

Jane Doe

vs.

Joseph Ladapo

Taped Transcription

February 21, 2023



Med Def_001350

1

2 JANE DOE,

3 Plaintiff,

4 vs.

5 JOSEPH LADAPO,

6 Defendant.

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12 TRANSCRIPTION OF VIDEO RECORDING

13 HOUSE HEALTH AND HUMAN SERVICES

14 FEBRUARY 21, 2023

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22 TRANSCRIBED AUDIO RECORDING BY:

23 Julie Thompson, CET

24

25 Job No.: 322529

February 21, 2023

Page 2

1 Thereupon,

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

4 *****

5 CHAIRMAN FINE: The Health and Human
6 services Committee will come to order.

7 Sabrina, please call the role.

8 THE CLERK: Chair Fine.

9 CHAIRMAN FINE: Here.

10 THE CLERK: Representatives Persons-
11 Mulicka.

12 VICE-CHAIR PERSONS-MULICKA: Here.

13 THE CLERK: Representative Salzman.

14 REPRESENTATIVE SALZMAN: Here.

15 THE CLERK: Skidmore.

16 REPRESENTATIVE SKIDMORE: Here.

17 THE CLERK: Amesty.

18 REPRESENTATIVE AMESTY: Here.

19 THE CLERK: Anderson.

20 REPRESENTATIVE ANDERSON: Here.

21 THE CLERK: Baker.

22 REPRESENTATIVE BAKER: Here.

23 THE CLERK: Clemons.

24 Cross.

25 REPRESENTATIVE CROSS: Here.

February 21, 2023

Page 3

1 THE CLERK: Dunkley.
2 REPRESENTATIVE DUNKLEY: Here.
3 THE CLERK: Edmonds.
4 REPRESENTATIVE EDMONDS: Here.
5 THE CLERK: Gantt.
6 REPRESENTATIVE GANTT: Here.
7 THE CLERK: Grant.
8 REPRESENTATIVE GRANT: Here.
9 THE CLERK: Koster.
10 REPRESENTATIVE KOSTER: Here.
11 THE CLERK: Massullo.
12 REPRESENTATIVE MASSULLO: Here.
13 THE CLERK: Plakon.
14 REPRESENTATIVE PLAKON: Here.
15 THE CLERK: Rizo.
16 REPRESENTATIVE RIZO: Here.
17 THE CLERK: Snyder.
18 REPRESENTATIVE SNYDER: Here.
19 THE CLERK: Trabulsy.
20 REPRESENTATIVE TRABULSY: Here.
21 THE CLERK: Woodson.
22 REPRESENTATIVE WOODSON: Here.
23 THE CLERK: Yarkosky.
24 REPRESENTATIVE YARKOSKY: Here.
25 THE CLERK: A quorum is present.

February 21, 2023

Page 4

1 CHAIRMAN FINE: Thank you, Sabrina.

2 As we begin, I ask everyone to silence
3 their cell phones.

4 So members, we are going to be having a
5 discussion today, a panel presentation on a subject
6 that has a lot of charged emotions around it. And
7 so before we get into it, I want to lay out some
8 protocol rules that will be inflexible and enforced
9 strictly.

10 First, just so everyone knows, there will
11 not be public comment today. The purpose of today
12 is to hear from the seven experts on both sides that
13 we have invited to come and speak today. The second
14 thing, as it relates to questions, members may have
15 questions. We're going to allow all seven speakers
16 to speak for 10 to 12 minutes each, and at the end
17 of that, we will take questions, you know, should
18 people have any.

19 And then the third thing relates to
20 disruptions. The sergeant staff has been
21 preauthorized to remove people. There will not be
22 warnings. You'll be removed. If I can hear you
23 breathe from my seat, that will be the standard. So
24 I would encourage people to keep that in mind.
25 We're going to have a hearing. We're going to hear

February 21, 2023

Page 5

1 from these folks. It's going to go for as long as
2 it goes, and then we are going to be done. And
3 don't test me. I'm sure you won't like the outcome.

4 All right. Members, today we have a panel
5 of experts today to talk about gender dysphoria and
6 various procedures that are being performed or
7 prescribed on minors as a result. With us today is
8 Dr. Scot Ackerman, the chair of the Florida Board of
9 Medicine, Michael Biggs, a PhD and an associate
10 professor of sociology from the University of
11 Oxford, Dr. Michael K Laidlaw, an endocrinologist,
12 Dr. Stephen B. Levine, a psychiatrist, Chloe Cole,
13 someone who has experienced this personally and will
14 share her story with us, and David Leatherwood with
15 an organization called Gays Against Groomers. We
16 will also have a doctor. I don't think she's here
17 yet. I apologize that I can't pronounce her name,
18 Dr. Sidhbh Gallagher, who is a doctor from Miami.

19 And those are our seven speakers. I would
20 note that of the seven, five are either PhDs or
21 doctors. We only have two non-academics or medical
22 professionals that are here today.

