHAIRMAN DIAMOND: Is the mic on, sir?

SURGEON GENERAL LADAPO: Okay. All right. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIRMAN DIAMOND: Thank you, Mr. Wilson.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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related care to any child or adult.

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

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

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

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

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

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

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

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

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

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

So while the State has used exceptional

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

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

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

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

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

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

In closing, I ask you to uphold the

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

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

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

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

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

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

CHAIRMAN DIAMOND: Mr. Tellechea says no.

UNIDENTIFIED MALE: Okay.

ATTORNEY TELLECHEA: Not yet.

CHAIRMAN DIAMOND: Sir, could you please introduce yourself?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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DR. VAN METER: That's correct.

CHAIRMAN DIAMOND: Just gender dysphoria, correct?

DR. VAN METER: That's correct.

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

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

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

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

CHAIRMAN DIAMOND: Thank you so much.

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

CHAIR ACKERMAN: I resemble that.

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

DR. HALLER: Very much so.

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

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

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

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

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

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DR. HALLER: Correct.
CHAIRMAN DIAMOND: All right. Now, at University of Florida, your policy is that no individual under the age of 18 is permitted to undergo so-called bottom surgery. So this is orchiectomy, penectomy, vaginectomy; is that correct?
DR. HALLER: That's correct. We do not refer any children for those surgeries.
CHAIRMAN DIAMOND: So just to help me understand, if there were an institution here in Florida that was recommending it for, let's say, 17 years old, 17-year-old individuals, would you state that that is outside of the standard of care?
DR. HALLER: Well, I think that would get into your example of your approach versus Dr. Ackerman's approach in a patient. But for us --
CHAIRMAN DIAMOND: He's wrong, of course.
DR. HALLER: -- that would be outside of -- of course, he's accepting that he's wrong, and you're right. I think that's why there's the practice of medicine.
CHAIRMAN DIAMOND: No. But I'm trying to understand why did you pick 18 years old as opposed to 17 or 16? How did your institution come to

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establish that age cutoff?

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

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

DR. HALLER: That is correct.

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

DR. HALLER: That's my understanding.

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

DR. HALLER: Correct.

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

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

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

CHAIRMAN DIAMOND: Okay.

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

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

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

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

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

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

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

CHAIRMAN DIAMOND: So will you --

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

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

DR. DAYTON: No, sir.

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

DR. DAYTON: Yes.

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

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

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

DR. DAYTON: Yeah.
CHAIRMAN DIAMOND: It's not predicated on physiology, it's -- anatomic physiology. It's more predicated on capacity to make these decisions. Is that a fair statement or am I off?
DR. DAYTON: I mean, you can probably tell based on my lack of too many wrinkles that I wasn't a part of those guideline-making procedures, but that would be my assessment. Yeah.
CHAIRMAN DIAMOND: So an ability to understand the full -- and obviously, unemancipated minors don't give consent. They give assent.
DR. DAYTON: Assent, yeah.
CHAIRMAN DIAMOND: All right. Have you had circumstances where you've had children who espoused a certain position, and perhaps there's one parent that's in agreement and one that is in disagreement?
DR. DAYTON: Yes. That is common.
CHAIRMAN DIAMOND: It is common?
DR. DAYTON: Yeah.
CHAIRMAN DIAMOND: And how do you try and resolve that? Obviously, you try and resolve it. But what happens when there's not a resolution? Does that child not proceed with the treatment -- with the care?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You were kind enough to share with me a

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

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

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

DR. HALLER: I think that's cruel and

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

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

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

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

DR. DAYTON: Right.

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

DR. DAYTON: Yeah.

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

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

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

DR. HALLER: I agree. I concur.

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

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

Dr. Wasylik, please.

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

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

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

DR. HALLER: No, sir.

DR. WASYLIK: Okay.

DR. HALLER: Not me personally.

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

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

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

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

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

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

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

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

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

DR. WASYLIK: Thank you so much.

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

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

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

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

DR. DAYTON: You guys are the best.

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

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

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

Any other questions?

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

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

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

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

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

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

CHAIRMAN DIAMOND: Further discussions?

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

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

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

DR. HALLER: I don't.

DR. CAIRNS: Why?

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

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

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

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

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

DR. DAYTON: One of the issues.

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

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

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

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

DR. HALLER: Yeah --

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

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

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

Any other comments? Dr. Vila?

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

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DR. DAYTON: Yes.
DR. HALLER: Yes.
DR. VILA: And how many patients were enrolled in that study?
DR. DAYTON: So I have a retrospective study I'm doing right now on about 200 patients within our clinic. Nothing published yet, but we're analyzing data right now.
DR. VILA: So it's retrospective.
DR. DAYTON: Yeah.
DR. VILA: Are you looking at long-term outcomes?
DR. DAYTON: So that's kind of where we're coming into -- you know, have not yet, but needing to create a registry more formally to look at long-term outcomes. Because we can retrospectively look, but we're not necessarily, you know, systematically collecting like surveys from our patients and things like that to do a more prospective. But I do agree that that would be a really great next step that we need to pursue.
DR. VILA: You know, you're a major university. You've got -- looked at your website. You've got the big staff. You've got a degree, a master's degree in doing studies and constructing

studies. I mean, I think you're the place to do it. I guess I'm just really kind of surprised that you have all these patients.

