

Jane Doe

vs.

Joseph Ladapo

Taped Transcription

October 28, 2022



Med Def_001058

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAPO,

6 Defendant.

7

8 CASE NO. 423CV114RHMAF

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TRANSCRIPTION OF AUDIO RECORDING

13

FLORIDA BOARDS OF MEDICINE AND OSTEOPATHIC MEDICINE

14

JOINT RULES/LEGISLATIVE COMMITTEE RULE WORKSHOP

15

OCTOBER 28, 2022

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TRANSCRIBED AUDIO RECORDING BY:

23

Julie Thompson, CET

24

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Job No.: 322529

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

4 *****

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

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

13 CHAIRMAN ZACHARIAH: Yes.

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

16 Dr. Diamond.

17 DR. DIAMOND: Present.

18 MS. STRICKLAND: Dr. Ackerman.

19 DR. ACKERMAN: Present.

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

22 Dr. Derick.

23 DR. DERICK: Present.

24 MS. STRICKLAND: Dr. Di Pietro.

25 DR. DI PIETRO: Present.

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

3 Dr. Hunter.

4 DR. HUNTER: Present.

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

7 Dr. Pages.

8 MS. STRICKLAND: Mr. Romanello.

9 MR. ROMANELLO: Here.

10 MS. STRICKLAND: Dr. Schwemmer.

11 DR. SCHWIMMER: Present.

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

24 Chair, you have a quorum.

25 CHAIRMAN ZACHARIAH: Well, thank you so

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Dr. Zachariah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 Go ahead, Dave.

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

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

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1 to hear your one --

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

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

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

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

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

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

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

6 DR. DIAMOND: Thank you.

7 CHAIRMAN ZACHARIAH: Any other board
8 members?

9 Yes, Dr. Hunter.

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

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

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

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

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1 CHAIRMAN ZACHARIAH: Any other board
2 members?

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

7 Next is Dr. Kristin Dayton.

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

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

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

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

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

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

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1 speak more loudly if that would help.

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

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

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

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

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1 Pediatrics at (indiscernible).

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

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

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

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

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

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

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

25 I always think of one of our patients who

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 suppression as adolescents.

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

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

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

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

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

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

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

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

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

3 Any board members?

4 Okay. Go ahead, Dr. Hunter.

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

6 DR. DAYTON: Yes, thank you.

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

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

11 DR. HUNTER: Correct.

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

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

16 DR. DAYTON: Absolutely.

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

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

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

25 DR. HUNTER: And what percent --

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

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

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

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

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

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1 someone has died from suicide.

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

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

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

10 DR. DAYTON: From our clinic?

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

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

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

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

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

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1 DR. HUNTER: Okay.

2 CHAIRMAN ZACHARIAH: I think that --

3 Dr. Di Pietro.

4 DR. DI PIETRO: Thank you.

5 Dr. Dayton, can you hear me?

6 DR. DAYTON: Yes, I can.

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

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

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

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

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

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

22 CHAIRMAN ZACHARIAH: Yeah, Dr. Hunter.

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

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

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

17 CHAIRMAN ZACHARIAH: Thank you.

18 Are there any board members, any questions?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 to answering any questions you may have.

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

4 Board members, any questions?

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

7 CHAIRMAN ZACHARIAH: Yes. So Dr. David.

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

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

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

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

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

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

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

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

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

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

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

8 DR. JANSSEN: It's muted again.

9 DR. DIAMOND: Let's try again. Over the
10 last several nights, I had the opportunity to review
11 the interim findings from Dr. Hilary Cass, and I'm
12 sure you know Dr. Cass is a world-recognized
13 authority on this subject and she has been appointed
14 as the chair of the Independent Review of Gender
15 Identity Services for Children and Young People for
16 England's National Health Service. And it's
17 actually very interesting when I read the reports,
18 they're actually very beautifully written. The
19 language is beautiful in terms of the subtly and the
20 nuances of the language.

21 And in the interim reports of the different
22 items that we're discussing today, really the area
23 that her team has focused on as the most problematic
24 is that of pubertal blockers. And it's remarkable
25 how humble they are in their admission of how little

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

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

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

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

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

23 DR. DIAMOND: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 CHAIRMAN ZACHARIAH: Yeah.

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

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

4 Yeah, Dr. Hunter?

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

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

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

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

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

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

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

25 Literature and the research on the impact

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

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

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

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

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

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

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

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

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

19 DR. KALTIALA: Why?

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

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

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

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

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

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

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

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

12 DR. LAIDLAW: Can you hear me now?

13 UNIDENTIFIED SPEAKER: A little bit better.

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

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

19 DR. LAIDLAW: Is that better?

20 DR. ACKERMAN: Oh, much. Yeah.

21 DR. LAIDLAW: Okay. Sorry about that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 DR. LAIDLAW: Darn, okay.

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

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

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

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

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

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

8 Board members have any questions?

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

11 DR. LAIDLAW: Yes.

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

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

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

4 CHAIRMAN ZACHARIAH: Thank you.

5 Board members?

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

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

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

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

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

16 CHAIRMAN ZACHARIAH: Any other board
17 members?

18 DR. DERICK: I have a question.

19 CHAIRMAN ZACHARIAH: Dr. Amy.

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

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

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

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

10 DR. LAIDLAW: Appreciate it. Thank you.

11 CHAIRMAN ZACHARIAH: I really appreciate
12 it.

13 Next is Dr. McNamara.

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

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1 hold in high regard.

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

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

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

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

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

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

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

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

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

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

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

25 The authors also make no effort to engage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 protocols. I myself have performed statistical
2 analysis on and reviewed several observational
3 studies where the independent effect of an
4 intervention on an outcome was detected with a
5 single cohort of participants. Either the June 2nd
6 report's authors are not qualified to conduct such
7 an influential literature review, or their baseless
8 claims are purposeful.

9 Perhaps the most glaring, and repeated, and
10 troubling error in this report is the singling out
11 and thoughtless dissection of single studies rather
12 than engaging with the entire body of evidence. As
13 I said, at least 16 studies show that puberty
14 blockers and hormones benefit patients with gender
15 dysphoria, but none appear in the June 2nd report
16 and are treated fairly. This is likely an effective
17 way to dismiss consensus and throw fog up around the
18 issues at hand, but it should not and cannot guide
19 healthcare.

20 Before legal interference a year ago, the
21 United States was not out of step with practice in
22 other countries. No other country in the world has
23 prohibited the provision of gender-affirming care
24 for youth. Despite the picture painted by some, in
25 Sweden, Finland, the United Kingdom, Canada, and

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1 others, gender-affirming healthcare is available to
2 any adolescent whose clinician recommends it as long
3 as the required consents are obtained. I submit to
4 the board an amicus free from Stonewall U.K. et al.,
5 which details an accurate account of gender-
6 affirming care in other countries from those who
7 provide it.

8 In conclusion, I emphasize that standard
9 medical care for gender dysphoria does need
10 generally accepted medical standards and it is not
11 experimental or investigational. Nothing in the
12 state of Florida's June 2nd report calls into
13 question the solid medical evidence that underlies
14 consensus recommendations of WPATH, the Endocrine
15 Society, the AAP, and many others.

16 I urge the board to read out report, not
17 rely on the June 2nd, which is full of
18 misinformation and errors. And as physicians and
19 scientists, the members of the board can give the
20 June 2nd report the critical scrutiny it deserves
21 and make the right decision for Floridians. Thank
22 you so much for your time.

23 CHAIRMAN ZACHARIAH: Well, Dr. McNamara,
24 thank you for the very eloquent presentation.

25 Now, the board members, any question for

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1 Dr. McNamara?

2 I think Dr. Derick first and then

3 Dr. Hunter.

4 DR. DERICK: Certainly a percentage of
5 non-gender conforming children with gender dysphoria
6 will not have persistence and will be post pubertal
7 homosexuals. What is the way that these children
8 are identified in clinic in your clinical
9 experience?

10 DR. MCNAMARA: I heard you here and there,
11 in and out, so I'm going to repeat your question and
12 you'll tell me if I have it right. You're asking
13 about younger children who present with gender
14 dysphoria and you're asking about their chances of
15 persistence into their adolescent years?

16 DR. DERICK: What I'm asking is, there are
17 a certain percentage, which is debatable, of kids
18 who have nongender conforming behavior and have
19 gender dysphoria that does not persist.

20 DR. MCNAMARA: Yeah.

21 DR. DERICK: And so my question is what are
22 the discussions and what are the mechanisms to
23 determine these children? Because those children
24 might have a different course of action than
25 children who will ultimately have persistent gender

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1 dysphoria.

2 DR. MCNAMARA: Yeah. I mean, I think one
3 of the prevailing themes of all of our testimony
4 today is that it's highly individualized. These
5 children and their families meet with therapists,
6 with experts on gender dysphoria, a range of options
7 to help this child live authentically and
8 comfortably are offered. For prepubertal children
9 though this does not include medications of any
10 kind, and I really want to state that clearly. That
11 is stated emphatically in clinical practice
12 guidelines from WPATH and the Endocrine Society.

13 CHAIRMAN ZACHARIAH: I think Dr. Hunter, I
14 think you were next.

15 DR. HUNTER: This is going to be more of a
16 statement but then I would like Dr. McNamara to
17 comment. The concern seems to be with the June 2nd
18 report, and I just wanted to clarify that this -- my
19 reading of the June 2nd report, my understanding of
20 the June 2nd report, this is not a Florida report,
21 this is a report from McMaster University in Ottawa,
22 Canada, okay.

23 And I agree those people who wrote the
24 report are not physicians, they are not involved in
25 gender medicine, but they are experts in evidence

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1 reviewed. McMaster University being the home of the
2 term "evidence-based medicine." Gordan Guiette
3 coined that term, and these are all trainees of
4 Dr. Guiette. And I think there was some concern in
5 the literature that if evidence is not reviewed in a
6 systematic fashion and it is reviewed by people
7 heavily involved in the field that the conclusions
8 may in fact be biased.

9 So I don't think there's a bigger name in
10 evidence-based medicine than McMaster University and
11 the experts who reviewed the literature in this
12 area. I just wanted that clear and for the record,
13 and if Dr. McNamara would like to comment on that.

14 DR. MCNAMARA: I'm not sure if you'd like
15 me to comment but I really couldn't hear much of
16 what you said. I apologize if I've missed --

17 DR. HUNTER: Should I try to say it again?

18 DR. ACKERMAN: Yeah. Speak louder.

19 DR. HUNTER: I think to describe the
20 evidence reviewers as inexpert and not qualified
21 when it's coming from McMaster University where the
22 term evidence-based medicine and they have an entire
23 program in reviewing the quality of evidence, I
24 think that's --

25 DR. MCNAMARA: I see. Yeah, I actually can

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1 respond to that if you would like, quickly. The
2 National Academy of Medicine stipulates that
3 systematic reviews must be conducted by people who
4 have specific clinical and research expertise in the
5 area at hand. The National Academy of Medicine,
6 about 10 to 15 years ago, I believe developed
7 standards (indiscernible), and those are viable by a
8 system used from outside of the United States in
9 this report.

10 CHAIRMAN ZACHARIAH: Next, Dr. Pages, and
11 Dr. David.

12 DR. PAGES: Can you hear me? So the first
13 gender clinic was established in 2007 in this
14 country, and now we see there are over, I believe
15 around 50 gender clinics. So my question to
16 Dr. McNamara, as an adolescent medicine expert, why
17 in your opinion are we seeing this significant
18 increase in gender dysphoria in children, especially
19 in the adolescent population?

20 DR. MCNAMARA: I have so much to say about
21 that and I really value this question. First of
22 all, we're not seeing much larger numbers. I think
23 that that has been blown out of proportion and
24 discourse, but if you look at the absolute numbers,
25 it's not exponential by any means. The fact of the

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1 matter is that we live in a more forgiving and
2 nurturing environment than we did 20 years ago for
3 gender expansive identities. I believe that there
4 are -- there are trans and nonbinary role models.
5 There are people that are trailblazing and showing
6 young people that it's safe to be who they are.
7 That's my simplest answer.

8 The data do not back up the social
9 contagion claim at all. If social contagion was
10 indeed driving these "spread" of gender dysphoria --
11 I really dislike even saying that -- the numbers of
12 young people identifying as trans or gender
13 expansive would be much higher. Another way to
14 think about it is this is a predominantly,
15 overwhelmingly cis gender society and young people
16 are far more exposed to cis gender social norms,
17 social contagion would work in the reverse if that
18 were the case.

19 So I appreciate this question, I appreciate
20 the opportunity to speak to it. I want to just
21 pushback substantively that we're seeing much larger
22 numbers and that represents a change. I think
23 merely young people feel safe to be who they are.

24 CHAIRMAN ZACHARIAH: Well, thank you.
25 Dr. Pages, one of the reports that I read said that

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1 in 2007 there was 1 and now in 2020 there's over 300
2 in the United States. That's what I read.

3 Dr. David.

4 DR. DIAMOND: Dr. McNamara, good morning.
5 Thank you for joining us from scenic New Haven,
6 Connecticut. I'd like to ask you the same question
7 as I asked Dr. Janssen, which is that our colleagues
8 in Europe, who I'm sure you would agree are of
9 goodwill, are trying to do the best for their
10 patients, clearly are not bigots. How do you
11 explain this obvious paradox that these individuals
12 who had been the leaders in a more permissive
13 approach to the treatment of minors with gender
14 dysphoria, how do you explain the paradox of their
15 institutions taking a more conservative approach
16 whilst we in the United States have moved to a more
17 permissive approach? How do you address that,
18 ma'am?

19 DR. MCNAMARA: I suppose that I disagree
20 with the assessment that international guidelines
21 are more conservative. In my experience, in my
22 professional collaborations across the country, I
23 have observed gender-affirming care being practiced
24 according to clinical practice guidelines. I don't
25 really see any substantive differences in other

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1 countries. And I do believe --

2 DR. DIAMOND: But Dr. McNamara, I must
3 interrupt you.

4 DR. MCNAMARA: -- put a thorough primer on
5 some of these issues.

6 DR. DIAMOND: Doctor, I must interrupt you
7 though. You just mentioned that you don't see any
8 substantive difference. However, we just heard
9 experts telling us that for example in NHS, going
10 forward, the use of some of the medical
11 interventions will be on a clinical trial, so I'm
12 not sure why you say there's no substantive
13 difference.

14 DR. MCNAMARA: That's a wonderful question.
15 Thank you for highlighting that. The word trial
16 does not appear at all in that document. They're
17 not proposing clinical trials, they're simply
18 proposing to gather data. So I think the
19 distinction between a trial and an observational
20 study is really important. There will be no
21 randomization to different types of treatment. And
22 also, those are bulleted guidelines. There's really
23 nothing specific in there yet. What they want to do
24 is gather evidence moving forward, just roll out
25 more perspective studies.

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1 DR. DIAMOND: Understood. And just as an
2 aside, in our August meeting, the one item that I
3 think everyone agreed upon is that there is a
4 pressing need for better data, so I could concur on
5 that. I would also like to ask you --

6 DR. MCNAMARA: Yeah. There's always a need
7 for better data. Sorry, I didn't mean to interrupt.

8 DR. DIAMOND: I'd also like to ask you at
9 Yale New Haven what are your policies of treatment
10 with respect to age cutoffs for referrals of
11 individuals for so-called bottom surgery and
12 so-called top surgery? Do you have any hard and
13 fast age cutoffs or is it an individualized
14 assessment?

15 DR. MCNAMARA: Individualized based on
16 pubertal stage which follows the WPATH and Endocrine
17 Society guidelines.

18 DR. DIAMOND: So for example, are patients
19 being referred at Yale New Haven at age 17 or 16 for
20 bottom surgery? I'm just curious.

21 DR. MCNAMARA: No.

22 DR. DIAMOND: What age would that be?

23 DR. MCNAMARA: I -- what do I think of
24 what?

25 DR. DIAMOND: What age would it be that --

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1 you seem to have a cutoff that you just put
2 discrimination for referrals, and I'm asking for
3 bottom surgery is it age 18? Is it age 17?

4 DR. MCNAMARA: So to be honest, it's so
5 rare. I've never referred a patient for bottom
6 surgery. I don't know of a recent case in which
7 it's been done here. I think what we're dealing
8 with is extremely rare cases in which that's done.
9 And to my knowledge, it has not been done under the
10 age of legal majority in my institution.

11 DR. DIAMOND: And I believe that's the
12 policy at University of Florida and other
13 institutions here in the state. What about for
14 so-called top surgery or mastectomy?

15 DR. MCNAMARA: The exact same thing. To be
16 honest, I've never referred a patient for a surgery.
17 I've never had a patient express that they desire
18 top surgery. And I've never had to explore that
19 because, again, it's quite rare.

20 DR. DIAMOND: I'm a little surprised
21 because --

22 DR. MCNAMARA: I think they're
23 (indiscernible) cases in the past year that have
24 been reported.

25 DR. DIAMOND: I'm a little surprised

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1 because I believe at some of our institutions, we
2 are seeing biologic females being referred at age 16
3 for a mastectomy. But that's not your experience,
4 ma'am; is that correct?

5 DR. MCNAMARA: No. It's not my experience.

6 DR. DIAMOND: Thank you.

7 DR. ACKERMAN: I have a question. Zach,
8 over here to your left.

9 CHAIRMAN ZACHARIAH: Yeah. Go ahead,
10 please.

11 DR. ACKERMAN: So I'm confused,
12 Dr. McNamara. You really are an advocate for
13 gender-affirming care and what I'm hearing from you
14 and other speakers is this is healthy for people,
15 it's healthy for mental health, it's healthy for
16 them in general. So why would you not refer a minor
17 for surgical sex affirming surgery?

18 DR. MCNAMARA: You know, I -- I also
19 appreciate this question because it lends insight
20 into the shared decision-making process. I've never
21 referred a patient for surgery because a patient has
22 never desired surgery who I've cared for. It's all
23 about what the patients want, how that fits into the
24 informed consent model, and how that is -- and how
25 that goes along with clinical practice guidelines.

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1 DR. ACKERMAN: I'm sorry, so what age group
2 are you seeing? I think up to 25 or something?

3 DR. MCNAMARA: 10 to 25.

4 DR. ACKERMAN: Yeah. So at no age has any
5 of your patients desired to have surgery for their
6 mastectomy, a phalloplasty, a phallectomy, none of
7 that?