23 In your packet you will find the CVs for
24 each of our clinical and academic panelists. In
25 addition, I want to draw your attention to the last

February 21, 2023

Page 6

1 tab in the packet. This is someone we asked to
2 speak, but she was unable to be here. But I would
3 encourage you to read it. It is an article written
4 by Jamie Reed, who is a lesbian, who describes
5 herself as politically to the left of Bernie Sanders
6 and who has written a whistleblower article on her
7 experience dealing with these issues in the state of
8 Missouri and a copy of the letter that she sent to
9 the Missouri Attorney General. I wish you good luck
10 reading the article. I have tried on about five
11 occasions. I cannot get to the end before I become
12 sick. So I encourage you to read it. It's a good
13 thing to read if you, you know, want something to do
14 here or certainly afterwards.

15 Panelists, I greatly appreciate your time,
16 taking the time to be here with us today. I'm going
17 to ask each of you, like I said, to give some
18 opening remarks, no more than 10 to 12 minutes, and
19 then we'll move to member questions.

20 We're going to start with Dr. Ackerman, who
21 is here in person. You'll notice we have three of
22 our panelists will be joining us remotely, but we're
23 going to start with Dr. Ackerman. Thank you for
24 being here. He's with the Board of Medicine. He's
25 here to brief us on recent actions taken by the

February 21, 2023

Page 7

1 Board of Medicine to regulate certain medical
2 procedures that are being proposed on children.

3 Dr. Ackerman, you are recognized.

4 DR. ACKERMAN: Thank you. Thank you,
5 Chairman Fine, Vice Chairman Persons-Mulicka,
6 ranking members and Committee members for the
7 opportunity to speak with you and appear to you this
8 afternoon. So I have some prepared remarks I'd like
9 to start with this morning -- this afternoon rather,
10 and I look forward to being questioned by you later,
11 if you wish.

12 So my name is Scot Ackerman. I'm a
13 physician. I'm an M.D. I'm a radiation oncologist
14 practicing in Jacksonville, Florida. I'm currently
15 the Chair of the Florida Board of Medicine, and I'm
16 here to speak to you today about the Board's efforts
17 to promulgate rules relating to the standards of
18 practice for the treatment of gender dysphoria and
19 minors in Florida.

20 So as a bit of background, as you know, the
21 Boards of Medicine and the Board of Osteopathic
22 Medicine are apolitical bodies that have the primary
23 mission of protecting the people of the state of
24 Florida. As with any issue before our boards, the
25 Board members look to the available science and

February 21, 2023

Page 8

1 appropriate standards of care while putting aside
2 any personal feelings they may have on issues that
3 are presented before them.

4 In June of 2022, so just about eight months
5 ago, the Boards of Medicine and Osteopathic Medicine
6 received notice from the Department of Health that
7 it intended to present a petition to initiate
8 rulemaking regarding the treatment of gender
9 dysphoria in Florida.

10 During the Board of Medicine's regular
11 meeting on August 5, 2022, the Board hosted State
12 Surgeon General Joseph Ladapo and others
13 representing the position of the department. Equal
14 time was then granted to experts from the University
15 of Florida, specifically from the Department of
16 Pediatrics and Pediatric Endocrinology, who held an
17 opposing position from the department, from the
18 Department of Health.

19 Three major points were revealed to us
20 during that meeting. So three things came out after
21 hearing from the department and from the experts
22 from the University of Florida, and the first thing
23 that came out was this first so-called bottom
24 surgery. Now, bottom surgery is removing the
25 phallus. Bottom surgery would be to add a phallus

February 21, 2023

Page 9

1 to a woman who has a vagina.

2 And so we found out that bottom surgery is
3 generally not offered to minors at major medical
4 centers in Florida, but so-called top surgery is
5 infrequently offered to minors in major medical
6 centers. So top surgery is a mastectomy on a woman
7 or a girl or breast augmentation to a man. So we
8 found out that top surgery is infrequently offered
9 to minors in major medical centers in Florida. And
10 we also found out that there have been instances in
11 Florida where females as young as 15 years old have
12 undergone mastectomies.

13 The second thing that came out was that
14 there was significant substantive differences
15 between large medical societies throughout the
16 United States and in Europe regarding the treatment
17 of minors with gender dysphoria. So there was no
18 singular, unquestioned standard of care. Anyone
19 that says that, we found and we felt that anyone
20 that says there's a single standard of care, that
21 that's just not accurate, that there are multiple
22 differences -- there's substantial differences in
23 the different societies. There's a number of
24 societies that all agree, and there are many
25 societies that have a different opposing opinion.

February 21, 2023

Page 10

1 And third -- am I still on? Yeah. Third,
2 the chief point of agreement amongst all the experts
3 is that there's lack of high-quality research on the
4 subject of gender dysphoria and the treatment of
5 gender dysphoria. So there's no standard of care,
6 and there's high agreement that there's lack of
7 high-quality research.

8 So at the end of that meeting, the Board
9 voted to initiate rulemaking. A week later, the
10 Board of Osteopathic Medicine met, and they hosted
11 the State Surgeon General and others representing
12 the position of the department. And at the
13 conclusion of the Board of Osteopathic Medicines
14 meeting, they also voted to initiate rulemaking.

15 Now, you understand there's two separate
16 boards, the Board of Medicine, the M.D. board, and
17 the Osteopathic Medicine, which is the D.O board.
18 So we put together a joint -- both boards, a joint
19 rules and legislative committee, and we held a
20 workshop to consider and possibly develop rule
21 language.