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

DR. VILA: I know that.

DR. HALLER: And I would think --

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

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

DR. DAYTON: Yeah.

DR. VILA: It's there.

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

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

DR. DAYTON: Yeah.

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

CHAIRMAN DIAMOND: Any other questions at this time?

Thank you so much.

DR. HALLER: Thank you.

CHAIRMAN DIAMOND: We appreciate all of your time.

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

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

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

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

UNIDENTIFIED MALE: We'd like to go.

UNIDENTIFIED MALE: Here we go.

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

UNIDENTIFIED MALE: (Indiscernible)

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

Good afternoon.

RUTH VELINAIZO: I am support. Thank you.

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

NAKORA KATAKO: I'm in opposition.

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

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

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

CHAIRMAN DIAMOND: Thank you.

Elaine Jones of Fort Lauderdale. Elaine Jones? No.

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

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

CHAIRMAN DIAMOND: Thank you.

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

UNIDENTIFIED MALE: Okay.

CHAIRMAN DIAMOND: Tywin (phonetic) from

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

Good afternoon.

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

CHAIRMAN DIAMOND: Thank you.

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

Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

CHAIRMAN DIAMOND: Thank you.

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

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

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

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

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

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

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

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

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

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

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

process.

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

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

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

Thank you.

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

REPRESENTATIVE ESKAMANI: Absolutely.

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

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

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

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

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

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

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

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

REPRESENTATIVE ESKAMANI: Correct.

CHAIRMAN DIAMOND: But again, my

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

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

CHAIRMAN DIAMOND: All right. Thank you so much.

REPRESENTATIVE ESKAMANI: Thank you.

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

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

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

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

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

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

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

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

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

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

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

CHAIRMAN DIAMOND: Thank you.

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

Next is Gianna Cook from Palm Beach Gardens.

GIANNA COOK: Should I go up here or there?

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

GIANNA COOK: Can you hear me?

CHAIRMAN DIAMOND: Yes -- not really.

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GIANNA COOK: Maybe up there. Yes.
CHAIRMAN DIAMOND: Good afternoon.
GIANNA COOK: Hello.
CHAIRMAN DIAMOND: Yes.
GIANNA COOK: There we go. I'm happy to be here today. I would just love to affirm the people who are saying to not agree or to not take part in the petition, to oppose the petition. I think an interesting thing you mentioned earlier, a quote, you know, the unexamined life, I think another philosophy thing that we can pick up on, because I am a philosophy major, is existentialism in like making meaning. I think it's really important to let people decide who they are and to help them with that. By the same token, if somebody tells you who they are, you kind of have to -- you accept that, right.
Like, if I said -- if you started saying, her name's not Gianna. It's like a completely different name, and she doesn't use -- like, she's not a she. She's like a completely different person. That wouldn't be like respectful. That wouldn't be regular. And me saying, hi, my name is Gianna, I, you, she, her, you saying, no, she doesn't do that, that's completely wrong. The

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persistence in that is highly illogical.

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

CHAIRMAN DIAMOND: Thank you.

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

Cruzita Kenotis (phonetic) Cruzita Kenotis, please.

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

CHAIRMAN DIAMOND: Sure.

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

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

Hello.

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

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

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

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

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

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

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

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

CHAIRMAN DIAMOND: No, talk to me.

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

CHAIRMAN DIAMOND: Thank you.

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

Good afternoon.

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

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

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its deep pain and struggle.

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

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

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

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

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

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

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

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

CHAIRMAN DIAMOND: Thank you very much.

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

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

DENNIS CONKLIN: Thank you. Dennis

Conklin, 4581 Northwest Sixth Court Plantation.

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

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

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

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

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

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

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a left knee?

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

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

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

CHAIRMAN DIAMOND: Thank you very much.

DENNIS CONKLIN: I'll yield back my time.

CHAIRMAN DIAMOND: Thank you very much.

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

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

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

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

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

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

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

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

And we know that if we provide people with

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

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

CHAIRMAN DIAMOND: Thank you very much.

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

So, Scott Powell, you are next.

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

Go ahead, sir.

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

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

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

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

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

If we look at the petition details, we

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

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

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

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

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

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

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

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

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

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

OSA FIGUERIS: Good afternoon.

CHAIRMAN DIAMOND: Good afternoon.

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

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

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

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

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

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

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

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

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

JO STAZIAKI: Can you hear me? Okay.

CHAIRMAN DIAMOND: Go ahead, please.

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

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

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

CHAIRMAN DIAMOND: (Indiscernible)

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

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

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are able to establish a correlation pretty, pretty strongly.

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

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

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

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

CHAIRMAN DIAMOND: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BETHEL FARGO: Could I please finish --

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

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Thank you.

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

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

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

CHAIRMAN DIAMOND: Thank you very much.

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

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

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going to take some more public comments.

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

(END OF AUDIO RECORDING)

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CERTIFICATE OF TRANSCRIPTIONIST

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

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

Julie Thompson

Julie Thompson, CET-1036

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