8 DR. MCNAMARA: Right. None of my patients
9 have desired that surgery at that moment in time.
10 We discuss openly --

11 DR. ACKERMAN: So again, if gender-
12 affirming care is what's proper, why have you not
13 recommended that surgery?

14 DR. MCNAMARA: I don't -- I think what --
15 what I'm trying to say is that I haven't recommended
16 that surgery, I haven't helped facilitate it because
17 none of my patients have expressed a desire for it.
18 That's my --

19 DR. ACKERMAN: Right. So I'm an
20 oncologist. Patients don't come to me requesting
21 desire for chemotherapy, but I recommend
22 chemotherapy because that's what's best for them.
23 So as a physician, if you think that gender-
24 affirming care is best for your patients why have
25 you not recommended surgery on any of your patients?

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1 DR. MCNAMARA: Gender-affirming care does
2 not equal surgery.

3 DR. ACKERMAN: I understand. There's a
4 continuum --

5 DR. MCNAMARA: You know, I think they're a
6 little bit different.

7 UNIDENTIFIED SPEAKER: That behavior is
8 inappropriate, please.

9 CHAIRMAN ZACHARIAH: We need to have some
10 quorum here, so we would appreciate it if you do not
11 do those actions at this point in time. Let's have
12 an intelligent and cohesive conversation, please.

13 DR. ACKERMAN: Dr. McNamara, I understand
14 there's a continuum of puberty blockers, sex
15 hormones to change the sex, and surgery. And what
16 we've heard from all the other experts is that
17 there's this whole continuum is part of gender-
18 affirming healthcare. So do you think that the
19 surgery is part of gender-affirming healthcare or
20 not?

21 DR. MCNAMARA: I do think it's part of
22 gender-affirming healthcare for some individuals.

23 DR. ACKERMAN: Okay. So but you don't
24 recommend it to anybody is what you just said?

25 DR. MCNAMARA: That is not an appropriate

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1 characterization of what I said. I have not had a
2 patient who has expressed a desire for it in my
3 experience.

4 DR. ACKERMAN: Again, they may not express
5 the desire but you as a physician make
6 recommendations to patients based on what you think
7 is best for their overall care. So you have never
8 made the recommendation? Just want to get that on
9 the record. Did you hear me?

10 DR. MCNAMARA: Yeah, I have. I can hear
11 you.

12 DR. ACKERMAN: So are you going to answer
13 my question or just not?

14 DR. MCNAMARA: Oh, I'm sorry. Did you ask
15 another question? I promise I can only hear about
16 50 percent of what you're saying.

17 DR. ACKERMAN: So my question was, have you
18 ever -- you know, as a physician, we recommend
19 treatment to patients based on our judgement of
20 what's best for their care. And so in the continuum
21 of gender-affirming healthcare, surgery is part of
22 that.

23 DR. MCNAMARA: Yeah.

24 DR. ACKERMAN: And so I'm asking you have
25 you ever recommended surgery to your patients?

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1 DR. MCNAMARA: I don't tell anybody, "You
2 need surgery. You should get surgery." That's not
3 how gender-affirming care works. Physicians don't
4 tell patients what they should do with their bodies
5 or their gender expression.

6 DR. ACKERMAN: I understand. Again, as an
7 oncologist, I give my recommendation as to what they
8 need. So again, just answer the question yes or no.
9 Have you ever recommended surgery for your patients?

10 DR. MCNAMARA: I have -- I wonder if maybe
11 we're disagreeing on the definition of
12 recommendation.

13 DR. ACKERMAN: Okay. I'm done. Thank you.

14 DR. MCNAMARA: Is there a --

15 CHAIRMAN ZACHARIAH: Dr. McNamara, I have
16 one question. Just one question that as a board
17 member. My only question is that if tomorrow a
18 patient comes to your office and that person says he
19 or she believes that they need a top or bottom
20 surgery, would you recommend the surgery? The
21 patient really wants the surgery done. He or she
22 believes that they must have the surgery done.
23 Would you recommend the surgery, yes or no?

24 DR. MCNAMARA: At what stage of the
25 patient's care are we in?

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1 CHAIRMAN ZACHARIAH: What's that?

2 DR. MCNAMARA: At what stage are we at in
3 this patient's care?

4 CHAIRMAN ZACHARIAH: No. The patients that
5 you see for gender dysphoria. If the patient comes
6 to you and the patient believes that he or she needs
7 the surgery, would you recommend surgery? Please
8 answer yes or no.

9 DR. MCNAMARA: I can't do that. How old is
10 this patient?

11 CHAIRMAN ZACHARIAH: Let's say 17.

12 DR. MCNAMARA: 17, okay. And how long has
13 this patient been in my care for?

14 CHAIRMAN ZACHARIAH: Well, I didn't talk to
15 the patient. Let's assume the patient had it for
16 several years and now the patient believes that he
17 or she must have the surgery.

18 DR. MCNAMARA: Must have the surgery.

19 CHAIRMAN ZACHARIAH: Yes.

20 DR. MCNAMARA: And what kind of surgery are
21 we talking about specifically?

22 CHAIRMAN ZACHARIAH: Either the top or the
23 bottom surgery.

24 DR. MCNAMARA: Either surgery, okay. So if
25 a patient came to me after they had been in my care

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1 for several years and they expressed a strong desire
2 for a gender-affirming surgery and they were 17, the
3 WPATH guidelines state that this patient should be
4 referred for an informed consent discussion with a
5 qualified surgeon who can discuss the risks and the
6 benefits of that surgery with them. I would
7 facilitate that referral and refer that person to an
8 expert in the surgery that they desire.

9 CHAIRMAN ZACHARIAH: You would recommend
10 the surgery?

11 DR. MCNAMARA: I would allow the surgeon to
12 discuss the options, the risks, and the benefits,
13 because that is not my specific area of expertise as
14 somebody who does not practice any surgery.

15 CHAIRMAN ZACHARIAH: Thank you,
16 Dr. McNamara. Next is Dr. Pages and Dr. David.

17 DR. PAGES: I have another question for
18 you, Dr. McNamara. Can you please walk us through
19 the assessment that gets done in your clinic when a
20 patient presents with issues on possible gender
21 dysphoria before they get referred to an
22 endocrinologist for further treatment?

23 DR. MCNAMARA: I'm actually wondering if I
24 could refer that question to Dr. Dayton who is an
25 endocrinologist who practices in your state? I feel

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1 like she would be the more appropriate person to
2 answer.

3 DR. PAGES: No, but I'm sorry. I want your
4 opinion as an adolescent medicine expert, because
5 when they get to the endocrinologist they are
6 already affirmed. Am I correct?

7 DR. MCNAMARA: Say that again.

8 DR. PAGES: I want your opinion as an
9 adolescent medicine expert because they go to see
10 you or a psychologist before. Once they get to the
11 endocrinologist, they usually go there for
12 treatment, so they're pretty much affirmed when they
13 get there.

14 DR. MCNAMARA: I don't think that that's
15 true. I apologize this is so hard, I can hear about
16 50 percent of what you're saying again and very
17 limited. It's not quite a yes or no because --

18 DR. PAGES: I'm sorry?

19 DR. MCNAMARA: -- we all follow the same
20 guidelines.

21 DR. PAGES: I was just curious about what's
22 the assessment done in your clinic before they get
23 referred to an endocrinologist? You as an
24 adolescent medicine patient. You see a teenage girl
25 that is going through issues with sexual identity,

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1 gender dysphoria. How do you approach these
2 patients? Who do you send them to when you come to
3 see you, referred by their pediatrician?

4 DR. MCNAMARA: I believe what you're asking
5 is how do we approach these patients in their
6 adolescent years. We approach them initially with
7 an interdisciplinary team. So for all intents and
8 purposes, in the provision of gender-affirming care,
9 Dr. Dayton, for instance, and I, practice the exact
10 same type of clinical care. She is an
11 endocrinologist, I am an adolescent medicine
12 specialist. We're both physicians. We're both
13 totally capable of providing this care in the same
14 way. And Dr. Dayton is able to provide youth
15 friendly, developmentally appropriate care for
16 adolescents. The initial approach is just with a
17 team of supportive clinicians. They work with
18 psychiatry, psychology, social work, and others as
19 we've discussed.

20 DR. PAGES: So how long does a patient get
21 seen by a psychologist, psychiatrist before they
22 move forward is my question? How in depth is this
23 evaluation of an adolescent? Especially females,
24 we're seeing more in the female population that are
25 having this issue before they move to

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1 endocrinologist. Because a lot of the times they go
2 to the endocrinologist and these kids are already
3 affirmed by somebody. So who is doing the
4 affirmation of these children is my question?

5 DR. MCNAMARA: It's all individualized. It
6 truly depends on the individual. It does take quite
7 some time for people to move from the initial
8 assessment, the first visit, to any sort of
9 medication, things along those lines. But people
10 are ready for different things at different stages
11 in their life and their journey. It's a really
12 tough question to answer with an absolute. It's
13 impossible, actually.

14 CHAIRMAN ZACHARIAH: And Dr. David, you
15 will ask the last question because we've been going
16 on for 40 minutes.

17 DR. DIAMOND: Thanks. Dr. McNamara, we are
18 regulators. That's why we're trying to ask some of
19 these questions. Cases come in front of us. We see
20 terrible things happening every day. So when we're
21 asking some of these questions it's because this is
22 what's going to come in front of us. I think what
23 Dr. Ackerman was trying to get a sense of was how do
24 we respond when we see cases of 14- or 15-year-old
25 biologic females having mastectomies? Is that in

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1 the public interest of the great state of Florida,
2 or is it not? That's what we're really trying to
3 get at. We're asking for your help.

4 So for example, as a -- I'm asking your
5 personal opinion now. At age, let's say 15, is it
6 an appropriate consideration in your professional
7 experience that mastectomy be a consideration for an
8 individual whom, in your opinion, has gone through
9 all of the requisite antecedent steps?

10 DR. MCNAMARA: I'm wondering if I could
11 give this question to Dr. Janssen, one of our
12 additional experts who is really, truly an expert on
13 that process?

14 CHAIRMAN ZACHARIAH: David, if she cannot
15 answer the question, I need to stop the meeting and
16 take a 10-minute adjournment.

17 DR. DIAMOND: Yes, sir.

18 CHAIRMAN ZACHARIAH: Let the meeting
19 adjourn for the next 10 minutes. Thank you so much,
20 Doctor.

21 (Recess taken)

22 CHAIRMAN ZACHARIAH: Can we get started?
23 Okay. Let's get started. At this time we will have
24 some discussion about what will happen to the rule
25 language. Can we all have some attention? Can you

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1 please stop talking in the back if you don't mind.

2 Hello? Okay. Let's start the discussion about the
3 rules, board members.

4 Dr. Diamond, do you want to start? Just
5 kidding.

6 DR. DIAMOND: I believe Romanello had some
7 comments.

8 MR. ROMANELLO: So Mr. Chair, let me start
9 the discussion on the development of a potential
10 rule.

11 Am I on?

12 Mr. Chair, let me start the discussion with
13 the development of a potential rule by reminding the
14 board that we historically have prescribed and
15 regulated standards of care. In fact, one of the
16 rules in the Florida Administrative Code that this
17 board submits rules to is chapter 64B8-9, which is
18 entitled, "The Standards of Practice of Medicine."
19 And in that chapter, this board -- and there's a
20 parallel rule for our osteopathic physicians.

21 That rule historically has created
22 registries and standards for such practice areas as
23 prescription drugs to treat obesity, office surgery
24 standards, opioid dispensing and prescription,
25 electrolysis, use of laser and light-based devices,

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1 medical marijuana, including a consent form. And by
2 extension, this board regulates the standard of care
3 of a physician when they are supervising a PA or an
4 anesthesia assistant. And most recently, we took up
5 the issue of the Brazilian butt lifts. So we have a
6 -- and Mr. Tellechea, who has been board counsel for
7 a long time, could probably think of other areas
8 where the board has weighed in on standard of care
9 issues.

10 So this morning, it was certainly helpful
11 to hear from the subject matter experts, as well as
12 to review the materials in the portal that we were
13 provided, and to hear the questions of my much more
14 learned colleagues.

15 Mr. Chair, I believe that based upon the
16 testimony that we heard this morning and the
17 materials in the portal that the risks of puberty
18 suppressing therapies, cross hormonal therapy, and
19 surgery, those risks outweigh the possible benefits
20 and that there is a lack of consistent, reliable,
21 scientific peer-reviewed evidence concerning the
22 efficacy and safety of such treatment.

23 And with that in mind, for discussion
24 purposes, I would propose a rule that would prohibit
25 such therapies. And again, I'm talking about

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1 puberty blocking therapies, such as GRH, and I'll
2 look to my colleagues to better define what that
3 looks like, as well as kind of cross hormonal
4 therapies and surgery to treat gender-affirming care
5 or gender dysphoria for patients under the
6 chronological age of 18.

7 CHAIRMAN ZACHARIAH: Do you make this in
8 the form of a motion?

9 MR. ROMANELLO: I do.

10 CHAIRMAN ZACHARIAH: Well, we have a motion
11 on the floor. Do I hear a second?

12 DR. ACKERMAN: I'll second that.

13 CHAIRMAN ZACHARIAH: There is a motion and
14 a second. Is there any further discussion regarding
15 that?

16 DR. ACKERMAN: Yes. I think we --

17 CHAIRMAN ZACHARIAH: Yeah, go ahead.

18 DR. ACKERMAN: I think we should have some
19 further discussion regarding that. I think there's
20 more to it. It was a simple motion. I assume
21 Mr. Romanello put that motion in a fairly simple way
22 right now, so we can discuss this, but I think that
23 there's more to it than that that we need to get
24 through and regarding young Floridians that are
25 already in the process, regarding children that

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1 might have other disorders in where those
2 medications would be appropriate in children that
3 have genetic chromosomal aberrations that need to be
4 addressed.

5 So I just want to -- I don't know how to --
6 I don't want to necessarily incorporate that into
7 the motion but I'm just putting that out there as a
8 point of information and I'm looking for some
9 guidance of how we encompass that in there, as well.

10 DR. DIAMOND: Dr. Ackerman, I think what
11 you're saying is that this is specifically limited
12 to individuals with gender dysphoria. It has no
13 application to individuals with disorders of sexual
14 development. Is that correct?

15 DR. ACKERMAN: That's part of, Dr. Diamond.
16 I think there's some other medical disorders where
17 these children would benefit from some of these
18 drugs. I just would want to make sure that we flush
19 through that and make those drugs still available
20 for the --

21 DR. DIAMOND: Precocious puberty, for
22 example.

23 DR. ACKERMAN: Exactly. Exactly.

24 MR. ROMANELLO: So to that point,
25 Dr. Ackerman and Dr. Diamond, right, the motion I

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1 had talked specifically about the treatment of
2 gender affirmation care or gender dysphoria.
3 Certainly open to expanding that or contracting it
4 and creating -- you know, and I would look to add.
5 I mean, if it's pretty --

6 DR. ACKERMAN: I guess my input is just I
7 want to make it clear that that's what it's for and
8 that these drugs remain available for those that
9 need it that have other disorders. And just saying
10 that in there as part of the motion is a healthy
11 thing to do.

12 MR. ROMANELLO: Yeah.

13 CHAIRMAN ZACHARIAH: See, we have a motion
14 on the floor but we're not going to vote on it until
15 we have full discussion by the board --

16 DR. ACKERMAN: By the board or by the
17 committee?

18 CHAIRMAN ZACHARIAH: By this committee --
19 with this committee. And we can have some public
20 hearing before we actually vote on the issue. But
21 right now, I just wanted to make sure we had a
22 motion, and we can hear from the rest of the board
23 members. Then I will have to allow the public to
24 speak on either side of the issue and then we can
25 vote on the issue.

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1 Other board members?

2 Dr. Hunter.

3 DR. HUNTER: I think we should -- and I'm
4 not sure how this would be done but to include that
5 the standard of care would involve availability of
6 psychotherapy to address the gender dysphoria,
7 distress associated with gender dysphoria, and as
8 we've learned, any other comorbid mental health
9 issues, anxiety, depression.

10 Also, there's -- that I don't believe was
11 brought up, the concern about the high rate of
12 children with neurodevelopmental disorders, such as
13 autism, and ADHD, and others, that are involved in
14 this, that those also have to be addressed. That
15 this isn't just a moratorium but that this is -- the
16 standard involves psychotherapy.

17 DR. DERICK: I'll --

18 CHAIRMAN ZACHARIAH: Yeah, please.

19 MS. JUSTICE: I'll try to say I have some
20 hesitation. I just -- I haven't heard enough about,
21 from my perspective, perhaps the unintended
22 consequences of pulling the guidance around this
23 treatment out from the medical community and into
24 this realm. Not to say that we are not part of that
25 community, right. But I just want to make sure that

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1 we're thinking about potential unintended
2 consequences for the population that would be served
3 by this treatment. In particular, mental health as
4 we've heard from many of the experts today.

5 I recognize from the work that I do that
6 that is a service that is in dire shortage. And so
7 I do think we have an obligation to consider
8 potentially the unintended consequences of any work
9 that we might do here, and consider buffers for
10 that, however that might go. I don't know.

11 UNIDENTIFIED SPEAKER: You folks are the
12 physicians. I think that's something that you're
13 going to have to consider and address through your
14 motions.

15 CHAIRMAN ZACHARIAH: Dr. Diamond.

16 DR. DIAMOND: So Mr. Romanello, to help
17 develop this it's your intent that this motion is
18 limited to individuals with gender dysphoria, and
19 specifically excludes individuals with disorders of
20 sexual development and other types of medical issues
21 as Dr. Ackerman referenced.

22 The second point would be, with your
23 motion, is your intent that once this rule may be in
24 effect, would it take -- would it have jurisdiction
25 over all persons? Would it have jurisdiction only

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1 over those individuals who have not yet begun
2 treatment? Obviously, if a person is currently
3 under hormonal therapy, that is an important item to
4 consider.

5 MR. ROMANELLO: A potential unintended
6 consequence that Ms. Justice had raised and aware
7 of. Yes. So, you know, the answer to your first
8 question is yes. It would exclude, my proposal or
9 my thoughts would be to exclude those conditions
10 that Dr. Ackerman had first spoke about. And
11 certainly welcome the remainder of the board to add
12 other conditions that would be excluded from the
13 rule.