22 In preparation for our meeting on October
23 28th -- so this joint meeting was October 20th in
24 Dania. And we asked the Board staff to invite
25 subject matter experts with differing viewpoints,

February 21, 2023

Page 11

1 and these subject matter experts represented three
2 separate cohorts. So we brought in Florida licensed
3 pediatricians and pediatric endocrinologists who are
4 actively treating minors with gender dysphoria.
5 That's the first cohort. We also invited scientists
6 who had expertise in the current clinical data, the
7 second cohort. And then we invited representatives
8 from the large American clinical societies, who many
9 of these sites endorse this sort of gender
10 affirmative care.

11 So ultimately, we invite all these people.
12 They didn't all come. Ultimately, we had
13 representatives from the University of Florida, the
14 University of Oxford, Yale University, University of
15 Turku in Finland, and the Children's Hospital of
16 Chicago. And we also had a private practice
17 endocrinologist from California who participated in
18 the meeting.

19 A formal invitation was also extended to
20 the Endocrine Society, and they declined the
21 invitation. We also sent formal invitations to
22 physicians who were actively practicing at many
23 pediatric hospitals in Florida, specifically the
24 Nicklaus Children's Hospital in Miami, Johns Hopkins
25 All Children's Hospital in St. Petersburg, and Joe

February 21, 2023

Page 12

1 DiMaggio Children's Hospital in Hollywood, and all
2 of these chose not to come to our meeting.

3 During the Committee meeting October 28th,
4 there also very emotionally powerful public comment
5 that was received from us from both the affirmative
6 and negative positions on the issue. Ultimately, a
7 motion was passed approving draft rule language for
8 consideration by the Boards.

9 So then on November 4th, we had a joint
10 meeting of the Boards. So those are rules-making
11 Committee. We had a joint meeting of both Boards,
12 and on November 4th, that meeting was held to
13 consider this draft language.

14 Again, we had public comments at that
15 meeting representing both the affirmative and
16 negative position on the issue. And ultimately,
17 both Boards approved proposed language to establish
18 the practice standards for the treatment of gender
19 dysphoria in minors.

20 The language was published in the Florida
21 Administrative Register on November 14th, and then
22 following publication of the language, a number of
23 requests -- we received a number of requests for a
24 rules hearing. So just a couple of weeks ago,
25 February 10th, both the Boards of Osteopathic

February 21, 2023

Page 13

1 Medicine, the Board of Medicine held a joint hearing
2 here in Tallahassee to receive and consider
3 argument, comments, and questions for those that
4 requested rule hearing.

5 I want to point out to you we've got six
6 requests for a rule hearing. And the rule hearing
7 is to hear from people who are experts or who this
8 rule might affect. So they can tell us maybe if we
9 missed something, if we need to tweak our rule or
10 something. We had six people request, and two came
11 to a rule hearing. And so with the two we had, one
12 was someone who came and wanted us just to throw
13 away the rules completely, and the other was the
14 department that came to us wanting the Board of
15 Osteopathic Medicine to remove the research
16 exemption in our rule.

17 So at the conclusion of the meeting, we
18 also heard public comment that day as well. So at
19 the conclusion of the meeting, the Board of Medicine
20 took no action to amend its proposed rule, and the
21 Board of Osteopathic Medicine passed a motion to
22 remove the IRB exemption from its proposed rule. So
23 at the end of the meeting, both Boards had proposed
24 identical rules. And these rules are 64B8-9.019 and
25 64B15-14.014, and they are in your packet under my

February 21, 2023

Page 14

1 name. And they're titled Standards of Practice for
2 the Treatment of Gender Dysphoria in Minors. I
3 could read them to you if you wish. But --

4 Thank you. Thank you, Chair.

5 So the rule promulgated by the Board of
6 Medicine will be submitted for adoption. These
7 rules that you have in your packet will be submitted
8 for adoption on or about later this week, February
9 24th, and it will become effective on March 16th
10 provided a rules challenge is not filed with DOA,
11 the Department of Administrative Hearings.

12 The rule promulgated by the Osteopathic
13 Medicine was republished on February 15th, and it
14 will proceed through the normal rulemaking process
15 for adoption as soon as allowed pursuant to Florida
16 law because, remember, that rule was changed a bit.
17 So that has a little bit different process.

18 And so that's the end of my comments. I'm
19 available either now or later as you wish to answer
20 questions. Thank you.

21 CHAIRMAN FINE: Thank you. And thank you
22 for being here and making the effort. That was a
23 very thorough description. And again, members, the
24 rules are in your packet. That way, you don't have
25 to read them out loud. I'm sure people will have

February 21, 2023

Page 15

1 questions, but, like I said, we're going to let
2 everybody get through their presentations first. So
3 thank you. Thank you, Dr. Ackerman.

4 Now we're going to go to the screens, and
5 we're going to hear from Professor Biggs, who's
6 joining us remotely from the UK, all the way -- it's
7 a little later there than it is here. He will be
8 talking about his research on this issue and the
9 recent shifts in clinical protocols in European
10 countries.