14 The second point, Dr. Diamond, is, you
15 know, my rule would be a prospective rule to take
16 effect, and I would look to board counsel to help on
17 a prospective start date. And then recognize,
18 though, that a potential consequence of a
19 prospective rule would be that it would have an
20 impact on minors who are currently somewhere in the
21 continuum of care that we talked about earlier
22 today.

23 And so for those patients I would propose
24 that we continue that care but that we -- to ensure
25 kind of the safety and ensure an educated and

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1 well-informed patient that we enhance the consent
2 process for those sorts of therapies. Very similar
3 to the way that this board in the past has created
4 specific consent forms for the use of and dispensary
5 of medical marijuana. And so with respect to a
6 potential consent, I would, again, for the board's
7 consideration -- three, I think significant portions
8 of the consent. Again, very similar to what we did
9 with marijuana.

10 So the first, I think is that we need to
11 create some sort of a multispecialty type of
12 consent. We heard the witnesses today, specifically
13 Doctors Dayton and McNamara, agree to a
14 multidisciplinary approach when treating patients
15 seeking gender-affirming or dysphoria type of
16 treatment. So a multidisciplinary consent to
17 include, you know, concurrence from pediatrics,
18 endocrinology, psychiatry. And even I heard, you
19 know, about social workers, licensed clinical social
20 workers, for the importance of ensuring that
21 patients who go through this treatment to have
22 adequate support during the treatment and following
23 the treatment. So I think that's the first thing
24 that I would propose that we consider in creating a
25 consent.

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1 The second, similar to marijuana, would be
2 highlighting and specifically documenting the
3 patient's or the family's attempt with alternative
4 treatments for gender dysphoria, or gender
5 affirmation. You know, counseling -- and again, I
6 don't know what's at the very beginning of the
7 continuum, but before we get to puberty blockers and
8 such, were there other alternative treatment options
9 considered?

10 And then finally, a section where we would
11 specifically require the identification of risks
12 associated with such treatment. You know, the
13 irreversibility or the permanency of, you know,
14 surgery, the effects of puberty blockers. And
15 again, I would look to my colleagues to weigh in on
16 what the appropriate list of risks are. But it
17 would seem that for the protection of patients, and
18 for patients, minor patients and their parents or
19 guardians to be fully and knowingly informed, that
20 they would have that list of risks presented to them
21 at the time of treatment.

22 CHAIRMAN ZACHARIAH: Other board members?

23 DR. SCHWEMMER: Dr. Zachariah?

24 CHAIRMAN ZACHARIAH: Go ahead, Sandra.

25 DR. SCHWEMMER: Mr. Romanello, you talk

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1 about a consent but yet, we're talking -- who would
2 be signing this consent?

3 MR. ROMANELLO: Yeah. So the parents or
4 guardian of the minor patient.

5 CHAIRMAN ZACHARIAH: Any other comments
6 from the board?

7 DR. DIAMOND: So again, Mr. Romanello, if I
8 understand you correctly you are proposing a
9 prospective rule and as an interim measure, are you
10 stating that individuals currently receiving this
11 therapy should receive this enhanced education and
12 asked to go through an enhanced consent process? Am
13 I understanding that correctly?

14 MR. ROMANELLO: Yes.

15 DR. DIAMOND: So if I understand correctly,
16 if this rule were promulgated, there would be some
17 time window that individuals who are currently
18 receiving care would be asked and required to go
19 through this enhanced consent process in order to be
20 able to continue on this treatment; is that correct?

21 MR. ROMANELLO: Yes.

22 DR. DIAMOND: Thank you.

23 DR. ACKERMAN: So this is the end of
24 October. If we put this rule forth at this
25 committee, it then goes to the Board of Medicine and

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1 the Board of Osteopathic Medicine for their next
2 meetings, which is not next week's meeting -- is it
3 next week's meeting that we're talking about? The
4 joint meeting. So it would go to that meeting next
5 week and then that joint committee can then decide
6 when it would go into effect. Whether it would go
7 in effect immediately, or 1st of the year, or 1st of
8 December, or what. We would discuss that I guess
9 next week.

10 MR. ROMANELLO: So can I just -- so
11 Mr. Tellechea, if there's a rule that's acted upon
12 today, procedurally, it would go to the Joint
13 Committee next week and then to each respective
14 board at their next regular meeting? Or does it
15 just stop at the joint meeting?

16 EXECUTIVE DIRECTOR TELLECHEA: Well, is it
17 going to be the full board that's going to be
18 meeting jointly?

19 UNIDENTIFIED SPEAKER: Yes, Ed.

20 DR. ACKERMAN: Yes. Next Friday.

21 EXECUTIVE DIRECTOR TELLECHEA: Then if it's
22 the full board that are meeting jointly, both of the
23 full boards, then that could be the final stop if
24 necessary.

25 CHAIRMAN ZACHARIAH: Does any of the other

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1 board members want to make any comments before I
2 allow the public hearing?

3 DR. DI PIETRO: So just to touch on what I
4 mentioned earlier, I'm in full support of a
5 multidisciplinary team. I think that's of the
6 utmost importance in this to have a mental health
7 counselor, a board-certified pediatric
8 endocrinologist, a board-certified pediatrician --
9 not a nurse practitioner -- a board-certified
10 physician, and part of a multidisciplinary team to
11 ensure that we're doing this correctly.

12 Because it's very easy a lot of times, and
13 I'll use an emotional support animal as a perfect
14 example, to get a letter from someone stating that
15 you need something. And I think the -- for the
16 safety and welfare of these children who very well
17 might need this, it is extremely important to have
18 that multidisciplinary team to make sure that the
19 pediatric endocrinologist is the one who is
20 assisting with hormones, and that the social worker
21 or the psychologist is making sure that there's a
22 support system in place for these children.

23 But I do have a question. So if we're
24 talking about this and the informed consent, sorry,
25 this is for over the age of 18?

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1 MR. ROMANELLO: No. Under the age of 18.

2 DR. DI PIETRO: Okay. That's where I was a
3 little confused. So we're talking this informed
4 consent process with this multidisciplinary team
5 approach for under the age of 18, correct?

6 MR. ROMANELLO: Yes.

7 DR. DI PIETRO: Okay.

8 CHAIRMAN ZACHARIAH: Dr. Hunter.

9 DR. HUNTER: If this -- where this
10 discussion is going, and I'm hearing what
11 Ms. Justice had to say about there is not -- there's
12 a concern about access to mental healthcare and I
13 think mental healthcare should be part of the
14 standard of care. I'm not sure what the role the
15 board has in this area, but we've heard that the
16 research is very conflicted in this area, very low
17 quality. Would a board rule need to include the
18 option of research in this area where these could be
19 used in IRB protocols, IRB approved protocols,
20 research protocols, what England, and Finland, and
21 Sweden have in plan with the appropriate safety and
22 ethical oversight?

23 DR. DIAMOND: Dr. Hunter, are you referring
24 to psychologic care, or are you talking about
25 hormonal care? Please be more specific.

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1 DR. HUNTER: I would be talking about all
2 of that. Yes.

3 DR. DIAMOND: So if I understand you
4 correctly, you would prefer to have a rule in place
5 that outside of participation in a clinical study,
6 these actions that Mr. Romanello enunciated would be
7 prohibited, but you would be willing to entertain
8 them on a clinical study that meets certain
9 specifications? Ala, the National Health Service
10 approach?

11 DR. HUNTER: Yes. Yes. With certainty of
12 safety and ethical oversight.

13 CHAIRMAN ZACHARIAH: Dr. Amy.

14 DR. DERICK: Yeah. I feel I would be
15 supportive of that, too, in order to continue
16 investigating the science.

17 DR. DIAMOND: Dr. Hunter, could you give us
18 a little bit more of your sense as to the mechanics
19 of these studies? Would this have to be an IRB
20 approved study? Would it be limited to a university
21 setting? Could it be in the office setting? What
22 is your -- do you have any sense on this?

23 DR. HUNTER: No doubt it would have to be
24 IRB approved, no doubt. And that hopefully would
25 provide the safety and ethical oversight. I think

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1 I'd prefer it being a center, like a university, a
2 Florida based medical school. I would be even more
3 grateful if it involved international experts,
4 Dr. Cass and the NHS, and Dr. Kaltiala in Finland.
5 And the partner in a way like that, so we do get
6 good quality data, so we know what's the best thing
7 for these kids.

8 DR. DIAMOND: And so Dr. Hunter, again, I'm
9 trying to understand, you're proposing that there
10 would be an allowance that minors who have given
11 appropriate -- whose parents have given appropriate
12 consent, and the child of course given assent, that
13 there would be a mechanism for clinical trials to be
14 conducted, ideally in the university setting, both
15 with GRH agonist and with cross-sex hormones?

16 DR. HUNTER: No.

17 DR. DIAMOND: So please revise.

18 DR. HUNTER: That I think is to be
19 determined, and I think that's what the NHS guidance
20 is saying, that they are writing those now. So to
21 be -- I think we cannot be that specific at this
22 point.

23 DR. DIAMOND: So therefore, you would be
24 supportive of a rule but include in that rule an
25 exception that there could be a carve out for

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1 appropriate research studies and not be more
2 specific than that. Is that correct?

3 DR. HUNTER: Correct.

4 UNIDENTIFIED SPEAKER: So IRB approved --

5 EXECUTIVE DIRECTOR TELLECHEA: So this is
6 something that's going -- this is a whole new area
7 that you folks are entering into within the context
8 of a standard of care rule, and it's going to have
9 to be specific. You cannot be -- just provide these
10 generalized terms for an IRB approved study in a
11 university setting.

12 DR. DIAMOND: I agree with that. Because,
13 Dr. Hunter, I understand what your intent is is to
14 have flexibility to help further scientific research
15 but it's going to make Ed's job impossible. It
16 won't be -- there's going to be no way to enforce
17 these provisions and it will lead to a lot of
18 confusion.

19 EXECUTIVE DIRECTOR TELLECHEA: Yeah. I
20 mean, it's something that's going to have to be
21 clear, understandable, defensible, and it has to be
22 written by next Friday.

23 ATTORNEY MCNULTY: Can I interject? Just
24 one other option that I was thinking of as you were
25 making this presentation and listening to this

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1 discussion is the opportunity for maybe a registry,
2 a Florida registry, which the state has done in
3 other situations. And it would allow then for, you
4 know, the families to optionally enter into a
5 registry. You know, that could be a potential. But
6 then the information about that individual and the
7 therapies could be captured. And it could be -- you
8 know, you could start a registry that could monitor
9 and give data back to the boards to be able to have
10 our specific Florida data to be able to review.

11 EXECUTIVE DIRECTOR TELLECHEA: I think the
12 problem with that, that that goes beyond the
13 standard of care rule.

14 ATTORNEY MCNULTY: Okay.

15 EXECUTIVE DIRECTOR TELLECHEA: So I don't
16 really think you would have the authority to create
17 that registry and to be able to enforce it and all
18 that through the standard of care practice. I think
19 that would be something that you would need to go to
20 the legislature and ask the legislature to create.

21 ATTORNEY MCNULTY: Yeah. My thoughts
22 around that were that, you know, certainly as we've
23 heard with, you know, the testimonies this morning,
24 the patient specific therapies would -- you know, it
25 gives more of a general umbrella, I suppose, to

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1 reporting on those case specific treatments, so --
2 and variation of age. You know, I still think that
3 registries are very helpful. You know, so are -- of
4 course, so are the studies, but when you have small
5 participation in those studies. We know we're going
6 to have a small participation in the registries, and
7 so, you know, the conclusions may not be as direct
8 in a registry as one would conclude in a study with
9 an IRB, but I still think it opens an opportunity to
10 be able to monitor this ongoing situation,
11 therapies. Anyway --

12 CHAIRMAN ZACHARIAH: Any other comments
13 from the board?

14 DR. ACKERMAN: I just want to make sure
15 we're all on the same page here, or I understand
16 what we're talking about here. Mr. Romanello
17 proposed a rule which was seconded by me. Now I'm
18 hearing discussion about a registry and is this
19 registry a loophole to avoid the rule, or is this
20 registry for those individuals that are already in
21 care?

22 ATTORNEY MCNULTY: Collecting data.

23 DR. ACKERMAN: Collecting data on who? I
24 mean --

25 ATTORNEY MCNULTY: Those individuals who

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1 are already in care.

2 DR. ACKERMAN: I'm sorry, if we're having a
3 rule, the rule is the rule, and you can't go around
4 the rule by having a registry.

5 ATTORNEY MCNULTY: And Dr. Ackerman, my
6 comments were only within the discussion of what we
7 were talking about with IRB. My thoughts were about
8 a registry, but I agree.

9 CHAIRMAN ZACHARIAH: See my concern with a
10 registry is you can form all the registries you
11 want, nobody is going to enroll. Why would you do
12 it? What is in it for you? So you can get your
13 records public. Nobody is going to register in the
14 registry, it's not going to happen.

15 DR. ACKERMAN: Well, they're anatomized.

16 CHAIRMAN ZACHARIAH: Yeah.

17 DR. ACKERMAN: No, you would. A lot of my
18 patients are in registry trials. It's all
19 anatomized. They don't -- the records aren't
20 public.

21 CHAIRMAN ZACHARIAH: I agree but, you know,
22 treatment for a cancer, treatment for a heart
23 disease is slightly different than what we're
24 dealing with.

25 MR. ROMANELLO: So, Mr. Tellechea, so we

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1 can make your job a little harder, right. So I
2 think what you're hearing from the board though is
3 kind of a coalescing around the idea of excluding
4 from the rule clinical trials. Like IRB approved,
5 academically sponsored. I don't know, I would look
6 to Doctors Diamond, and Hunter, and Ackerman, and
7 others to weigh in on how to define that. But we
8 certainly don't want to impair progress. We want to
9 promote the continued research in this area for the
10 betterment of all patients. So how could be
11 accomplish that? I mean, I wouldn't want a rule
12 then to inhibit or chill clinical research.

13 EXECUTIVE DIRECTOR TELLECHEA: Well, you
14 would write it in such a way that, as you stated
15 earlier from the outset is that the current
16 procedures are prohibited unless it is done under a
17 -- you know, these particular circumstances. And
18 I'm going to need from you, you know, clinical
19 trials, you know, what type of language you would
20 put in there to make it clear that these are the
21 type of clinical -- that under these circumstances,
22 that it would be approved. So it's a prohibition
23 except for under these circumstances, and then you
24 would have to outline what the particular
25 circumstances are, in a clear, you know, enforceable

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1 manner.

2 DR. ACKERMAN: And I think it's difficult
3 to craft the language to allow for clinical trials,
4 and I think it could easily be gamed.

5 DR. DIAMOND: Dr. Hunter, how would you
6 respond to Dr. Ackerman's comment on that?

7 DR. HUNTER: I probably would agree with
8 that but I -- we need to learn more in this area.
9 We need to learn more.

10 DR. DIAMOND: So I think where we stand
11 right now is there's a sense that if promulgate a
12 rule, it should be a prospective rule. Number two,
13 that those individuals who are currently receiving
14 therapy, that those individuals be required to go
15 through a process of more robust consent as was
16 discussed. And then number three, that the rule, if
17 we were to go and set a chronologic age of 18 for
18 these different points of bifurcation, GHRH agonist,
19 cross sex hormones, and surgical procedures, that
20 there be an opportunity for exceptions to be made in
21 the limited context of robust clinical studies
22 conducted at the appropriate centers. Those are the
23 different elements I'm trying to help synthesize
24 here. Is that the sense of where we stand right
25 now?

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1 DR. ACKERMAN: I think it is but the last
2 thing you said is the difficult thing to define what
3 a robust clinical study is and define what those
4 appropriate centers are. That's my reservation
5 about that. And there's -- not to --

6 ATTORNEY MCNULTY: Where are they normally
7 done?

8 DR. ACKERMAN: Well, I guess other rules
9 that we have, we keep -- those rules are for
10 Florida, and people may do things contrary to those
11 rules in other states.

12 EXECUTIVE DIRECTOR TELLECHEA: Well, you
13 only have jurisdiction in Florida, okay, so --

14 DR. ACKERMAN: I understand. I know but my
15 point -- that's what I'm saying. We have
16 jurisdiction in Florida but if we have a rule here
17 and people do research in another state, similar to
18 the fat transplant to the butt, if they do some
19 research in the state that shows that our rule is
20 not appropriate, then we change our rule. And so
21 people can do research, just not in Florida.

22 ATTORNEY MCNULTY: So we would want them
23 done in university centers?

24 DR. ACKERMAN: No. I don't think we need
25 to make any comment about research. Just leave it

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1 at that. I think it's too -- I think it's difficult
2 for us to craft appropriate language for that. And
3 so I think if there's a rule, there's a rule. And
4 if there's research done, the research can be done
5 in Yale.

6 UNIDENTIFIED SPEAKER: Right.

7 CHAIRMAN ZACHARIAH: Any other discussion?

8 DR. DERICK: Can someone re-read for me
9 because -- can someone re-read the motion that's
10 currently on, that's seconded?

11 DR. DIAMOND: I think where we are, we're
12 trying to develop a sense of different elements --

13 DR. DERICK: I know. I'm still a little --
14 because whenever the motion was initially given,
15 there was a specific age given, and so that's what
16 I'm trying to clarify. So after the age of 18, the
17 consent process we're speaking of is no longer
18 applicable, correct?

19 DR. DIAMOND: Correct. So --

20 DR. DERICK: That's what I needed
21 clarification on.

22 DR. DIAMOND: So for example, my sense
23 would be that once we moved past this, I was also
24 going to make a motion that for individuals who have
25 passed the age of majority that there should be no

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1 restrictions on hormonal therapy or restrictions
2 regarding surgery. I think a person, for example,
3 who is 25 years old, who is mentally competent, to
4 go and tell that person no, I think that is
5 inappropriate. I would like to see this limited
6 just to minors. I think that the state perhaps
7 overreached a little bit on its initial petition
8 when it spoke to individuals who had passed the age
9 of majority.

10 DR. DERICK: I agree with that.

11 DR. DI PIETRO: Will we have opportunity to
12 discuss again after public comment?

13 CHAIRMAN ZACHARIAH: Yeah, sure.

14 DR. DIAMOND: Yes. Perhaps we have some
15 comment now.

16 CHAIRMAN ZACHARIAH: Okay. So let's get
17 the public comments. The comments are for a
18 timeframe of three minutes. And again, if someone
19 who came before you, if they have already stated
20 their case, there's no reason to repeat it, for the
21 interest of time.

22 The first speaker is Zoe Hawes -- am I
23 saying it right? H-a-w-e-s. Zoe Hawes. Yeah.
24 Please come forward.

25 ZOE HAWES: My name is Zoe Hawes. I'm a

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1 23-year-old wife and expectant mother, who at the
2 age of 16 believed I was a boy and that
3 transitioning would bring me peace. Growing up, I
4 experienced a lot of trauma. I was molested when I
5 was 6. My parents divorced when I was 8. My mom
6 attempted suicide when I was 13. I was diagnosed
7 with depression and anxiety in middle school, and I
8 couldn't accept my body and puberty. I just wanted
9 to escape.

10 By the age of 16, I was very unstable and
11 suicidal. I came to believe I was male in a female
12 body after reading a memoir about someone who had
13 transitioned. I came out to my mom who was scared I
14 was going to kill myself if she didn't affirm me. I
15 was immediately taken to a gender therapist who
16 diagnosed me with gender dysphoria and wrote a
17 letter recommending I start testosterone after only
18 three months of therapy.

19 I started T 7 months after coming out at
20 the age of 16, and I really thought transitioning
21 was going to fix everything. My period stopped,
22 facial hair grew. Pretty soon, I was passing as
23 male. At first, I was elated, but my mental health
24 did not improve. I became more suicidal, more
25 unstable, and the anxiety became debilitating. The

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1 testosterone was never questioned as a contributing
2 factor to my increasing instability. I was in and
3 out of mental hospitals six times while being
4 affirmed as a male and supported in my decision to
5 transition by my doctor, psychiatrist, immediate
6 family, and even church. I was also diagnosed with
7 complex PTSD and OCD during this time.

8 I desperately wanted top surgery and a
9 hysterectomy but couldn't afford them. After a
10 serious suicide attempt in February of 2018, I
11 realized that just changing my appearance was not
12 going to take away the pain, so I started working
13 really hard in therapy, but I still believed I was a
14 male.

15 A year later, in 2019, I had a life
16 changing encounter with Jesus and begin to find deep
17 healing and peace within myself. After nearly four
18 years of being on testosterone, I decided to
19 detransition and accept my womanhood. My mental
20 health improved exponentially. I'm no longer in
21 therapy, nor even on mental health medication. I
22 have not been suicidal or hospitalized since
23 stopping testosterone.

24 Three years later, my menstrual cycle has
25 still been irregular, I still have to shave my face

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1 daily, and I struggle with hormonal acne. I'm truly
2 grateful I never got surgery because now I'm happily
3 married and 28 weeks pregnant. But if I had gotten
4 the surgeries that I so desperately wanted as a
5 teenager, that would have stolen this future from
6 me. So I'm asking the board to create a rule that
7 makes it unethical for doctors to prescribe these
8 hormone treatments for people under the age of 18
9 and surgeries under the age of 21. Thank you.

10 CHAIRMAN ZACHARIAH: Thank you, Zoe, for
11 the courage, and appreciate you coming before the
12 board.

13 Next is Rachael Foster (phonetic).

14 RACHAEL FOSTER: Hello, my name is Rachael
15 Foster, and I am a 32-year-old de-transitioned
16 woman. At 21, I was diagnosed with gender identity
17 disorder, as it was at the time, and spent the next
18 five and a half years taking synthetic testosterone.
19 I was told by my psychologist and by my general
20 practitioner she referred me to that if I did not
21 take this drug, I would kill myself.

22 Within a few weeks, I went from talking
23 with my psychologist to being prescribed synthetic
24 testosterone. I was discouraged from seeing an
25 endocrinologist and was told all effects except hair

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1 growth and hair loss were reversible. This was a
2 lie. My provider failed to assess risks based on my
3 medical history or in fact critically analyze
4 whether I was fit to consent, or if there were more
5 psychological reasons for my distress around my sex.

6 In addition, my therapist lied on
7 documentation to say I had been her patient for far
8 longer than I had been and that I had no preexisting
9 conditions that might affect my gender identity
10 disorder diagnosis.

11 There are many compounding factors for why
12 I felt wrong in my body. At 17, I was diagnosed
13 with schizophrenia with major depression, now
14 diagnosed with schizoaffective disorder. I also
15 have a history of sexual abuse and trauma. I
16 disclosed these things to my psychologist and
17 prescribing physician but was still told that I need
18 to transition.

19 At the age of 26, I began to experience
20 renal failure. I was jaundiced, vomiting, and
21 urinating blood. The only drug I was on at this
22 time was synthetic testosterone. I saw a new
23 practitioner who suggested I stop the injectable
24 synthetic testosterone in exchange for a topical
25 version at a much lower dose. My symptoms improved.

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1 At 27, I stopped all together.

2 Shortly after, I experienced the first of
3 three transsystemic attacks, also called
4 ministrokes. Then at 28, I was diagnosed with
5 endometriosis and adenomyosis. At 29, I lost my
6 uterus and my cervix to the disease and had a
7 hysterectomy. After the operation I discovered that
8 my vaginal tissue was excessively thinned and
9 weekend by testosterone use. I had multiple tears
10 which lead to infections. I also learned that my
11 ovaries no longer function, and I am on supplemental
12 estrogen.

13 Today, I implore you to consider the risks
14 these medical experiments have and stop this method
15 of treatment. We cannot consent to treatment as
16 experimental as this. No one, child or adult,
17 should have to go through the constant health
18 battles I've been through. Instead of my mental
19 health being taken care of, I was sold a medication
20 that has left me with physical pain, emotional
21 trauma, and the same mental illness I had before.
22 Medical intervention should not be taken to effect
23 emotional distress over one's body. Thank you.

24 CHAIRMAN ZACHARIAH: Thank you, Ms. Foster.

25 Next is Chloe Cole (phonetic).

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1 CHLOE COLE: My name is Chloe Cole, and I
2 am an 18-year-old de-transitioned female from the
3 Central Valley of California. I was what some may
4 refer to as a trans kid as I transitioned between
5 the ages of 12 to 16. I began my social transition
6 by cutting my hair, wearing boys' clothes, and
7 asking my family and friends to refer to me using a
8 new name.

9 At 13, I started taking puberty blockers
10 and testosterone. And at 15, I underwent a double
11 mastectomy in which my breasts were removed, and my
12 nipples were grafted. And yet, at 16, after years
13 of medically transitioning, I came to realize that I
14 severely regretted my transition. It has been over
15 a year since my last testosterone injection.

16 During my diagnosis for dysphoria and the
17 consultations for my treatments, the overall picture
18 of my life just went completely unaddressed. From a
19 young age, I was actually quite a very feminine
20 girl, although I did somewhat model myself after my
21 older brothers. Up until my transition I had
22 relatively normal levels of teen distress, but my
23 early exposure to social media and the internet led
24 to my body image worsening. I was introduced to
25 inappropriate content and an echo chamber of

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1 far-left ideology, such as that sex and gender are
2 separate, women are inherently victims, men are
3 inherently superius in every way, and that dysphoric
4 children need hormones and surgeries in order to
5 live. These reductive ideologies have crept their
6 way into science, and by extension, medicine.

7 I knowingly gave my mind and eventually my
8 body to an anti-science movement that reduces
9 womanhood to long hair, Barbie dolls, dresses, and
10 false self-perception. I actually developed more
11 psychiatric issues the further I went into
12 transition. I was on the verge of suicide for
13 nearly all of high school. Some things went
14 undiagnosed for years until after I stopped
15 transitioning, like autism and body dysmorphia.

16 All that talk about mental health, self-
17 perception, pronouns, and ideology leads me to the
18 question why is the mental health epidemic not being
19 addressed with mental health treatment to get at the
20 root causes for why female adolescents like me want
21 to reject their bodies? I was not suicidal before
22 going on hormones, and yet, doctors asked my parents
23 the question, "Would you rather have a dead daughter
24 or a living son?" This is not how medical
25 professionals are supposed to talk. This is how

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1 activists talk.

2 What was the cost of treating mental health
3 with barbaric surgeries? I have bandages on my
4 chest today, over two years post op, because my
5 nipples leak fluid and they stain my clothes. I
6 have no breasts. I want to be a mother someday, and
7 yet, I can never naturally feed my children, my
8 future children. My breasts were beautiful and now
9 they have been incinerated for nothing. Thank you,
10 modern medicine.

11 CHAIRMAN ZACHARIAH: Well, thank you so
12 much, Chloe, for coming here today.

13 Next is Camille Keifel (phonetic).

14 CAMILLE KEIFEL: My name is Camielle
15 Keifel. I stand here before you today, Florida
16 Board of Medicine, in hopes that you'll make the
17 right decision regarding transitioning children and
18 take greater consideration for adults.

19 Prior to my transition, I had spent 20
20 years of mental health therapy with conventional
21 modalities. I didn't respond well to medication,
22 saw a gender therapist, and had two rounds of
23 transcranial magnetic stimulation therapy. I was
24 diligent and wanting to heal, but nothing my doctors
25 offered had healed me because they always saw my

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1 issue strictly as a mental one.

2 I was 30 and at the end of my rope when I
3 transitioned. At the time, I believed I was
4 nonbinary. I struggled with severe mental illness
5 and suicidal ideation. I had a trauma history.
6 When I was in sixth grade, my best friend had been
7 raped by her brother. Being a girl meant I was
8 vulnerable. I started to present more masculine.
9 This should have been a red flag, yet, within months
10 of requesting top surgery, it was performed on me.

11 I developed complications after my surgery.
12 There were many times I didn't know if I would make
13 it through the night. If I made this mistake as an
14 adult, a young girl could too. Not only did my
15 surgery exacerbate my mental health issues, I now
16 struggle with physical complications as well.
17 Presenting and taking on another gender was a way
18 for me to escape womanhood. Escape is not a valid
19 way of dealing with trauma. You will have to deal
20 with it eventually.

21 I was able to work through these difficult
22 emotions and improve my mental health through a
23 holistic approach. I had physical health issues
24 that had been previously overlooked. Had that been
25 managed, I would have never gotten the surgery. The

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1 surgery was an abhorrent misdiagnosis. The goal of
2 healthcare should always be to get to the root cause
3 of the problem. Today I am more grounded than I
4 have been in my entire life, but I am mutilated.
5 Between my carved-up body and the physical
6 complications, I often question if there's anything
7 on the other side. Where my breasts were are
8 hollow, I can never get them back. I can never fit
9 a dress the same way again. I can never breastfeed.
10 Who will love me? You know what keeps me going?
11 Stopping this from happening to someone else. Thank
12 you for your time. You will have a lot to consider,
13 and I know you will make the right decision.

14 CHAIRMAN ZACHARIAH: Thank you, Ms. Keifel,
15 for coming. I appreciate you spending time with us.

16 Next is Shay Scheffler (phonetic).

17 SHAY SCHEFFLER: Hi. My name is Shay. I
18 started identifying as transgender at 22 while still
19 in college. Before that, I was just a feminine gay
20 man. Being asked about my pronouns led me to
21 research transgender ideology, and pretty quickly I
22 got convinced that I was transgender woman. I was
23 able to get hormones really easy through Fenway
24 Health (phonetic) and was only on them for a year
25 before receiving facial feminization and breast

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1 augmentation surgeries at 23.

2 Taking hormones actually worsened my mental
3 health but therapists thought it was because I was
4 stuck in the wrong body. They're clearing me for
5 sex reassignment surgery by diagnosing me with
6 gender identity disorder. Immediately after SRS I
7 was super excited to start a new life. I was happy
8 for a few months while recovering.

9 However, soon I realized that my new part
10 wasn't what doctors promised me. My new vagina
11 started constricting, despite reverse dilation which
12 resulted in me developing vaginal stenosis. This
13 left me unable to have penetrative sex, which
14 adversely impacted my mental health. I also lost my
15 sex drive, my motivation to achieve anything, and
16 became brain fogged and lethargic. I had multiple
17 unsuccessful revisions attempting to get a few
18 inches of new vaginal tunnel. I even had colon
19 vaginoplasty. The last revision was at the
20 University of Miami by Dr. Christopher Salgado in
21 2018 and has left me with a colorectal fistula.
22 I've been all over the country trying to seek help,
23 but I have received none.

24 Earlier this year after hitting rock bottom
25 with my depression, I reached out to a new

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1 therapist. This therapist helped me realize that I
2 have complex PTSD from a traumatic childhood and
3 also pointed out that I have body dysmorphia, OCD,
4 borderline personality, and bipolar disorders. I
5 also realized I had internalized homophobia. I
6 realize now that medical transition was sold to me
7 as a hardware fix for software issues.

8 A few months ago, I started
9 de-transitioning by taking testosterone. However,
10 it is traumatic to be on testosterone without having
11 functional genitals. Moreover, my back hurts every
12 day due to a psoriasis and scoliosis that I
13 developed post SRS. I'm now dependent on synthetic
14 hormones for life.

15 I traded my perfectly healthy genitals for
16 an artificial one-inch tunnel that is sexually
17 nonfunctional. I realize that I'm never getting
18 back a functional penis and full detransition is not
19 really possible in my case. I feel stuck in
20 surgically created body. I believe nobody under 18
21 should be allowed to medically transition. Sex
22 reassignment surgery should only be allowed in very
23 rare cases after full psych evaluations. Patients
24 should be made aware that what they're really
25 getting is a cosmetic surgery and it's a genital

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1 approximation surgery that does not change
2 biological sex. Thank you.

3 CHAIRMAN ZACHARIAH: Well, thank you so
4 much.

5 Next is Billy Burley (phonetic).

6 BILLY BURLEY: Good morning, members of the
7 board of medicine. My name is Billy Burley and I
8 used to be transgender. When I was about five years
9 old, I started having the reoccurring thought that
10 God made a mistake, I'm a girl. I prayed before
11 going to bed and always asked, "God, please make me
12 a girl before I wake." If I could have, I would
13 have chosen any path that would have transformed me
14 into a girl.

15 In my early 20s, I sought help for the
16 disconnect between my mind telling me I was a woman
17 and my body telling me I was a man. In seeking help
18 and doing my own research, the message I received
19 was that I had to change my body to match my mind.
20 I decided to follow the therapists' and medical
21 researchers' encouragement to change my body. I
22 started on testosterone blocker and estrogen. My
23 emotions were up and down, and my body was changing,
24 but I was supposedly on this new road to happiness,
25 which made me happy.

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1 In my first surgery, I had a penile
2 inversion, an Adam's apple shave, and a brown shave.
3 After the surgery, the doctors and nurses had
4 difficulty stopping the bleeding from my new vagina.
5 My artificial vagina was packed with gauze and a
6 sandbag was placed on my lower abdomen, but the
7 bleeding did not stop. I received a blood
8 transfusion and plasma and eventually, the bleeding
9 did stop. My two-week stay in the hospital turned
10 into a three-week stay. But changing my penis to an
11 artificial vagina required two surgeries, so about
12 four months later, I was back for part two,
13 labiaplasty.

14 I was desperate for the happiness I believe
15 was ensured me. After this, I had additional
16 feminization surgeries but no matter how many I had,
17 every time I looked in the mirror, I saw a man
18 looking back at me. I tried hard to resolve the
19 conflict between my mind and my body but after seven
20 years of trying, I had more problems at that point
21 than when I started on the road of transition.

22 The bottom line is that the therapists and
23 medical researchers were wrong. I have fully
24 transitioned back to male. I am happily married. I
25 have two beautiful stepdaughters. And I have peace

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1 of mind and body. I was an adult when I made the
2 horrible decision to transition. The therapists and
3 doctors failed to help with my underlying problems.
4 They identified me as transgender, and they were
5 wrong. How often are they wrong? I urge you to
6 create a rule that makes it unethical for doctors to
7 prescribe gender converting treatments or puberty
8 blockers for people under the age of 18. Thank you
9 for hearing my testimony.

10 CHAIRMAN ZACHARIAH: Thank you, Mr. Burley,
11 for coming and talking to us.

12 Next is Cat Cadison (phonetic).

13 CAT CADISON: I'm Cat, a de-transitioned
14 woman, singer, and molecular biologist. As a child,
15 I was artistic, nerdy, and socially awkward
16 struggling to find my place in the world. I was
17 subjected to both abuse and bullying beginning in
18 toddlerhood. As a result, I felt alien in my body
19 very early on. If I was a body, I thought I could
20 protect myself.

21 At 5, I asked my mother if it was possible
22 to change genders and she said no. For the next
23 eight years, I disliked my sex but believed I was
24 resigned to my fate until age 13 when I came across
25 an online forum for transgender people. That day I

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1 began believing that the reason I suffered from
2 anxiety, depression, and anorexia nervosa was
3 because I should have been born male. I read that
4 if one had gender dysphoria it meant she was trans
5 and that she was extremely likely to take her own
6 life if she didn't transition. But back then in the
7 mid-2000s, gender-affirming culture did not yet
8 exist. My parents, peers, and pediatrician did not
9 affirm me, for which I am now grateful.

10 My cross-sex identification persisted until
11 age 17 when my parents took me to a gender
12 therapist. They hoped he would take a holistic
13 approach considering my many comorbid mental health
14 issues, but he affirmed as a boy immediately. The
15 therapist began using he/him pronouns for me, and my
16 appointment three, he suggested I started
17 testosterone. My parents were astounded and did not
18 comply with his recommendations.

19 I was unable to pass as male without any
20 medical interventions, and I temporarily desisted.
21 But my unhealthy beliefs about gender such as you
22 cannot be happy unless you transition, continued to
23 fester in my mind. After years of rumination, this
24 culminated in me deciding to medically transition.
25 I obtained testosterone by calling Planned

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1 Parenthood and was prescribed after just a 30-minute
2 phone conversation.

3 Within months of starting testosterone, I
4 experienced side effects such as liver and gall
5 bladder damage, heart palpitations, and the
6 permanent loss of my natural singing voice. This
7 was what ultimately influenced me to detransition as
8 I realized appearing as a man was not worth
9 sacrificing my music. But if this hadn't been my
10 tipping point, I might have pursued surgery and come
11 to regret it as countless others have.

12 If I had been prescribed puberty blockers
13 at age 13, I'd likely be suffering from infertility,
14 osteoporosis, and/or stunted brain development. All
15 gender-affirming care is experimental, lacking
16 controlled studies, and sufficient data on its
17 long-term outcomes, so I caution against treating
18 patients of any age in this manner. However,
19 patients younger than 25 when the brain is fully
20 developed are particularly vulnerable.