11 Professor Biggs, you're recognized.

12 PROFESSOR BIGGS: Thank you. Thank you
13 very much for this invitation.

14 So I'm an associate professor of sociology
15 at the University of Oxford. Five years ago, a few
16 of my students told me to educate myself on the
17 subject of transgender children, and so I read the
18 literature on gender medicine. I was very surprised
19 by just how poor quality the published research was
20 and also by suspicious absence of some data.

21 So to take one example, the world's largest
22 pediatric gender clinic in London started research
23 on puberty blockers in 2010. In 2018, I discovered
24 that results -- their results had been suppressed,
25 and I campaigned to force the clinic to publish

February 21, 2023

Page 16

1 those results. I've now published original research
2 of my own in journals like Archives of Sexual
3 Behavior, Journal of Sex & Marital Therapy, and the
4 Journal of Pediatric Endocrinology and Metabolism.

5 Because the time is limited, I'm just going
6 to focus on one intervention for children
7 experiencing gender dysphoria, and that is puberty
8 suppression. So puberty blockers are a class of
9 drugs -- gonadotropin-releasing hormone agonists
10 such as Lupron. Lupron is probably the most common
11 brand name you will know in America. These drugs
12 stop the production of sex hormones. For males,
13 these drugs achieve chemical castration, quite
14 literally. The drugs are licensed for a few medical
15 conditions, such as prostate cancer in men and
16 precocious puberty in children. But they've never
17 been licensed to treat gender dysphoria, not in the
18 UK, not in the U.S.A., nowhere in the world.

19 Puberty suppression is intended for
20 juvenile transsexuals, and I use that phrase because
21 that's the title of the article that was published
22 in 1996 to introduce this particular use. A GnRH-a
23 can be administered from Tanner stage two, which is
24 the beginning of puberty. And so that could be a
25 girl, for example, as young as nine years old. Kits

February 21, 2023

Page 17

1 (Indiscernible) for puberty blockers claim
2 that this is analogous to treating precocious
3 puberty, and that's -- precocious puberty is when,
4 for example, a girl, maybe age five, might start
5 developing breasts. But that treatment means
6 delaying a puberty that arrives abnormally early so
7 that the child can undergo puberty at the normal
8 age. By contrast, puberty suppression for gender
9 dysphoria means stopping normal puberty in order to
10 prepare the child to take cross-sex hormones for the
11 rest of their life.

12 Ninety-six percent to ninety-eight percent
13 of children who start on puberty blockers continue
14 on to cross-sex hormones, and that continuing to
15 cross-sex hormones typically happens around the age
16 of 15.

17 Now, the only robust scientific evidence
18 favoring this intervention comes from a longitudinal
19 study of 70 Dutch teenagers. de Vries et al in 2014
20 published outcomes shortly after surgery. So the
21 patients were around the age of 20. Several
22 psychological measures showed improvement, though
23 these measures were taken for us only a subset of
24 patients, sometimes as few as 32 individuals.
25 Gender dysphoria also appeared to decline, but the

February 21, 2023

Page 18

1 latter finding was probably an artifact of the
2 measures of the fact that they switched the measures
3 of dysphoria halfway through the research, as Dr.
4 Levine has been very clear in pointing out.

5 de Vries et al acknowledge that one patient
6 was killed by necrotizing fasciitis during the
7 vaginoplasty. So out of 70 patients -- they started
8 with 70 patients -- that's a death rate exceeding 1
9 percent, which is incredibly high for a group of
10 healthy teenagers. de Vries et al didn't mention
11 that the death was actually a consequence of puberty
12 suppression, as I'll explain a bit later.

13 The Dutch researchers have recently
14 followed up this patient cohort, but they've not
15 published the results. Therefore, we lack any
16 knowledge of the outcomes in the longer term. And
17 this is for a treatment that has been going on for
18 more than a quarter of a century.

19 The only attempt to actually replicate the
20 Dutch study came from the gender clinic in London,
21 which you might know as the Tavistock. So they
22 administered GnRH-a to 44 teenagers. Because they
23 found the results after two years weren't positive,
24 the researchers decided not to publish the results.
25 And as I said, my campaign eventually forced them to

February 21, 2023

Page 19

1 publish their research and revealed that puberty
2 suppression didn't improve psychological functioning
3 and didn't reduce gender dysphoria.

4 There are now a handful of American
5 longitudinal studies, but they're much worse in
6 quality. Instead of replicating the measures
7 pioneered by the Dutch and also repeated by the
8 British teams, each American team of researchers
9 chose a different set of psychological measures.
10 And the studies are also flawed by tiny samples,
11 high rates of attrition, which are unexplained, and
12 dubious statistical methods.

13 So what then do we know about puberty
14 blockers? Well, it's certainly true that early
15 puberty suppression produces a much closer
16 resemblance to the opposite sex. Patients are more
17 likely to pass superficially. However, this benefit
18 disadvantage must be weighed against several serious
19 costs.

20 First, for males, early puberty separation
21 makes subsequent genital surgery more risky and less
22 satisfactory. The penis is so undeveloped that a
23 normal vaginoplasty is usually impossible. A normal
24 vaginoplasty means inverting the penis, but instead
25 a portion -- in this case, a portion of the

February 21, 2023

Page 20

1 intestine has to be used to line this newly created
2 orifice. Leakage from the intestines immediately
3 after surgery is what killed that first Dutch
4 patient, the early Dutch patient at the age of 18.
5 So that was an indirect consequence of puberty
6 suppression.