21 Because puberty blockers stunt brain and
22 bone maturation leading to lifelong disabilities, I
23 advocate for the complete cessation of prescribing
24 them to gender dysphoric youth and for no other
25 medical interventions to occur prior to age 25.

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1 Thank you.

2 CHAIRMAN ZACHARIAH: Well, thank you so
3 much, Ms. Cadison.

4 Next Helena Kershner (phonetic).

5 HELANA KERSHNER: Hello, my name is Helena
6 Kershner and I'm 24 years old. I'm here today as a
7 de-transitioner with grave concerns about the
8 so-called gender-affirming model of responding to
9 minors and young adults who believe they are
10 transgender.

11 As a young girl, I had no discomfort with
12 being female. What I did have was a history of
13 family issues, difficulty fitting in with other
14 girls, eating disorders, self-harm, and depression.
15 When I was 14, I began spending a lot of time online
16 in communities where countless other troubled
17 adolescent girls were encouraging each other to
18 interpret social, emotional, and body image
19 difficulties as signs of gender dysphoria with the
20 belief that body modification would be a
21 transformative solution.

22 When I took steps in the direction of being
23 trans, I received more positivity and encouragement
24 than I had ever experienced. By age 17, I
25 identified as a trans boy and was fully convinced

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1 that my only chance at living a happy life would be
2 to take hormones and undergo surgeries to change my
3 body.

4 My school counselors and school therapist
5 both affirmed my beliefs, and the psychologist even
6 told my mother that she was risking my suicide if
7 she would not agree to testosterone treatments. But
8 thankfully, she was not intimidated.

9 I went to a Planned Parenthood a few weeks
10 after my 18th birthday. None of the clinicians were
11 interested in what was behind my desperation to
12 change my body. They told me that because I seemed
13 so sure they would prescribe the hormones that day,
14 forgoing blood tests. I told the clinicians that I
15 wanted a high dose, so I would see more changes in
16 my body. They agreed and prescribed me 100
17 milligrams of testosterone per week.

18 The mental health effects of testosterone
19 were profound. I began experiencing uncontrollable
20 episodes of rage and paranoia where I was a danger
21 to myself and others. I also became more suicidal
22 and self-harming. Due to this, I was hospitalized
23 twice. None of the clinicians in the hospital or
24 outpatient center ever mentioned testosterone as a
25 possible source for my mysterious new symptoms.

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1 Instead, I was prescribed a litany of psychiatric
2 drugs.

3 This time was so dark that it caused me to
4 question the original promises of a joyful trans
5 life, and after five years of identifying as trans
6 gender, I stopped taking testosterone and began the
7 journey of de-transitioning. My mysterious new
8 mental illness went away soon after and has never
9 returned.

10 I am forever grateful that clinicians were
11 not able to affirm me any further. I am very
12 fortunate to not have experienced any obvious
13 physical detriments, but the negative impact of the
14 so-called gender affirmative care on my life cannot
15 be understated. Not only was I in serious danger
16 under the influence of testosterone, but the mental
17 process of returning to reality, accepting my body,
18 coping with everything that happened, and facing the
19 mental health issues that were compounded by these
20 experiences has been very difficult.

21 I ask the board to see these dangers of
22 gender affirmation and create a rule prioritizing
23 exploratory psychotherapy and long-term health over
24 dangerous cosmetic interventions for these
25 vulnerable young people. Thank you.

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1 Thank you, Ms. Helena.

2 Next is Ted Haley (phonetic). Yeah, please
3 proceed.

4 TED HALEY: Yeah. I've got 31 minutes. I
5 could do it but you all might not want to listen, I
6 don't know. I want to be fair to everybody.

7 Okay. First of all, it is an honor and a
8 privilege, and I am humbled to be here to testify to
9 the Medical Board of Florida. I also want to say to
10 all my trans friends, been there, done that, got the
11 badge. Not many people are going to say this but
12 being transgender is not easy. It takes a lot of
13 courage, you have to be brave and determined. So no
14 matter what you say, being transgender is difficult.

15 Well, with that, I want to say thank you to
16 Dr. Laidlaw, I can confirm that what he says
17 personally is true. All the things that he laid
18 out, I got the badges. What makes me qualified?
19 Well, at age eight, I too had gender dysphoria. But
20 I was an old school because back then you couldn't
21 do anything. So I had to wait until I was 50. But
22 in that time, I had to wait until then, I had five
23 adopted children and I was, you know, divorced and I
24 had free range because my kids were adults,
25 basically. But what did I do? I did it all.

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1 Everything you could do. Two facial feminization
2 surgeries, trach shave, in and out bottom surgery,
3 hundreds of hours of electrolysis. If you've ever
4 done that, it is painful.

5 So why am I telling you all this? I'm
6 telling you because yeah, I was happy for a few
7 years. It's kind of like buying a car, you know, an
8 expensive one with the real expensive payments.
9 Then a few months later, you get buyer's remorse.
10 Well, that was me. I was very happy for about 8 to
11 10 years, then I started experiencing waves of
12 depression so severe that, yes, I might not be here
13 today had it been for my faith in God and the fact
14 that I'm raising my granddaughter.

15 This is a serious issue. We don't take it
16 lightly. I don't take it lightly. I have two
17 friends that have died in these procedures, medical
18 procedures. They're dangerous. This is something
19 very, very serious. I have two trans friends that
20 committed suicide. Yes, I know what it's about.

21 So what am I asking? Is that the medical
22 board seriously consider delaying this until the age
23 of consent. I was 50 years old when I transitioned,
24 and it took me to 62 to figure it out. So if me at
25 62 can't figure out, how in God's green Earth is a

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1 minor going to? They want to be a fireman one day,
2 a policeman, a boy, or girl, whatever. But I know
3 you all will make the right decision. They you for
4 the privilege to being here and thank you trans
5 friends for being here too.

6 CHAIRMAN ZACHARIAH: Thank you, Mr. Haley.

7 Next is Yako Shenfield (phonetic).

8 YAKO SHENFIELD: Ladies and gentlemen, good
9 afternoon. What you're about to hear is tragic. My
10 name is Yako Shenfield and last year on August 22nd,
11 I buried my beloved daughter because of what gender
12 transition treatment did to her. My daughter had
13 been in counseling for depression since the age of
14 15 but had never said anything about gender
15 dysphoria to her counselor.

16 At age 17, her mother told me that she was
17 transgender. She did suffer from rejection in
18 school and was seeking affirmation. Five of her
19 friends announced they were transgender. When she
20 said that she was trans, she finally had her peers'
21 acceptance, so she thought. And she had not
22 previously experienced in high school, I mean the
23 acceptance.

24 When my daughter went to college, she began
25 taking testosterone. When I saw her at the college,

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1 she was very depressed. Actually, she was almost
2 rejected for non-performance of her academic
3 studies. A social worker presented a meeting with
4 my daughter. Her name is Shannon Sonnet, MSW
5 (phonetic). She told me that my daughter was going
6 to get a double mastectomy. When I objected to her
7 taking such a drastic step at such a young age at
8 that point, 19 or 18 and a half, the social worker
9 told me I was a typical chauvinist male. I am a
10 typical chauvinist male who doesn't love his child
11 enough. She said, "This is what we are going to do,
12 and you need to just get on board." The social
13 worker assured me that everything would be fine if I
14 just loved my daughter.

15 My daughter had a double mastectomy at age
16 19. Exactly when, I don't know, because she didn't
17 speak to me for about two years. It wasn't my
18 decision, it was her decision. At some point,
19 finally, it was very painful to me that separation
20 from my child. Things were amended. I accepted her
21 and to the best that I could because inside, I was
22 in such dichotomy of feelings because I rejected
23 this whole journey. I think it's against God. It's
24 against biology as we heard from Dr. Laidlaw.

25 UNIDENTIFIED SPEAKER: Time.

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1 I'm talking, okay.

2 UNIDENTIFIED SPEAKER: Time.

3 UNIDENTIFIED SPEAKER: These people also
4 cheated. I was the second person here that handed
5 in my speaker card and none of these people --

6 CHAIRMAN ZACHARIAH: Excuse me. You've got
7 to stay quiet.

8 You know, Mr. Shenfield, thank you so much.
9 Your three minutes has expired. I really appreciate
10 you coming.

11 Now let's go on to -- you're next.

12 UNIDENTIFIED SPEAKER: Okay. I'd like to
13 called --

14 CHAIRMAN ZACHARIAH: No, no. You had three
15 minutes and that's it.

16 UNIDENTIFIED SPEAKER: Next, please, Bob
17 Flynn (phonetic). Bob Flynn if you're here, we're
18 calling you.

19 CHAIRMAN ZACHARIAH: Sir, we are not going
20 to allow it. You have to sit down. You have to do
21 an orderly manner and you're going to run this
22 meeting. You sit down. I am just telling you, you
23 sit down, or somebody will sit you down.

24 UNIDENTIFIED SPEAKER: We're calling Bob
25 Flynn at this time.

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1 Mr. Bob Flynn, please.

2 MARY FLYNN: Mary Flynn. We both have
3 cards. Would you prefer just Bob and then I go
4 later, or --

5 UNIDENTIFIED SPEAKER: No. I'm okay with
6 both of you, please.

7 MARY FLYNN: Okay. I'll start in the
8 essence of time. So my name is Dr. Mary Flynn; I'm
9 a consulting psychologist and a proud mother of a
10 transgender child who is now 12 years old. It's a
11 joy to raise this beautiful child and everything
12 we've heard before is nothing that I've ever heard
13 before in any support group, by any physician, by
14 anything.

15 So to be clear, our child at age 4 was --
16 came out as transgender. She told us who she is.
17 We worked with a panel of experts, just to your
18 point. We have a full team of people. She meets
19 with a psychologist every single week. She's met
20 with three over the years.

21 For the past 8 years, we've been on this
22 beautiful journey helping our child who had suicidal
23 ideation at age 5 and now is a healthy, happy 12-
24 year-old thriving in Florida. But we are scared
25 we're going to have to move because she has started

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1 gender-affirming care at age 12. She has a puberty
2 blocker. And you all have the power to save her
3 life and all of the lives of these people that need
4 this medicine. You actually have the power here.

5 If we did not have this medicine, she would
6 not be alive. We are so proud of her, and we are so
7 proud to be in Florida where they have allowed her
8 to get her care. What you're talking about is
9 waiting until age 18. Well, they won't be here.
10 This group commits suicide. They will not be here.
11 So we need the medication, please.

12 BOB FLYNN: We want to put the hands -- we
13 want to put the control in the hands of the parents,
14 right. We want to be able to make these decisions
15 for our kids. One lady said, "Wait until they're
16 25." We all have the ability to be able to make
17 these decisions as adults. For every study, there
18 is always a counter study, right. We've heard that
19 today through in and throughout.

20 And I feel that, you know, we can answer
21 these questions and we should let these children
22 proceed and put the capability in the hands of the
23 parents, so that the kids can do their thing, okay.
24 When you take that medication away, we can't do that
25 decision. And now the burden is on our daughter.

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1 We'll probably have to move, and that is even deeper
2 despair for her.

3 And what happens in the Netherlands is the
4 same thing that happening here. It's all political.
5 100 and 30 something bills have already been
6 positioned, and that, as a result, against
7 transgender care. And that to me is just atrocious.
8 We're here to support our kid. I need you to help
9 us support our kid. At least keep us to have the
10 tools to support our kid.

11 UNIDENTIFIED SPEAKER: Thank you very much.

12 CHAIRMAN ZACHARIAH: Thank you. Next is
13 Blaze Treatis (phonetic).

14 BLAZE TREATIS: Good morning. I'd like to
15 thank State Surgeon General Joseph Ladapo for
16 seeking Florida medical guidelines which prohibit
17 medical doctors from prescribing puberty blockers
18 and cross-sex hormones for children, and from
19 performing sex change surgeries on children.
20 Dr. Ladapo correctly asserts that puberty blocker
21 drugs and cross sex hormones cause irreversible
22 lifelong injury to children such as loss of bone
23 mass, blood clots, and lifelong sterility.

24 Until the Florida legislature criminalizes
25 medical doctors performing genital mutilation

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1 surgery on children, the Board of Medicine and Board
2 of Osteopathic Medicine should adopt the
3 recommendations of State Surgeon General Ladapo. It
4 is an oxymoron to call sex change surgery for
5 children "gender-affirming care." As there is no
6 care being provided but instead only child abuse
7 which has been outlawed and criminalized in some
8 states in America.

9 What is happening is that social media,
10 such as TikTok, promotes gender dysphoria which
11 leads to peer pressure among teenagers and preteens
12 to succumb to the pressure to believe that they
13 should try to become the opposite sex. In the
14 extremely rare cases of gender dysphoria, the child
15 invariably is experiencing depression will pass with
16 time and perhaps, treatment. The solution to the
17 temporary depression in children is not irreversible
18 side effects of puberty blocking drugs and cross-sex
19 hormones and life altering, irreversible sex change
20 surgery.

21 It is way past time for women and feminists
22 to reject men's false assertion that men can become
23 women by putting on a dress and makeup and take some
24 hormones. When feminist succumb to the false
25 demands of these transgender men who claim now to be

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1 women, the feminist are victims of what they say
2 they are fighting against, which is patriarchal men
3 dominating and controlling them, women. Transgender
4 men dominating girls and women in high school
5 sports, in college sports, public discourse, public
6 policy, and every other aspect of society. Women
7 should stand up against this attempt by transgender
8 men to dominate women.

9 University of Kentucky swimming champion
10 Riley Gaines has been outspoken on television
11 arguing against transgender men such as Leah Thomas
12 being allowed to dominate women swimmers in the
13 college swimming championships. Ms. Gaines spoke
14 the truth when she said that "Womanhood is not a
15 mental disorder suffered by men." That concludes my
16 remarks.

17 I would just like to say that I agree with
18 the board member in the front who says to leave the
19 clinical studies out of this proposed rule. It
20 seems to be complicating it greatly. And as the
21 gentleman said, there's 49 other states where these
22 studies can be done, and I think it would be better
23 to leave that out. I appreciate you. It looks like
24 you're going in the right direction. Please
25 continue. Thank you.

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1 ATTORNEY MCNULTY: Thank you. Calling Hope
2 McClay, please.

3 HOPE MCLAY: Hi, I'm Hope McClay. This is
4 my mother. I am not a medical professional. I am
5 not a scientist. I am just here as a mother. In
6 2023, I was a mother to three little boys. Today, I
7 am the mother of two little boys and one beautiful
8 little girl.

9 Our journey started since my daughter could
10 walk or talk. Ever since she could walk or talk,
11 she presented as female. I thought I had a very
12 creative little boy, possibly would grow up to be
13 gay and never leave his mother. She would wear
14 dresses, fashion long hair out of t-shirts.

15 And it wasn't until -- and we allowed this
16 to continue inside the home, but outside the home,
17 we forced her to conform and to be a boy. We
18 physically, at times, had to force her to put her
19 boy clothes on. We physically had to force her to
20 cut her hair and keep a short haircut. And these
21 escalated to such an extent that it was becoming
22 distressing, really for all of us, to physically
23 force a child.

24 My daughter is a very determined person.
25 She's always known who she is. At one point, she

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1 came up to me at about three and a half years old
2 and begged me, crying, and said, "Please, don't make
3 me be this way anymore. This is not who I am. I
4 want to die." And while I know it sounds profound
5 that a three-and-a-half-year-old would be able to
6 say these words, we still did not support her. What
7 we did was we educated ourselves and we went to
8 professionals.

9 We went to some of the best professionals
10 in the state of Florida who helped us understand
11 what transgender is. I didn't really know what that
12 was. And so we supported her social transition and
13 her journey. Today she is almost 10 years old. She
14 is a competitive synchronized swimmer. And no, she
15 does not dominate the sport. She just had her level
16 one test and failed magnificently, but she loves the
17 sport.

18 She -- we're not looking to have surgery,
19 we're not looking to do anything harmful to our
20 daughter other than support her mental health. It
21 would be psychologically damaging if she had to go
22 through puberty as a male. It would be
23 psychologically damaging for her siblings, for our
24 family.

25 All we're asking is that the medical

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1 professionals treat each patient individually. Our
2 doctor is here in this room. We have sought out
3 psychiatry, psychological, medical, pediatric,
4 endocrinologist's help. So we do not make these
5 decisions lightly, but these are the decisions that
6 should be made by the families not by the state and
7 not by a board. Thank you.

8 ATTORNEY MCNULTY: Thank you.

9 CHAIRMAN ZACHARIAH: Okay. Next is
10 Dr. Edward Drass.

11 EDWARD DRASS: Good morning, Board. I'm
12 Dr. Edward Drass. I practiced here in Florida for
13 the last 40 years. I've done general internal
14 medicine and family practice. I also chaired our
15 hospital ethics committee for 12 years. Today I
16 loudly speak out against all forms of chemical and
17 surgical cross-sex therapy.

18 I've seen the full range of mental illness
19 in children, adolescents, and young adults. We all
20 agree mental illness is destructive for the
21 individual, the family, and for society. Many of
22 the individuals that I've seen that are LGBTQ or
23 transgender have significant levels of mental
24 illness, and often, this mental illness has not been
25 satisfactorily addressed by counseling or

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1 psychotherapy. Is it not the best practice to
2 address psychopathology with approved psychotherapy
3 before instituting lifechanging, unhealthy
4 transition treatments?

5 Gender identity disorder only came to my
6 attention five or six years ago, but it's now
7 diagnosed in the code book for mental illness, the
8 DSM-5 as Gender Dysphoria. It appears that we're
9 dealing with an unprecedented epidemic of mental
10 illness in adolescent females. This demographic
11 comprises the bulk of the 4400 percent rise in new
12 cases of gender dysphoria seen in the past few
13 years.

14 So I ask you physicians, for what other
15 disease do we allow an adolescent patient to make
16 his own diagnosis and then demand a preferred
17 treatment? As the Board of Medicine, what ethical
18 standards must be met when providing sex
19 reassignment? What standards of care have been
20 established for this treatment? Does the board
21 supervise quality control and satisfactory outcomes
22 for doctors and clinics offering these services?
23 What is a satisfactory outcome? These are all
24 questions that need to be asked when you decide the
25 rules for transgender treatment.

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1 I think other countries and judicial
2 systems are well ahead of the United States in
3 making this determination. In the wake of the Bell
4 versus Tavistock verdict, as you heard from
5 Dr. Biggs, the NHS has reversed course in its
6 transition treatment advice. Florida should take
7 the lead from this decision.