7 Second, puberty suppression hinders the
8 normal accumulation of bone mass. Up to one-third
9 of teenagers who take GnRH-a for two years end up
10 with abnormally low bone density, putting them at
11 risk of osteoporosis in later life. Sweden has
12 drastically curtailed the use of puberty suppression
13 because one of the patients developed severe
14 osteoporosis at the age of 15, and several more
15 patients also had significant losses or failures in
16 terms of their bone density.

17 And Even more serious are the unknown
18 costs. All the evidence is that early puberty
19 suppression, followed by cross-sex hormones,
20 prevents the development of sexual functioning.
21 There'll be no libido and no capacity to orgasm, or
22 at least that's very likely -- a very likely
23 outcome.

24 What's really astonishing to me is that
25 clinicians who prescribe puberty blockers haven't

February 21, 2023

Page 21

1 bothered to study their effects on sexuality. And
2 in fact, the Dutch team, the lead researcher who I
3 mentioned, de Vries, recently said in an interview
4 that libido -- orgasm was an interesting question,
5 but one that they hadn't studied yet.

6 Also known is the effect on emotional and
7 cognitive development. A recent randomized
8 controlled trial of mice showed that GnRH-a caused
9 mice to manifest high levels of stress and high
10 levels of anxiety. Again, it's remarkable that
11 researchers have never studied the effect of puberty
12 suppression on cognitive measures like IQ.

13 Given the accumulating negative evidence
14 and the continuing failure of clinicians to collect
15 data, the English National Health Service in October
16 2022 released a draft specification for gender
17 services. In a reversal of an existing policy, it,
18 and I quote, "Will only commission GnRH-a in the
19 context of a formal research protocol."

20 And that's what I recommended to the
21 Florida Board of Medicine, that they should adopt
22 the same policy. I would argue that puberty
23 suppression should only be offered in a proper
24 randomized control trial. Obviously, it can't be
25 blind, but with -- there can be a treatment and a

February 21, 2023

Page 22

1 control group, which can be compared. Moreover, any
2 trial must guarantee follow up to continue into
3 adulthood and must guarantee to publish all the data
4 that is collected. Thank you.

5 CHAIRMAN FINE: Thank you. Thank you,
6 Professor Biggs. That was very, very thorough, and
7 I appreciate it.

8 Next, we're going to hear from Dr. Laidlaw,
9 who is here to talk with us about the clinical data
10 on treatments intended to change your sex. He is
11 joining us remotely from California and so thank
12 you. For you, it's a little bit earlier.

13 So Dr. Laidlaw, you are recognized.

14 DR. LAIDLAW: Thank you very much, Chair
15 and all. I have some slides. It's saying I cannot
16 share the content. I don't know if someone could
17 correct that, or I could just start.

18 CHAIRMAN FINE: We're working on it. But,
19 members, if we want to get started, I could also
20 move around if we think I should do that. But I do
21 believe the slides are in your packets. So the
22 folks in the audience can't see them. But if we're
23 going to get started --

24 DR. LAIDLAW: Okay.

25 CHAIRMAN FINE: -- you have your -- and

February 21, 2023

Page 23

1 we're working on it so that you can do that. Why
2 don't we give him like 30 seconds to see if we can
3 make it work, and then we'll --

4 DR. LAIDLAW: Okay.

5 CHAIRMAN FINE: -- start.

6 So what does he need to do now? Can you
7 try sharing your screen?

8 DR. LAIDLAW: Here we go. I think that's
9 -- yeah.

10 CHAIRMAN FINE: There you go.

11 DR. LAIDLAW: Okay. Can everyone see that?

12 CHAIRMAN FINE: All right. There we go.

13 Thank you, sir.

14 UNIDENTIFIED FEMALE: Yes.

15 CHAIRMAN FINE: Thank you, Dr. Laidlaw.

16 DR. LAIDLAW: Okay. Thank you very much.

17 And thank you, Chair and all, for having me here.

18 My name is Dr. Michael Laidlaw. I'm an
19 endocrinologist practicing in Rockland, California,
20 for about the last 15 years in private practice.
21 I've been looking into this area deeply for about
22 the last five years and have written papers and have
23 been an expert witness and given talks on this
24 subject throughout that time.

25 And so I'd like to go through with you some

February 21, 2023

Page 24

1 of the medical consequences from this treatment.
2 Being in endocrinology, we study glands and
3 hormones. When hormone levels are very high, they
4 can cause problems. We try to bring them back into
5 balance. If hormone levels are very low, that
6 causes various problems, and we try to bring those
7 into balance. And what you'll see here is what
8 they're doing with hormones is putting young people
9 way out of balance.

10 Just for some definitions, gender identity
11 is the internal feeling of being a boy or a girl or
12 some variation. Gender dysphoria is the discomfort
13 that results from having a perceived gender that
14 mismatched with the person's body. It leads to
15 significant distress and impairment lasting at least
16 six months. The majority of these children,
17 depending on what study you look at, but still the
18 majority will grow out of this by adulthood, some 50
19 percent to 98 percent, depends where you're looking.

20 So anytime we undergo any sort of treatment
21 for a condition, we want to have a definite
22 diagnosis. So if I want to treat diabetes, I want
23 to make sure someone has a really high blood sugar.
24 If we're going to treat cancer, we want a biopsy to
25 prove that there's a cancer there to treat.

February 21, 2023

Page 25

1 How can we prove the gender identity? Can
2 you find it on a scan, like a CT scan or a brain
3 biopsy or genetic testing? The answer is none of
4 the above. There is no definite physical evidence
5 of a gender identity, and, therefore, many kids will
6 grow out of this and will be harmed if they undergo
7 the treatments I'll describe.

8 A bit of basic biology, there's only two
9 human sexes. You can verify this by thinking of
10 your own fertilized ovum. When you developed, there
11 was a male sperm and a female egg that led to
12 development. This proceeds on in embryology, where
13 males and females initially have similar tubules,
14 but then there's a divergence, a split, with the
15 males developing male specific organs on one side
16 and the females on the other. This happens very
17 early in embryology, and the bridge cannot be
18 crossed thereafter.

19 There's four stages to gender affirmative
20 therapy: social transition or wearing clothes
21 stereotypical of the opposite sex or adopting
22 mannerisms, perhaps; puberty blockers, which
23 Dr. Biggs described very well; cross-sex hormones or
24 opposite sex hormones; and surgical modifications.

25 Just to have a look at one good long-term

February 21, 2023

Page 26

1 study of Sweden, they looked at 30 years of data for
2 324 individuals who had hormones and completed
3 surgery for transition. And over time, you can see
4 here year 0 to 30 years, survival rates dropped
5 dramatically after ten years for those who had
6 transitioned. They also found that they had three
7 times the rate of all-cause mortality and three
8 times the rate of inpatient psychiatric care and 19
9 times the rate of completed suicide compared to the
10 population of Sweden.

11 This is just showing what Dr. Biggs had
12 described. Puberty blockers, this is the pituitary
13 here, and these are the testes. They stop the
14 normal communication between these organs, resulting
15 in low testosterone for males, low estrogen for
16 females. These are the normal what we call Tanner
17 stages of puberty from early development to final
18 adult development in males and females.

19 And what the Endocrine Society is proposing
20 is to block this very early on Tanner stage 2. Why
21 is this important? Because fertility is established
22 around Tanner stage 4. So if they're blocked with
23 puberty blockers and then take hormones and have
24 surgeries, they will have infertility. And if they
25 have surgical removal of their organs, they will be

February 21, 2023

Page 27

1 obviously sterilized.

2 To move on to sex hormones or opposite sex
3 hormones, to give you an idea, this is showing
4 female adult testosterone levels. It's in a fairly
5 narrow range, from 10 to 50. Females do have some
6 amount of testosterone, which we associate with
7 males, but there is some smaller amount in females.
8 In a common endocrine condition that I see,
9 polycystic ovarian syndrome, they will be higher,
10 say from the 40 to 150 range. With rare endocrine
11 tumors, this will be much higher, say from 150 to
12 1000. And these are dangerous tumors which
13 generally have to have surgery or other treatments.

14 What are they proposing for hormones -- for
15 this treatment is to bring levels to 300 to 1000
16 level, which is on the order of these dangerous
17 tumors that I described and is some 6 to 100 times
18 higher than endogenous female levels.

19 What are the consequences on the body for
20 that? To stay with females here, but females and
21 males both have an increased risk of myocardial
22 infarction and death due to cardiovascular disease,
23 they found. Females will develop very high red
24 blood cell counts, which is also a risk for heart
25 disease. They can develop liver dysfunction, high

February 21, 2023

Page 28

1 blood pressure, various cancer risks of the ovary
2 and breasts, hirsutism, which is hair growth all
3 over the body in different portions, particularly
4 the face and abdomen, a deepening of the voice --
5 and both of those are permanent changes -- sexual
6 dysfunction and infertility.

7 For males taking estrogen -- again, these
8 are very high doses of estrogen -- there's a five
9 times increased risk of thromboembolism or deadly
10 blood clots, gallstones, high triglycerides are
11 possibilities. Breast cancer risk has been
12 increased by 46 times and also sexual dysfunction
13 and infertility.

14 What about going back to testosterone?
15 High doses of testosterone have, in terms of
16 psychological effects, have mainly been studied with
17 anabolic steroid abuse. And what they found in
18 those studies that some 23 percent of subjects using
19 these high doses met criteria for major mood
20 syndrome such as mania or major depression, and even
21 8 percent or so develop psychotic symptoms. So it's
22 a problem for the body and a problem for the mind to
23 have these hormones so grossly out of the normal
24 range.

25 To move on to surgeries, referred to

February 21, 2023

Page 29

1 earlier as top surgery or mastectomy, this is a
2 person who's natal female, born female. You can see
3 the male growth pattern on the face we call
4 hirsutism and the abdomen, and a surgical procedure
5 has been done to remove the breasts. Complications
6 from that, of course, the person will lose the
7 ability to breastfeed. The woman will lose the
8 ability to breastfeed. There can be significant
9 scarring of 7 to 10 inches that can widen and cause
10 problems, can cause pain. Loss of normal nipple
11 sensation and difficulties with wound healing are
12 possible complications.