8 A summary review of transgender medical
9 research concludes there's no support for medical
10 intervention for gender confused minors. Medical
11 transition procedures do not reduce youth suicide.
12 Childhood gender dysphoria usually dissipates by
13 adulthood. And the dramatic increase in gender
14 dysphoria in the recent past is likely driven by
15 social factors.

16 My recommendation to the rules committee is
17 that cross-sex medical and surgical treatment should
18 not be supported by organized medicine, the Board of
19 Medicine, the legislature, or insurance companies.
20 Thank you for what you're doing.

21 CHAIRMAN ZACHARIAH: Dr. Drass, thank you
22 so much.

23 ATTORNEY MCNULTY: I'm going to ask the
24 crowd to please be controlled. What we're trying to
25 do is to allow everybody to make comments, so please

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1 contain your -- we've got to control this, so that
2 we can allow everybody to have their time. So I'm
3 going to call Jude Spiegel (phonetic), and again, if
4 the crowd starts disrupting the speaker, you're
5 going to be asked to leave.

6 Jude Spiegel.

7 UNIDENTIFIED SPEAKER: They went to the
8 restroom real quick. Can we come back to them?

9 ATTORNEY MCNULTY: Okay. Then we'll call
10 the next, Ada Lopez (phonetic). And a reminder,
11 Ada, you have only three minutes.

12 ADA LOPEZ: Hello, my name is Ada Lopez and
13 I thank the board for giving me a chance to speak.
14 I'm a proud mom of a transgender son. Our child
15 attended Catholic school from pre-K through eight.
16 He was in the Girl Scouts, sang in the choir, was an
17 alter server. He used his recess time to raise
18 money for Operation Smiles. Those were the things
19 he was involved in at that time. He insisted on
20 being the first one to arrive at school every day.
21 He worked as a safety patrol. He used to volunteer
22 to stay after to help the teachers clean their
23 rooms. He was passionate about books, astronomy.

24 All of that started to change at the age of
25 13. He became reclusive, did not want to leave his

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1 room. He did not want to go to school. He lost
2 interest in all the things that he loved. We didn't
3 know what to do. He wanted to die. We took him to
4 therapists, doctors. I signed him up for teen club.
5 Even a youth group called Girl Talk. I gave him a
6 kitten. Nothing worked.

7 Finally, he came out to us at the age of 14
8 as a transgender boy. This was something new for
9 us. As a registered nurse, I knew how to look for
10 established national guidelines, recommendations. I
11 learned about WPATH and I took him, at that time, to
12 medical experts right here in Florida, starting with
13 his pediatrician who had known him since birth. We
14 saw endocrinologists, psychiatrists, psychologists,
15 social workers. I was presented with options and
16 made difficult decisions.

17 Today, my son has a new name that matches
18 his gender. He is a very happy 21-year-old college
19 student currently majoring in physics and astronomy.
20 Gender-affirming care made all the difference for
21 him. I am so grateful every day to have him. Next
22 month we're going camping. Now he spends his free
23 time going to the rock-climbing gym with his
24 friends.

25 I ask the board to keep all these

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1 lifesaving WPATH options open for all Floridians. I
2 can't even think of the harm that would have come to
3 him if we hadn't been able to access these
4 treatments. And when it's time to make difficult
5 decisions for parents, other people's opinions don't
6 matter. People want to have access to all the
7 options that can save their child's life.

8 ATTORNEY MCNULTY: Thank you.

9 CHAIRMAN ZACHARIAH: Thank you. Next is
10 Robert Roper (phonetic).

11 ATTORNEY MCNULTY: No, next.

12 CHAIRMAN ZACHARIAH: Next is Robert Roper.

13 JUDE SPEIGEL: You said my name when I was
14 in the bathroom.

15 CHAIRMAN ZACHARIAH: I understand that.
16 You're going to wait.

17 Robert Roper.

18 ROBERT ROPER: My name is Robert Roper.

19 I've been authorized to tell a story of a patient
20 named CG -- that's a pseudonym -- who has been
21 irreversibly harmed by medical transition as a
22 minor. Says this, "Had a rule placing restrictions
23 on gender transition treatments been in place in my
24 street, then I would not have been placed on the
25 fast-track to medical and surgical interventions and

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1 I would not at age 21 be facing a lifetime of
2 sterility and a mutilated body.

3 Like many de-transitioning young people, I
4 was a gender nonconforming child who was on the
5 autism spectrum and suffered from depression and
6 anxiety. At age eight, I did not like stereotypical
7 boy stuff. Instead, I liked girl stuff and the ways
8 girls behaved. Transgender websites told me I was a
9 girl if I like girl things. I began talking with
10 trans identifying people through phone apps.

11 At age 14, I told my parents that I was
12 trans and believed that I was a girl trapped in a
13 boy's body. My parents celebrated my trans identity
14 and took me to see gender-affirming therapists. The
15 therapist immediately affirmed my trans identity
16 without any psychological testing or exploring why I
17 believed I was trans. I then saw an endocrinologist
18 and a gender clinic at Providence Hospital. The
19 endocrinologist prescribed Estradiol and
20 spironolactone.

21 At age 15, I began the hormone regiment. I
22 experienced significant psychological complications
23 from the treatments. I became depressed to the
24 point that I was not getting out of bed. I became
25 too anxious to go anywhere or talk to people and

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1 ended up dropping out of school. I also developed
2 an eating disorder and an addiction to the internet.
3 I was not functioning healthfully, but my parents
4 continued to move me along the gender-affirming
5 path, scheduling surgery at age 17.

6 Soon after turning 18, I was flown to
7 Washington, D.C. where my testicles and penis were
8 removed. I was given a vaginoplasty to create an
9 artificial vagina and receive plastic surgery on my
10 face. At no point was I offered any alternatives to
11 medication and surgery. No one attempted to explore
12 my underlying reasons for my depression and
13 discomfort with my sex.

14 I soon realized that treatments had not
15 improved my life and I discontinued them at age 18.
16 Now at 21, I have a body that is completely ruined.
17 I have worried that my body is now going to be a
18 freak no matter what I do. Even with parental
19 consent, these treatments are putting kids on a path
20 of harm. I was not able to grow up in a healthy way
21 as a result of having been scared by these
22 treatments. I do not want to see other young people
23 harmed in this way. I believe these treatments
24 should be disallowed or seriously restricted for
25 children and young people like myself." Thank you.

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1 ATTORNEY MCNULTY: Jude Spiegel.

2 JUDE SPIEGEL: Hi, I'm Judge Spiegel. I'm
3 a transgender parent of two children and I've known
4 I was transgender since I was very young. I
5 suffered from suicidal ideation from the age of 10
6 to 26 and attempted suicide many times thinking it
7 was wrong to be who I was. I wanted changes I
8 didn't think I could ever have. I didn't feel safe
9 opening up about who I was until later in life. But
10 this isn't about me.

11 Let these decisions remain between parents,
12 children, and their doctors. If rules must be
13 adopted, then please adopt the World Professional
14 Association for Transgender Health Standards of
15 Care. I'm going to read the names of 17 transgender
16 teens I researched who chose suicide over living in
17 a world that refused to acknowledge or accept them.
18 Andrew Elijah Martinez (phonetic), Ash Hafner
19 (phonetic), Avril (phonetic), Blake Brockington
20 (phonetic), Charles Knolls (phonetic), Daniel France
21 (phonetic), Amelia Worth (phonetic), Emmot Castle
22 (phonetic), Fluod (phonetic), Haley Gabrielle
23 Feldman (phonetic), Jordan Howell (phonetic), Kyler
24 Prescott (phonetic), Leila Alcorn (phonetic), Leo
25 Etherington (phonetic), Melanie Rose (phonetic),

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1 Taylor Alesena (phonetic), and Zander Nicholas
2 MaHafeey (phonetic). Thank you.

3 ATTORNEY MCNULTY: Thank you.

4 CHAIRMAN ZACHARIAH: Next is Amie Aderberry
5 (phonetic). Is Amy Aderberry here?

6 Next is January Littlejohn (phonetic).

7 JANUARY LITTLEJOHN: My name is January
8 Littlejohn. I am a Florida mother of three children
9 and a licensed mental health professional. I am
10 here to offer my personal experience, not as a
11 counselor, but as a mom. In the spring of 2020, our
12 13-year-old daughter told us she was experiencing
13 distress over her sex, and she didn't feel like a
14 girl. She had expressed no previous signs of gender
15 confusion and her announcement came shortly after
16 three of her friends at school also claimed
17 transgender identities.

18 Soon afterwards, her mental health
19 spiraled. We worked with a licensed mental health
20 professional to help our daughter explore and
21 resolve co-occurring issues including low
22 self-esteem and anxiety. We also gave her more one
23 on one time, in person activities away from trans
24 influencers, limited her internet use, and declined
25 to affirm her newly chosen name and pronouns. We

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1 set appropriate boundaries and allowed her to choose
2 her hair and clothing but denied harmful requests
3 such as breast binders, puberty blockers, cross-sex
4 hormones, and surgeries.

5 It was clear from conversations that our
6 daughter was uncomfortable with her developing body
7 and had an intense fear of being sexualized. She
8 was filled with deep self-loathing and was in true
9 emotional pain but had been encouraged by peers and
10 influencers to believe that gender identity was the
11 source of that pain. What she really needed was for
12 us to help her make sense of her confusion and
13 remind her that hormones and surgeries could never,
14 ever change her sex or resolve her underlying mental
15 health issues.

16 I shudder to think what could have happened
17 if we had affirmed her false identity and consented
18 to medical treatments as opposed to what we did
19 through watchful waiting which was to lovingly
20 affirm her as she is, beautifully unique, and
21 irreplaceable, and undeniably female.

22 After several years, our daughter has
23 desisted and is on a path to self-love. I have
24 spoken to many parents in Florida, and they are not
25 being informed of all treatment options when they

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1 seek help for their child. Many times they are
2 being convinced by medical professionals that
3 affirmation and medicalization is their only option
4 to avoid the impending suicide of their child.
5 Suicide is told to these parents as if it is a
6 guaranteed outcome versus a risk factor for these
7 kids.

8 Unfortunately, gender dysphoric children
9 are being encouraged through activism and peer
10 pressure to disassociate from their bodies and to
11 believe their body parts can simply be removed,
12 modified, or replaced. The irreversible
13 consequences of medical transitioning including loss
14 of sexual and reproductive function cannot be fully
15 understood by children or teens who lack the
16 necessary cognitive maturity or experience.

17 These children deserve ethical, evidence-
18 based treatment that helps them explore and resolve
19 the true source of their distress. Please stop
20 enabling doctors to chemically castrate and cut off
21 the health organs of children and teens. Thank you.

22 ATTORNEY MCNULTY: Next, George Lopez.
23 George Lopez (phonetic).

24 Cory Hill (phonetic).

25 Okay. I have a card. Mr. Lopez, would you

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1 like to address the boards?

2 Okay. Cory Hill.

3 Jennifer Engles (phonetic).

4 JENNIFER ENGLER: I'm a licensed mental
5 health counselor in the state of Florida. I speak
6 for myself and my own experiences and education. I
7 have been counseling transgender youth since 2013,
8 and transgender people aged 13 and older, generally
9 make up between 60 to 80 percent of my active client
10 caseload at any time in my practice. I would not be
11 encompassing the full scope of my career if I did
12 not come here today to advocate for my clients'
13 mental health and wellbeing.

14 Some of the ethics of my profession,
15 according to the American Counseling Association's
16 code of ethics, are to do no harm, to work for the
17 good of the individual, and to respect the rights of
18 one to control their own life. The American Medical
19 Association's code of ethics echoes these themes. I
20 have both of these here. Please allow those of us
21 who specialize in working with certain issues to
22 continue to do so unimpeded. Most professionals who
23 work with the transgender community in any capacity
24 have been trained in gender-affirming care per the
25 WPATH standards of care, which I have here, version

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1 eight. It is for you if you would like this copy.

2 So we do this because it is a worldwide
3 standards of care that is best practice that has
4 been used for 43 years and through 8 editions. So
5 they do continue to evolve. This is not a static
6 document from 43 years ago. The research is
7 unbiased, apolitical, and well documented to be in
8 the best interest of the client or patient. What is
9 different about Florida's transgender citizens that
10 our Department of Health feels the need to determine
11 standards of care that are different from the entire
12 rest of the world?

13 Please do not make your decision for
14 political reasons. My clients, even the young ones,
15 are well aware that they are being used as political
16 pawns, and they are already being harmed by
17 discussions like the one we are having today. Today
18 the Department of Health and Board of Medicine are
19 not upholding the ethic of do no harm. They hear
20 you. They hear us. They are hurt.

21 Per WPATH, "Therapists and medical
22 providers are already discussing potential risks and
23 benefits of hormone therapy in order to write
24 referral letters." We do this. I have a form that
25 I fill out that I go through, check boxes of what I

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1 discuss. How many transgender people have you had
2 in depth conversations with regarding their lived
3 experiences? If you had the insight I have gained
4 from getting to know hundreds of transgender people
5 as a therapist, friend, advocate to the community,
6 and could understand how amazing transgender people
7 are and how much they truly contribute to all facets
8 of society, you would want to do everything you
9 could to help them thrive.

10 What if transgender people are just real
11 and just exist in greater numbers currently because
12 they have more reason for hope for a fulfilling and
13 authentically lived future? I want to be clear, I
14 do not tell my clients what choices to make about
15 their lives. I help them and their families to make
16 their own decisions.

17 CHAIRMAN ZACHARIAH: Well, thank you so
18 much. Next is Bob Framingham (phonetic).

19 BOB FRAMINGHAM: Members of the board, my
20 name is Bob Framingham and I have been personally
21 impacted by the harms of gender-affirming care
22 through watching my son transition. My son was
23 educated in Christian private schools from
24 kindergarten to grade eight, was an average,
25 well-behaved student. He played baseball little

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1 league, was pretty good. He expressed no confusion
2 over sex during childhood or adolescents. However,
3 he was socially awkward and did have mental health
4 issues.

5 Grades 9 through 12 he attended SAIL public
6 school in Tallahassee. SAIL is a very progressive
7 art school, and this is where he was exposed to the
8 false idea that he could have been born into the
9 wrong body. He earned a brown belt in Taekwondo and
10 is an Eagle Scout. At age 18, he could do 20 pull-
11 ups with one hand. Now he can't lift 40 pounds
12 because of his therapy in order to help him grow
13 breasts.

14 He was diagnosed with borderline
15 personality and severe depression in 2023. His
16 mental health issues began around age 14 shortly
17 after he started at school. It was clear that he
18 suffered from low esteem and self-hate. Tyler
19 announced that he was transgender at age 22 and
20 began transitioning for 6 years. This has not
21 improved his quality of life or resolved his mental
22 health issues. He dropped out of college, has no
23 meaningful romantic relationships, and he's not
24 anorexic. Clearly, there's a disconnect between
25 Tyler's brain and his body.

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1 He intends to alter his body, but I really
2 think he needs to alter his mind. I am deeply
3 concerned that his mental health will further
4 deteriorate once he comes to the realization that
5 making irreversible changes to his body will not fix
6 his pain.

7 So I would urge you to create a rule that
8 will protect children from making irreversible life-
9 changing decisions when their brains are not fully
10 developed. I would encourage you to put safeguards
11 in place even for adults seeking transition, like
12 counseling to address other mental issues that may
13 be the root cause of the confusion prior to any
14 surgery or hormonal intervention.

15 And I would suggest that having a true
16 informed consent where patients are fully informed
17 of the consequences of taking hormones, including
18 the rate of regret and the high risk of suicide 7 or
19 10 years after transition. Thank you very much.

20 ATTORNEY MCNULTY: Next, I have George
21 Lopez, Cory Hill, and Lindsay who would be next in
22 line, but they've chosen not to speak. But they are
23 opposed to the rule.

24 Next, I'll call Cassie.

25 Gus.

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1 Kevin Astle.

2 KEVIN ASTLE: Good afternoon. My name is
3 Dr. Kevin Astle. I'm an assistant professor with
4 the University of South Florida Taneja College of
5 Pharmacy. My statements today do not represent the
6 views of my employer. I hold several credentials
7 and board certifications including board certified
8 pharmacotherapy specialist. So in this role, I'm a
9 medication expert and I have the expertise to be
10 able to determine when medications are appropriate
11 and to evaluate the literature that's available for
12 medications.

13 I could preach to you about the
14 recommendations and rules that you are setting forth
15 today and how they contradict the recommendations of
16 all the major medical associations in the United
17 States, but you all are already aware of that. One
18 of the points discussed today is the informed
19 consent process and how for the children that you
20 want to continue on therapy that have already
21 engaged in gender-affirming care need this enhanced
22 informed consent process. That is already
23 occurring. That, along with the recommendations
24 made today, are evident that the guidelines have not
25 been reviewed. That the board here does not know

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1 what is actually being practiced in medical care
2 today and that these standards being proposed by the
3 board are outside of the standard practice in the
4 world.

5 Another point brought up today was for
6 research. You know, there's 49 states in the
7 country, let's let them do the research. What does
8 that say to our institutions here in the state of
9 Florida? That we're second class to the rest of the
10 United States? That the University of Florida, a
11 top five public institution where I'm a proud alumni
12 of, does not deserve to engage in research? Or
13 myself at the University of South Florida we cannot
14 engage in research for this topic just because we
15 live in the state of Florida? That will make us
16 second class to the rest of the United States and
17 that is not what we want to do.

18 And then finally on that, you talk about
19 not wanting to impair progress. This discussion
20 today, the fact that we're having this is impairing
21 progress, so that is all that's being done. This
22 country was founded on the principle of individual
23 rights and freedoms. Today you're making actions to
24 violate those freedoms for Floridians. You have the
25 right to choose whether or not you want to provide

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1 gender-affirming care in your practice. You have
2 that choice and that decision. You have the choice
3 and decision whether you should pursue gender-
4 affirming care yourself or for your children. Your
5 actions today are going to take that right away for
6 Floridians all across the state. And is that your
7 decision to make?

8 As a Board of Medicine, you're here to
9 guide medical practice. You're not here to
10 determine what is medical practice and what is not.
11 Your actions today would be in violation of your
12 role. You know, you're here to allow for safe
13 practice, not to dictate what is medical care and
14 what is not. When you graduated from medical
15 school, you took an oath to do no harm. These
16 decisions today will completely violate that oath,
17 and I think upon that your medical license should be
18 reviewed and should be considered to be revoked if
19 you pass this legislation. Thank you.

20 CHAIRMAN ZACHARIAH: Next is Patty Sullivan
21 (phonetic). Before -- you can come to the podium.
22 You will be the last speaker for the day. Let me
23 finish. Don't shout, you're not going to win. What
24 we're going to do, we'll give you an email for the
25 state of Florida. You send your information and

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1 whatever information you send will be a part of the
2 record.

3 UNIDENTIFIED SPEAKER: (Indiscernible) out
4 of the 100 or 1000 of people that are sitting in
5 here that vote.

6 CHAIRMAN ZACHARIAH: You know what -- okay.
7 Okay. Okay, that's fine.

8 Okay. Ms. Patty Sullivan, you may proceed.

9 UNIDENTIFIED SPEAKER: Their blood is on
10 your hands. Their blood is on your hands.

11 CHAIRMAN ZACHARIAH: That's okay. Let's
12 have some decency and quorum here.

13 Patty Sullivan, you may proceed.

14 PATTY SULLIVAN: Hi. My name is Patty
15 Sullivan and I'm with Parental Rights Florida. And
16 just a quick caveat since it was brought up, the
17 American School Counselors Association, the American
18 Medical Association, the American Pediatrics
19 Association, this is why this board is needed to
20 bring clear evidence-based rules and guidelines and
21 standards. The past president of the American
22 School Counselors Association in August in 2022 at a
23 national conference basically said, "Here in Florida
24 we have these laws made, and you need to learn the
25 rules, so that you can break the rules." So this is

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1 why you all are needed, and your expertise is needed
2 to bring these clear evidence-based standards.

3 I spent thousands of hours researching to
4 understand why specific Florida based and nationally
5 advocacy groups consistently opposed commonsense
6 family friendly legislation in Florida. I am a
7 Florida citizen. I'm a Florida mom. The research
8 that I did, hours and hours, confirmed these non-
9 medical organizations push gender-affirming medical
10 interventions even though real research shows the
11 majority of these children will resolve distress
12 after puberty.

13 UNIDENTIFIED SPEAKER: Bullshit.

14 PATTY SULLIVAN: Many of these parents with
15 gender dysphoric children are not being presented
16 with this critical information, nor are they being
17 given all the treatment options available to them to
18 treat their child's gender dysphoria such as
19 watchful waiting and counseling. If what is being
20 forced on these children and these families is so
21 valiant, why are these groups, why were they hiding,
22 and lying, and deceiving, and putting these support
23 guides behind the scenes and keeping parents out of
24 the loop. I have a school psychologist on video
25 telling administrators how not to tell the parents,

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1 through my research.

2 Why are these groups still pushing
3 irreversible medical transition procedures on
4 children when they know that the research shows that
5 the rate of completed suicide increases to 19 times
6 that of the normal population post transition?

7 Children with gender dysphoric issues deal with
8 profound and complex emotional issues. I had issues
9 that resolved from a childhood, and I'm married 34
10 years.

11 The consequences to a child making
12 permanent life altering decisions, taking drugs that
13 alter their moods and bodies, and then having their
14 genitals and breasts mutilated is beyond
15 comprehension.

16 The Florida Medical Board can put clear,
17 evidence-based rules, guidelines, and standards in
18 place and bring clear consequences for those who
19 would flagrantly break these rules and laws. And
20 the time for courage is now. I commend you and I
21 support you. Please do this and bring pause. Thank
22 you.

23 ATTORNEY MCNULTY: Thank you.

24 CHAIRMAN ZACHARIAH: Well, thank you so
25 much. The timing for the public comments have

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1 ended.

2 UNIDENTIFIED SPEAKER: Excuse me, Board of
3 Medicine, if --

4 CHAIRMAN ZACHARIAH: We'll take a
5 five-minute recess.

6 UNIDENTIFIED SPEAKER: I'm a State House
7 Representative here in Orlando. These are my
8 constituents, they deserve to speak.

9 CHAIRMAN ZACHARIAH: I understand that. I
10 understand that. You should know better. You are a
11 Representative. You know how this -- you represent
12 the House once in the state of Florida, so you
13 should obey the same rules. And the meeting is
14 adjourned for the next five minutes.

15 UNIDENTIFIED SPEAKER: You cut public
16 comment by one hour in Fort Lauderdale and you're
17 doing this shit again. We see you. We see everyone
18 of you and as long as you continue --

19 UNIDENTIFIED SPEAKER: We respectfully ask
20 for more time.

21 (Recess taken)

22 CHAIRMAN ZACHARIAH: Okay. Do you have a
23 quorum now? Yeah. We have a quorum. Let's talk
24 about the closing and the administrative matters.
25 Let's start with drafting the rule.

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1 Ed, do you want to start?

2 EXECUTIVE DIRECTOR TELLECHEA: We still
3 need some guidance on this issue regarding the
4 enhanced consent process. What do you want to see
5 in the consent?

6 MR. ROMANELLO: So do you think, Ed, that
7 you have enough specificity for the rule unrelated
8 to the consent form?

9 EXECUTIVE DIRECTOR TELLECHEA: You are
10 talking about the prohibition on the procedures for
11 people under 18?

12 MR. ROMANELLO: Yes.

13 EXECUTIVE DIRECTOR TELLECHEA: And making
14 it prospective?

15 MR. ROMANELLO: Yes.

16 EXECUTIVE DIRECTOR TELLECHEA: I have
17 enough on that.

18 MR. ROMANELLO: Okay.

19 EXECUTIVE DIRECTOR TELLECHEA: The enhanced
20 consent process though is what we're going to need
21 some more specifics on. What specifically you want
22 to see in that enhanced consent process.

23 MR. ROMANELLO: Got it. So I would
24 propose, as Doctors Biggs and Kaltiala -- I'm sorry,
25 as Doctors Dayton, Janssen, and McNamara propose,

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1 that any consent be predicated on a multi-
2 practitioner basis. Right. They all proposed a
3 multidisciplinary approach.

4 DR. ACKERMAN: Multidisciplinary panel. We
5 usually refer to it as a multidisciplinary panel.

6 MR. ROMANELLO: There you go.

7 DR. ACKERMAN: And we can say specifically
8 who should be on that panel.

9 MR. ROMANELLO: Right. So consisting of
10 pediatrics, psychiatry, endocrinology. And they
11 both spoke -- or all three of them spoke about
12 support systems and kind of mental health
13 counseling. And I think it was Dr. McNamara who
14 suggested a licensed clinical social worker when
15 Dr. Diamond was asking if you recommend those
16 surgical procedures to their patients and they said,
17 "Well, it would depend upon what the social worker"
18 -- you know, in part. So if we're going to have a
19 multidisciplinary panel, then I would suggest it's
20 pediatrics, psychiatry, endocrinology --

21 DR. DIAMOND: Pediatric endocrinology.

22 MR. ROMANELLO: Pediatric endocrinology and
23 a licensed clinical social worker.

24 DR. ACKERMAN: So can I just make a small
25 just recommendation? I don't think you need a

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1 psychiatrist but having a psychologist or licensed
2 clinical social worker, I think that's what I'm
3 hearing from them that would fill that niche.

4 ATTORNEY MCNULTY: So I'm a little unclear
5 about the role of a social worker.

6 DR. ACKERMAN: Well, a social worker is a
7 counselor like a --

8 ATTORNEY MCNULTY: No, I know what they do.
9 Just how that individual would integrate into this
10 multispecialty team and at what phase?

11 DR. ACKERMAN: Well, I think we heard from
12 them all that there was a psychological component to
13 this, and so the multidisciplinary panel, having a
14 psychological component to that. Because you have
15 the medical component with the pediatrician, the
16 endocrinologist component with the pediatric
17 endocrinologist, and the psychological component
18 with either a clinical psychologist or LCSW.

19 ATTORNEY MCNULTY: So where does the social
20 worker --

21 DR. ACKERMAN: That's the LCSW.

22 ATTORNEY MCNULTY: Yeah. But again, the
23 role of the social worker in that process.

24 DR. DERICK: To maybe evaluate the support
25 network for the individual.

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1 ATTORNEY MCNULTY: Okay.

2 DR. ACKERMAN: To assess, and to give
3 counseling, and to share with the panel that the
4 patient has been properly assessed.

5 ATTORNEY MCNULTY: Or, you know,
6 Dr. Derick, I think you answered my question. To
7 make sure that the individual has the appropriate
8 family support. Because some of these children, you
9 know, may not be in a two-parent family, you know,
10 they may be wards, have guardians. So the social
11 situation of the child I think answers my question.

12 CHAIRMAN ZACHARIAH: I have a question for
13 Dr. Hunter. Dr. Hunter, you deal with these things.
14 Do you think they should have a psychiatric
15 evaluation, or some psychiatrist involved in this
16 decision making?

17 DR. HUNTER: The level of mental
18 healthcare, whether it's psychology, psychiatry, I
19 think that's up for debate. One thing that I think
20 any consent needs to recognize and needs to share
21 with the patient and the family is the level of
22 evidence and what the systematic reviews have shown.
23 The NICE reviews out of England on puberty blockers
24 and cross-sex hormones are the best English language
25 reviews. The Swedish reviews are only summarized in

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1 English. They have not been translated from the
2 Swedish language to the English language with full
3 reviews. But any informed consent needs to disclose
4 the degree of evidence or lack thereof, whether who
5 that's coming from.

6 I agree it needs to be a multidisciplinary
7 process. That's what the Dutch said they would do.
8 And that needs to be -- the informed consent is not
9 a simple process in this setting. It has to include
10 surgery. I think it needs to include surgery
11 because once you're on the path of social
12 transition, there is good evidence that social
13 transition maintains that identity and changes the
14 desistence rates.

15 Once that's started, then you're on puberty
16 blockers. We've heard that puberty blockers lead 98
17 percent chance, 95 percent chance of cross sex
18 hormones. Now we're in the irreversible territory.
19 What percentage of those kids go on to surgery? So
20 for a 12, 13, 14-year-old to understand that, they
21 would then need to understand the surgical risks
22 because they're starting on a pathway that may not
23 go back, that may be irreversible.

24 So the consent process would have to
25 involve a surgeon, I believe, too, for the family to

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1 understand. The 12-year-old, 13, 14 year old might
2 not understand that but the parents, I think, are
3 due that knowledge of what the evidence review show
4 and the full gamut of what may proceed over the next
5 4, 5, 6 years.

6 DR. DIAMOND: Mr. Chair?

7 CHAIRMAN ZACHARIAH: Yes.

8 DR. DIAMOND: So again, going through these
9 different components, prospective rule I think is
10 clear. Enhanced consent, pediatrician, pediatric
11 endocrinologist, and I would say either a
12 psychologist or a licensed clinical social worker.
13 With respect to the point that Dr. Hunter is making,
14 I don't think I would be in concurrence that a
15 surgeon needs to be involved. I think that would be
16 very, very difficult, you know, just logistically.

17 I can understand that, and I appreciate
18 exactly where he's coming from but the logistics of
19 that may be difficult, so I would eliminate that
20 from the enhanced consent.

21 The third thing we were discussing is
22 whether or not to proceed with a research exemption.
23 And as know, Mr. Romanello made a motion, and it was
24 seconded. Dr. Hunter essentially made an amendment,
25 and I am supportive of that amendment. And in terms

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1 of language to help you, I would be of the opinion
2 that there's an exception that minors can be treated
3 with GHRH agonist or cross-sex hormones but only
4 under the auspices of a university sponsored/IRB
5 approved longitudinal trial in which the parents
6 give consent, the child gives assent, and there's a
7 continuing condition of receiving that intervention
8 that the child continue on that trial. And further,
9 that that proposed study must be presented to the
10 rules of the legislative committee for its approval
11 as a first step. Is that enough specifics for you?

12 EXECUTIVE DIRECTOR TELLECHEA: Yes. I
13 don't think you have the authority for that under a
14 standard of care rule.

15 DR. DIAMOND: So how would we go and try
16 and craft an exemption if that is the --

17 EXECUTIVE DIRECTOR TELLECHEA: I think you
18 need to remove the approval by the board.

19 DR. DIAMOND: Remove the approval of --

20 EXECUTIVE DIRECTOR TELLECHEA: Having the -
21 - coming before the board to have that type of
22 process approved.

23 DR. DIAMOND: So your contention would be
24 that my language would be sufficient except for that
25 it requires approval by the Rules and Legislative

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1 Committee; is that correct?

2 EXECUTIVE DIRECTOR TELLECHEA: I think that
3 would be -- yeah.

4 DR. DIAMOND: Okay. I'll stand with that.

5 UNIDENTIFIED SPEAKER: I would.

6 DR. HUNTER: I would just add that that
7 research is required to follow everyone well into
8 adulthood. That's the NHS language.

9 ATTORNEY MCNULTY: Is there an age?

10 DR. HUNTER: They just say -- the NHS
11 language -- they're still crafting their research,
12 but they do specifically say --

13 DR. DIAMOND: So Dr. Hunter, the issue that
14 we may have, while the child is receiving such
15 intervention, that's easy. But how do you go when
16 the person has now exceeded the age of majority and
17 is no longer perhaps receiving hormonal therapy, how
18 can it be required or mandated that the
19 participation continue?

20 DR. HUNTER: Well, you said no longer
21 receiving hormonal therapy. These transgender
22 patients need hormonal therapy for the rest of their
23 lives, so --

24 DR. DIAMOND: But also, we're not
25 regulating the care of individuals once they have

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1 reached majority.

2 DR. HUNTER: Correct. But this is where I
3 need clarification. This board is here for all
4 citizens of Florida, correct?

5 DR. DIAMOND: Of course.

6 DR. HUNTER: Not just those under the age
7 of 18.

8 DR. DIAMOND: But the motion on the table
9 is treatment of minors with gender dysphoria. My
10 particular position is that for persons that have
11 reached the age of maturity, that no intervention is
12 necessary.

13 DR. HUNTER: If we were going to give an
14 exception to research, I think we would want
15 research that is going to be valid and reveal data
16 that's legitimate and that would require long term,
17 longitudinal follow up.

18 DR. DIAMOND: I'm 100 percent with you.
19 How would we do that? How could we -- how could we
20 -- how could you affect that?

21 DR. HUNTER: That's going to be how well
22 the research is written. And that's beyond the
23 authority of this board.

24 DR. DIAMOND: I guess what you'd have to do
25 is maybe like any other study, if you sign up, we

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1 are asking in good faith that you agree to
2 participate in X period of time. But you know what,
3 if you drop off, it's a free country, we can't do
4 anything about that. I mean, perhaps that's the
5 best way to approach it. There's no way to mandate
6 that, of course.

7 DR. HUNTER: No.

8 CHAIRMAN ZACHARIAH: You know, Dr. Diamond,
9 I just want clarification. You said they either get
10 a psychologist on the case or a social worker. Is
11 that true? Because --

12 DR. DIAMOND: Well, I think that was what
13 -- I think that was what Dr. Hunter was saying is
14 that would meet his requirements.

15 Is that sufficient for you, Dr. Hunter? A
16 psychologist or a LCSW? Or was that not your
17 intent?

18 DR. HUNTER: Well, a related but separate
19 question. What does the current rule say just about
20 informed consent in general?

21 DR. DIAMOND: I don't think it specified.

22 EXECUTIVE DIRECTOR TELLECHEA: We don't
23 have rule that says -- about informed consent in
24 general. With the exception of for medical
25 marijuana and I think for --

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1 ATTORNEY MCNULTY: And cataract.
2 Cataracts.

3 EXECUTIVE DIRECTOR TELLECHEA: -- and for
4 cataract surgery. That's it.

5 DR. HUNTER: Okay.

6 EXECUTIVE DIRECTOR TELLECHEA: See that's
7 what I'm trying to get to. You know, when we did
8 those informed consent forms, we sat there, and we
9 drafted these forms in multiple meetings and we're
10 not getting that right now. We're getting the broad
11 outlines as what you want to see as part of your --
12 you know, the people, the entities that are going to
13 participate in the informed consent.

14 But if you all want or are expecting an
15 actual informed consent document to be used, you
16 know, or you're expecting an informed consent
17 procedure to be used, I'm going to need to know what
18 all those elements of that informed consent, what
19 those expectations are, so that they can be put in
20 the rule, so that the people that you are
21 regulating, the physicians who are involved in this
22 will know what those expectations are.

23 UNIDENTIFIED SPEAKER: Mr. Tellechea, we
24 don't have elements of the medical marijuana consent
25 in the rule, we just publish the standard form to

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1 use, right? I mean, the rule -- you don't go back
2 into the rule, there's not elements in the rule.
3 It's just here's the approved form.

4 ATTORNEY MCNULTY: But the rule adopted and
5 incorporated by reference the form, but that's part
6 of the rule.

7 UNIDENTIFIED SPEAKER: Why wouldn't we do
8 the same thing here? Why would we try to now draft
9 a form by committee? We've given -- I think we've
10 given the broad brushstrokes. Can you come back
11 with a proposed form that we can discuss? You've
12 heard about pediatric endocrinology, licensed
13 clinical social worker --

14 EXECUTIVE DIRECTOR TELLECHEA: We can work
15 and try to bring something back.

16 ATTORNEY MCNULTY: But what we wouldn't
17 have is the standards that you want, like all the
18 studies, the this, that, and the other, the
19 different prongs of it. For those other forms,
20 there were many meetings and people would work on
21 specific language that is inside the form. But for
22 example, you indicated you wanted to have the
23 certain risks associated with certain treatments.

24 MR. ROMANELLO: Yes.

25 ATTORNEY MCNULTY: But we don't know what

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1 those are. We don't know, the lawyers don't know
2 what those are.

3 MR. ROMANELLO: Yep. Agreed. I think that
4 Dr. Hunter had started to expand upon what some of
5 the risks associated with the therapies are, and I
6 would defer to my other physician colleagues to
7 modify or add to that list.

8 CHAIRMAN ZACHARIAH: Yeah, go ahead.

9 UNIDENTIFIED SPEAKER: I don't mean to
10 divert from this discussion but, you know, one thing
11 I heard was consistently from the experts the issue
12 of behavioral health and psychiatric diagnoses. And
13 I'm wondering if it would behoove us to have at
14 least two psychological evaluations.

15 I agree with the multidisciplinary team,
16 but hearing the testimony today, the fact that the
17 behavioral health conditions are so prevalent, would
18 it be appropriate to actually have the concurrence
19 include two behavioral health evaluations, clinical
20 psychologist, psychiatrist?