13 Just to emphasize, here's another study,
14 2018, I believe, showing how young patients around
15 the country are getting the surgery. There were two
16 13 year olds who had mastectomies, five 14 year
17 olds. You can see 15 and 16 year olds.

18 Professor Biggs had described the surgery.
19 I won't go too much into it, but again, the problem
20 with stopping a male at Tanner stage 2 is that
21 they'll have a very undeveloped penis and scrotum
22 area. Therefore, when the cavity is produced where
23 the penis is inverted inside, there's not enough
24 tissue. So a portion of colon needs to be attached
25 to it. There are other procedures, which increase

February 21, 2023

Page 30

1 your risk and risk for multiple surgeries.
2 Complications can include strictures of the urethra,
3 infection, prolapse, fistulas, injury to the sensory
4 nerves with partial or complete loss of erotic
5 sensation.

6 This is showing the phalloplasty or the
7 creation of a pseudo-penis. A swath of tissue is
8 taken from the forearm or thigh and rolled into the
9 pseudo-penis. This obviously can have very high
10 rates of complication, as you might imagine. One
11 study showed 76 percent had urethra fistulas or
12 urethral strictures. Other complications can
13 include infections like peritonitis. You'll
14 obviously have large scarring to the forearm or
15 thigh, possible injury to the sensory nerves.

16 So what is the basis for this type of
17 treatment? Who's making these rules or guidelines
18 and such? The Endocrine Society, which I belong to
19 and otherwise does very good work, except in this
20 area, produced clinical practice guidelines in 2017.
21 I think you should know that nine out of ten of the
22 persons who created these guidelines belong to the
23 organization called WPATH, which is an advocacy
24 group and is not a medical organization though it
25 has some medical doctors. So it's a very biased

February 21, 2023

Page 31

1 sample of physicians and others who created this
2 document.

3 They have in their disclaimer very clearly
4 that this does not establish a standard of care. So
5 if you hear it's a standard of care, they even said
6 it isn't the standard of care. If you look at the
7 grading of evidence, it's either low, very low
8 quality, or there's no evidence for what they're
9 doing.

10 Now, the WPATH, which I just talked about,
11 is an international organization. They create
12 standards of care which really exist within their
13 organization. It doesn't apply to anyone else and
14 shouldn't apply to anyone else. And with this
15 recent set, they actually lowered or removed the age
16 minimums for surgery. So any of the things that I
17 described and the other doctors described could be
18 done at any age, which is obviously extremely
19 dangerous, and children cannot consent to these
20 procedures. They also removed all guidelines for
21 minimum age of opposite sex hormones in
22 contradiction to the recommendation of their own
23 expert consensus. So this is an extreme document,
24 presents a grave danger to minors, and should not be
25 followed by any healthcare person in Florida or

February 21, 2023

Page 32

1 anywhere else in my opinion.

2 How can we help these kids? Well, they
3 have high rates -- Dr. Levine will, I'm sure, talk
4 about comorbid psychological illnesses. These need
5 to be treated and discovered. Perhaps they had
6 physical, sexual abuse or autism, problems in the
7 marriages, or family problems due to divorce. These
8 things need to be identified and properly treated by
9 qualified psychologists, psychiatrists, counselors,
10 and others who don't follow the WPATH model,
11 individual counseling, family counseling.

12 Just to emphasize, it's not a standard of
13 care. We don't have the technology to make a male
14 into a female or vice versa. Kids would not
15 understand this. We don't know long-term outcomes,
16 and what we do know for adults is not good.
17 Medications are being used off-label experimentally
18 and at high doses without proper FDA risk assessment
19 profiles. Evidence quality is very low, as we said,
20 and desisters and detransitioners have been ignored,
21 though there are some studies showing the problems
22 that they've had. Thank you very much for allowing
23 me to present.

24 CHAIRMAN FINE: Thank you. I very much
25 appreciate it and again look forward to the

February 21, 2023

Page 33

1 questions. That was an excellent presentation.

2 We're going to continue you with our
3 medical professionals. We're sort of hearing them
4 all up front. We're now going to hear from
5 Dr. Levine, who is the clinical professor of
6 psychiatry at Case Western Reserve University. So
7 he is not as far away. He's also joining us
8 remotely.

9 Dr. Levine, you are recognized.

10 DR. LAIDLAW: Thank you very much. I plan
11 to emphasize 13 ideas that I have found in the
12 literature written by those who affirm care for
13 children and adolescents and adults for transgender
14 phenomenon.

15 Each one of these 13 points, I believe, is
16 scientifically untrue. Nonetheless, they are firmly
17 believed, and when they are countered in meetings,
18 when they're confronted in meetings, it produces a
19 passionate outcry that it isn't true. But as far as
20 I can see, these 13 ideas are not scientifically
21 verifiable and are clinically, apparently,
22 incorrect.

23 Nonetheless, affirmative care doctors
24 assert them in their writings and in their speeches
25 repeatedly. And so having eavesdropped on this

February 21, 2023

Page 34

1 literature for all these years, I feel very strongly
2 that each of these points can be defended as
3 correct. That is, none of them are correct.