21 DR. PAGE: I agree with your statement. I
22 would support that.

23 CHAIRMAN ZACHARIAH: Go ahead. Go ahead.

24 DR. PAGE: No. I would support what you're
25 saying, like we have to make sure -- you know,

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1 address the underlying mental health issue that
2 could have triggered this gender dysphoria.

3 CHAIRMAN ZACHARIAH: Yeah. See but one of
4 the reasons I ask the question, if you listen to the
5 testimony of the experts and from the public,
6 psychiatric issues was a major role in that. It
7 really was, in almost all of them. And I strongly
8 -- one thing I strongly believe is that these minors
9 should have a psychiatrist or a psychology
10 evaluation. Not to be all -- what does a social
11 worker know about psychological issues? They're not
12 trained in that. No, they're trained in, you know,
13 homes and other issues.

14 EXECUTIVE DIRECTOR TELLECHEA: They're
15 talking about licensed clinical social workers.

16 DR. ACKERMAN: Yeah. They're trained in
17 psychological issues.

18 CHAIRMAN ZACHARIAH: Well, so far, their
19 psychological training, I have no problem. But my
20 concern is majority of them have significant
21 psychological issues and they must get some kind of
22 psychologic evaluation to make sure that that can be
23 resolved in some other fashion.

24 DR. ACKERMAN: And LCSWs do that. Not just
25 psychologists, LCSWs. They don't just arrange for

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1 homecare, they also do counseling and evaluations.

2 CHAIRMAN ZACHARIAH: Okay. If they're
3 trained to do so, I have no problem with that.

4 DR. DERICK: So if I'm understanding this
5 correctly, if a parent and a child desire to undergo
6 transitioning in the current proposed rule, they
7 would be able to do so but only at an institution as
8 part of a clinical trial with an IRB approval. And
9 that if you are someone who is currently undergoing
10 therapy, then this is where this informed consent
11 comes in in a minor.

12 DR. DIAMOND: That's correct.

13 DR. DERICK: Where there would be -- not a
14 cessation of treatment, but during the continuation
15 of treatment that they would be then reformed with
16 consent with this multidisciplinary team that's
17 chosen by the -- somebody, I don't know who that
18 would be. The person who was currently providing
19 care to them. And then the studies would be
20 presented to those people for consideration and then
21 they would be allowed to continue their therapy if
22 they chose to do so. Is that correct?

23 ATTORNEY MCNULTY: So what I'm hearing is
24 it's almost like we've got a staged evaluation.
25 Should we look at consent at each phase of the

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1 evaluation and therapy?

2 DR. DIAMOND: Well, I'm not sure I'm
3 understanding correctly. My understanding is, is
4 that the motion as intended was that as of a certain
5 date, these interventions are prohibited unless it's
6 under the strict auspices of a clinical trial,
7 analogous to what our colleagues in the United
8 Kingdom are doing.

9 Having said that, for individuals who are
10 currently receiving intervention, we recognize that
11 there may be actually some harm to stop, and
12 therefore, we are going to say there is an
13 opportunity to continue, but as a condition to
14 continue, there must be a documentation of this more
15 enhanced consent that occurs within a certain period
16 of time. That was my understanding of how
17 Mr. Romanello was trying to phrase it.

18 Nick, did I get that right?

19 MR. ROMANELLO: Yes.

20 ATTORNEY MCNULTY: And might as well, I
21 guess what I didn't clarify is as each of these
22 therapies evolve in advance, would an additional
23 consent, or at least requirement that the risks
24 associated with those therapies be -- you know, be
25 given, understood, and consented to? So as the

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1 individual progress, as the child progresses through
2 each phase of the therapy, the consent is already
3 there but do we want to add the additional consent
4 for the risk of the medication --

5 DR. DIAMOND: I want to understand. So
6 you're referencing a -- for example, a 12-year-old
7 who may be currently on GHRH agonist therapy, and
8 that the parent and the child express a wish to
9 continue. They've gone through and done the enhance
10 consent process. And then are you saying that it is
11 your intent that if that child were to then, and the
12 parents were then to have an interest in going on to
13 cross sex hormones that there would be a second
14 component of enhanced consent? Is that what you're
15 saying?

16 ATTORNEY MCNULTY: Yeah. At least a
17 comprehensive explanation of the consequences of
18 those drugs. Now, whether it's has part of the
19 first consent --

20 DR. DIAMOND: I don't know if that's going
21 to add anything further to what we're doing.

22 ATTORNEY MCNULTY: Okay.

23 MS. JUSTICE: Do we need to address that in
24 this rule? I mean, that has to occur already anyway
25 because --

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1 UNIDENTIFIED SPEAKER: It should.

2 MS. JUSTICE: Right. I mean, you're giving
3 a new treatment and arguably, that patient is not in
4 the same stage or condition that they were when they
5 initiated the prior treatment. So informed consent
6 is -- we don't need to address that in this rule, I
7 don't think. I don't mean informed consent period,
8 I mean at each phase.

9 ATTORNEY MCNULTY: Hearing the testimonies
10 from some of these individuals was pretty compelling
11 to the consequences --

12 MS. JUSTICE: I agree.

13 ATTORNEY MCNULTY: -- and you know, just
14 trying to make sure that we capture --

15 MR. ROMANELLO: But what I think
16 Ms. Justice is alluding to is if you're on puberty
17 blockers today and a year from now you're
18 recommended to start initiating cross sexual
19 hormones, that would require a separate consent form
20 because that's a new modality of treatment. And
21 then if you go three years down the line and you're
22 recommending surgical intervention, that would
23 require yet another -- so you're always going to
24 have those ongoing consent requirements, separate
25 and apart from --

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1 ATTORNEY MCNULTY: Maybe the simpler time,
2 or at least to try to get around this is just list
3 what that consent, or at least the consent that's
4 provided, what that has to contain. Right. Which
5 you've done. Instead of actually drafting the form.

6 DR. HUNTER: I think one of the problems
7 with the -- and I think everybody has a problem
8 worldwide in this consent area is there is so much
9 that is unknown. So to give a valid informed
10 consent requires the patient's understanding and
11 their capacity. Okay. It's -- we all question, as
12 a profession, the capacity of somebody under the age
13 of 18 to consent, let alone you mix in mental health
14 issues. So that's an issue. But the understanding
15 is the hard part because there is so much unknown
16 about this therapy.

17 So to provide an -- that's what makes it,
18 in my opinion, experimental, because there is so
19 much that is unknown and that's why it's moving back
20 into the experimental realm in Sweden, Finland,
21 England, as we've heard. So the ability to give
22 informed consent is nearly impossible.

23 DR. DIAMOND: Mr. Chair, if there's no
24 further discussion, perhaps we could call the
25 question?

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1 CHAIRMAN ZACHARIAH: Yeah. Because we only
2 have 10 more minutes. So what -- we can call the
3 question but what I really would suggest that let's
4 ask Mr. Tellechea what else does he need to do his
5 job?

6 DR. DIAMOND: Today.

7 EXECUTIVE DIRECTOR TELLECHEA: Well, I'm
8 going to need someone to sit down with me and
9 explain what you want to put in the informed
10 consent, because you're not giving me enough at this
11 point in time.

12 I mean, Donna? I mean --

13 ATTORNEY MCNULTY: I mean, I agree. Unless
14 you -- I mean, I agree overall with Ed. The other
15 option, which I think Dr. Schwemmer raised, was
16 instead of having like this detailed board form for
17 the informed consent, do you just want the elements
18 in your rule?

19 DR. DIAMOND: Elements, elements.

20 EXECUTIVE DIRECTOR TELLECHEA: Right. But
21 you need to tell me what the elements are.

22 ATTORNEY MCNULTY: But they need to be very
23 specific for everything.

24 MR. ROMANELLO: So the first element is
25 that it is a multidisciplinary panel that you are

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1 going to get the consent from, and that
2 multidisciplinary panel will include pediatric
3 endocrinology, pediatrician --

4 DR. ACKERMAN: And either a clinical
5 psychologist or licensed clinical social worker.

6 MR. ROMANELLO: -- and either a clinical
7 psychologist or a licensed clinical social worker.

8 ATTORNEY MCNULTY: Behavioral health, two
9 psych opinions?

10 MR. ROMANELLO: Yes. So --

11 ATTORNEY MCNULTY: Wait, wait. This is the
12 informed consent we're talking about?

13 MR. ROMANELLO: Yes.

14 ATTORNEY MCNULTY: So you want two of them
15 on there?

16 MR. ROMANELLO: Yes.

17 CHAIRMAN ZACHARIAH: Did he say two
18 separate people?

19 ATTORNEY MCNULTY: Two psychological
20 evaluations.

21 EXECUTIVE DIRECTOR TELLECHEA: Is this
22 going to be a consent form that the patient and the
23 family is going to read and sign off on?

24 DR. DERICK: I think the intention is that
25 certain types of physicians would be involved in

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1 provided the information that would be consented
2 upon. I just think it does seem kind of complicated
3 for people already undergoing therapy who have
4 already consented to this treatment then be
5 reconseented with a very specific group of people.

6 DR. DIAMOND: I agree with Dr. Derick.
7 These folks are undergoing treatment. The intent, I
8 believe, from Dr. Hunter and Mr. Romanello is to
9 simply say, "Hey, the rule allows you to continue
10 but please understand that you need to be aware of
11 these complexities." And there needs to be sign off
12 with the parent, the patient, of course, and I would
13 say a pediatrician, endocrinologist, and either a
14 psychologist or a LCSW and stop there. I wouldn't
15 go beyond that. I mean, I just wouldn't.

16 DR. DERICK: So you're saying you wouldn't
17 dictate what those people would be consenting about
18 but that they would just need to be consented with
19 those specialists.

20 DR. DIAMOND: They need to go and verify
21 that to the best of their professional abilities,
22 that the patient and the family are aware of the
23 risks, benefits, and alternatives of treatment as we
24 do whether it be cancer treatment or anything else.

25 DR. DERICK: For the record, I'm not aware

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1 of how that's different from what's currently
2 happening. Because these are the specialists who
3 are treating this patient population and they're
4 consenting the patients.

5 DR. HUNTER: I think the trouble we're
6 having is what the Dutch described in their studies
7 and in their papers is that informed consent in this
8 area is not a form, it's a long process. And they
9 talked about it being at least six months. I think
10 some of the reference is longer than that. It's a
11 process where they meet with all these people, and
12 they understand.

13 MS. JUSTICE: That's right.

14 DR. HUNTER: Understand the limitations.
15 Let me float this idea, because we're -- I see three
16 points that we're sort of coalescing around. One,
17 that psychological care be the standard. Number two
18 is that there be a moratorium on puberty blockers,
19 cross sex hormones, and surgery under 18. And
20 three, that a clinical trial be the only way to go
21 forward under 18.

22 The problem we're having is the problem
23 that everybody else is having is the kids that are
24 already being transitioned. And maybe we remain
25 silent on that expect to say when the clinical

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1 trials do exist, those kids need to be enrolled in
2 those trials. Because that's where an informed
3 consent process that is IRB approved, they'll spend
4 hours, and hours, and hours, and hours on that.
5 Okay. And maybe we remain silent on the kids
6 already in this system, but when we rehash that
7 issue at later meetings.

8 MR. DIAMOND: My bias would be to not do it
9 that way. These are people that have already
10 commenced under a certain understanding or set of
11 understandings. And I think that to require them to
12 go and then participate in a clinical trial, I think
13 that may be a bit too much. I fully get what you're
14 saying, it solves certain problems, but it may
15 create additional issues.

16 CHAIRMAN ZACHARIAH: Dr. Di Pietro.

17 DR. DI PIETRO: Trying to step back and
18 take a big picture view on this, I'm starting to
19 think about the problems that might happen. And the
20 biggest problem I can see beyond a lot is who is
21 ultimately responsible for the patient's care in
22 this informed consent. So is it the pediatrician?
23 Is it the pediatric endocrinologist? Like who is
24 responsible for making sure that the boxes have been
25 checked?

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1 DR. DIAMOND: Well, typically it would be
2 the individual who is actually prescribing the
3 medication.

4 DR. DI PIETRO: So it would -- okay. So
5 that's -- you know --

6 MR. ROMANELLO: So Mr. Chair, in the -- as
7 we're starting to get time compressed --

8 CHAIRMAN ZACHARIAH: Yes.

9 MR. ROMANELLO: -- can I suggest that we
10 consider the motions separate and apart from the
11 consent which we have not fully coalesced and come
12 to a consensus on? But we did have a motion and a
13 second and Dr. Diamond offered an amendment which I
14 would gladly accept.

15 DR. DIAMOND: Well, that was Dr. Hunter,
16 but I seconded it.

17 MR. ROMANELLO: Okay.

18 DR. PAGE: I have a question before you
19 move on. So in your motion you're talking about
20 conducting clinical trials. So do we need to
21 elaborate more on that? Like which institutions are
22 going to be allowed to do clinical trials? Can
23 anybody just do their own clinical trials in their
24 office or how do we go about that?

25 DR. DIAMOND: Well, like I said, in my

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1 comment I thought it would need to be an IRB
2 approved clinical trial at a university affiliated
3 center. Those are the two main components.

4 DR. ACKERMAN: Approved by the rules
5 committee?

6 DR. DIAMOND: No. Mr. Tellechea said that
7 would be problematic and we dropped that.

8 EXECUTIVE DIRECTOR TELLECHEA: You've got
9 to keep in mind, these are standard of practice
10 rules, all right. We can't create research studies
11 through standard of practice rules. We have to set
12 -- these are the regulations that the doctors who
13 are performing these procedures must adhere to. So
14 going off and trying to approve studies and all that
15 that's going to go way beyond your rulemaking
16 authority in this particular area.

17 MR. ROMANELLO: And what Doctors Hunter and
18 Diamond had come up with, an IRB approved study at
19 an academic institution without approval of laws and
20 rules I thought you said would have met --

21 EXECUTIVE DIRECTOR TELLECHEA: Yeah.
22 That's fine.

23 MR. ROMANELLO: That's what we're going
24 to --

25 EXECUTIVE DIRECTOR TELLECHEA: I know. But

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1 Dr. Ackerman was coming back around to that issue,
2 and I was trying to --

3 DR. ACKERMAN: Sorry, I was just trying to
4 clarify.

5 CHAIRMAN ZACHARIAH: So is the board ready
6 to vote on this motion?

7 DR. DIAMOND: Yes.

8 ATTORNEY MCNULTY: We need to maybe read it
9 back.

10 EXECUTIVE DIRECTOR TELLECHEA: Just to
11 clarify, we're not going to be dealing with informed
12 consent now. That's somewhere down the line we'll
13 deal with that.

14 MR. ROMANELLO: Yes.

15 EXECUTIVE DIRECTOR TELLECHEA: Okay. So my
16 understanding is that you're going to put the
17 prohibition on the puberty blockers, the
18 cross-hormone therapy, and the surgery under the age
19 of 18, for anyone under the age of 18, unless it's
20 being done within the auspices of the language that
21 you used, a university affiliated --

22 UNIDENTIFIED SPEAKER: IRB approved --

23 DR. DIAMOND: IRB approved.

24 EXECUTIVE DIRECTOR TELLECHEA: -- IRB
25 approved --

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1 DR. DIAMOND: University affiliated
2 clinical trial.

3 EXECUTIVE DIRECTOR TELLECHEA: Which you're
4 going to give me that specific language later on.
5 That's what I'm hearing at this point in time.

6 DR. DIAMOND: And that the rule is a
7 prospective rule.

8 EXECUTIVE DIRECTOR TELLECHEA: And it's
9 prospective. Yes.

10 ATTORNEY MCNULTY: Early, Dr. Diamond, I
11 think one board member mentioned that you also
12 wanted it in the rule that the drugs remain
13 available for treatment of other medical disorders
14 and that once the person reaches 18, no restrictions
15 on this. Did you want that in the rule?

16 DR. DIAMOND: Well, I think the easier way
17 to do is say that this rule applies exclusively to
18 minors with gender dysphoria. Make it easy. And I
19 think by doing that, there's no need to address
20 persons who reach the age of majority or other
21 medical conditions.

22 MR. ROMANELLO: Right.

23 CHAIRMAN ZACHARIAH: So we have a motion.
24 So restated the motion, seconded. Any further
25 discussion?

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1 DR. DI PIETRO: Sorry, so I just need to
2 reclarify. So we're off on informed consent and
3 we're back to IRB approved research for under 18?

4 MR. ROMANELLO: Yes.

5 DR. DERICK: I think there are three
6 elements.

7 DR. DI PIETRO: Yeah. Because for me,
8 they're not -- they're not separate issues because I
9 can't -- it would be very difficult for me to vote
10 on just that because the informed consent issue and
11 the absence of research is a whole different
12 element. So I'm just trying to clarify because I
13 feel like they're two completely separate issues.

14 CHAIRMAN ZACHARIAH: You know what, we have
15 a motion, the board second. Somebody had to vote on
16 it because it's past 1 o'clock, the meeting has to
17 end.

18 MS. PAGE: No. But I'm sorry, before we
19 vote, I agree with her comment. I think the
20 informed consent is very important.

21 EXECUTIVE DIRECTOR TELLECHEA: Then vote
22 against it. We need to vote now. We have a hard
23 stop on this meeting. It was noticed until 1
24 o'clock, so we have to --

25 CHAIRMAN ZACHARIAH: We have to stop the

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1 meeting at 1 o'clock. So we have a motion,
2 seconded. All in favor, say aye.

3 (Multiple ayes)

4 Any opposed?

5 (Multiple nays)

6 MR. ACKERMAN: They can't make motions.

7 CHAIRMAN ZACHARIAH: Let's see a motion in
8 favor?

9 (Multiple ayes)

10 Any opposed?

11 (Multiple nays)

12 So two opposed?

13 MR. ACKERMAN: Three opposed.

14 CHAIRMAN ZACHARIAH: Can we have the hands
15 up, the ones who opposed?

16 Okay. All in favor? Hold on, hold on.

17 Ma'am, would you please quiet. I'm conducting the
18 meeting. You are not conducting the meeting.

19 Okay. All in favor of the motion, raise
20 your hand. You don't have to hear it.

21 Okay. All opposed?

22 Okay. And the motion carries, thank you so
23 much and the meeting is adjourned.

24 (END OF AUDIO RECORDING)

25

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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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