4 And before I give you these 13, I want to
5 raise that one way of considering this big question
6 of trans care for youth is whether this is an
7 example of therapeutic advance to help afflicted
8 human beings, or whether this is yet another medical
9 misadventure that in medicine we have a history of
10 many medical misadventures, most recently and most
11 damaging is the opioid epidemic, where we began
12 prescribing in medicine opioids liberally without
13 scientific demonstration as to its use and its
14 utility and its harms. And now every state in the
15 United States and elsewhere is suffering from
16 premature death due to opioid abuse.

17 So here are the 13 things that are not true
18 in my view. A trans identity, once established, is
19 immutable, unchangeable, unchanging. This is
20 clearly not true. Second, trans identities are
21 primarily caused by prenatal biologic forces. That
22 is, the justification of the treatment is we're just
23 correcting some biologic embryologic mistake.

24 And third, sexual orientation is entirely
25 independent of gender identity. Sexual orientation

February 21, 2023

Page 35

1 is a bias that all of us have towards for romantic
2 and sexual purposes for members of a class of males
3 or females. And in the standards of care from
4 WPATH, it's been asserted that they're entirely
5 separate.

6 But when you watch the child develop from a
7 childhood to puberty to middle adolescence, you
8 often see that the first manifestation of gender
9 dysphoria before gender dysphoria shows up, it is
10 that I am attracted to members of the same sex. And
11 you watch the evolution throughout adolescence of
12 orientation, and you quickly see that they are not
13 entirely separate phenomenon like the advocates say
14 they are.

15 And the fourth idea that is not true is
16 that no form of gender identity is an abnormality,
17 and no form of gender identity is a symptomatic
18 reflection of some other problem. This is not a
19 psychologically tenable concept, but it is asserted
20 all the time. And you can read it in the standards
21 of care.

22 Fifth, gender dysphoria is a serious
23 medical condition, and it requires medical
24 intervention only if the patient wants it. So there
25 is some inherent paradox in that idea, right? It's

February 21, 2023

Page 36

1 a serious medical condition. That implies that we
2 should treat it, but we should only treat it if the
3 patient wants it.

4 Six, the associated emotional problems are
5 primarily due to living in a discriminatory world,
6 even though many of the children who were diagnosed
7 with gender dysphoria eventually previously have
8 been diagnosed with other problems.

9 Seven, no effective alternative approaches
10 to affirmative care exist. This is the only thing
11 that will save your child, we tell parents, you see,
12 and many of the practitioners actually believe there
13 are no alternate approaches. But Dr. Laidlow just
14 told us about an alternate psychiatric approach.

15 Eight, attempts to provide psychotherapy
16 are unethical versions of conversion therapy and
17 should be outlawed. You see, any attempt to help
18 the child and the family is called conversion
19 therapy, and people are urging that to be outlawed
20 in various jurisdictions.

21 Nine, affirmative care lastingly improves
22 mental health and social function. This is the
23 justification for the treatment, even though we
24 don't have studies that demonstrate that. We don't
25 have long-term studies at all that demonstrate that,

February 21, 2023

Page 37

1 and we have many studies that indicate -- and you've
2 seen slides of the death rates and a recent study
3 has reaffirmed the elevated death rates of
4 transsexual adults. So the idea that this improves
5 mental health is uncertain at best.

6 Ten, affirmative care reduces the rates of
7 suicidal ideation and prevents suicide. This is the
8 most powerful coercive untruth that parents of
9 teenagers are told. Would you rather have your
10 child -- visit your child in the cemetery or have a
11 trans child? And many people, including one of our
12 panelists today, have demonstrated the lack of
13 veracity of that assumption.

14 When we look at the Swedish studies, the
15 females who underwent sex reassignment surgery had,
16 I think, 40 times the suicide rate, and the average
17 suicide rate that was quoted was 19 times because
18 the male's suicide rate was a little less than 19.
19 So we realized that we are exposing people to great
20 risk of suicide in the long run. And when we don't
21 have follow-up studies of the youth, you see, we
22 need to be informing parents about what we do know
23 about the long-term outcomes, which is not happening
24 at all.

25 And the 11th idea is that teens, young

February 21, 2023

Page 38

1 teens know best what will make them happy in the
2 future. I hear that all the time because this is
3 their genuine true self. Not true. They don't know
4 what's best for them necessarily.

5 And, 12, meeting diagnostic criteria for
6 gender dysphoria predicts a good outcome to
7 affirmative care. That's not true either. And,
8 finally, regret and detransition are rare among
9 these patients. As the last two years have begun to
10 show, detransition is increasingly recognized.
11 Regret is -- when people assert that regret is rare,
12 it's because they're defining regret as telling
13 their original therapist that they wish they didn't
14 undergo this or asking to have their body rechanged
15 back to their original form, which is a very limited
16 concept of what regret represents.

17 So these 13 ideas, I think, stand as a
18 monument to the assertions that affirmative care,
19 the science of affirmative care, has already
20 established its superiority and its benefit. If
21 ideas that underpin intervention are not true, are
22 not correct, how can we trust the intervention
23 itself? I think that's all I wanted to say to you
24 today, and I'm happy to answer any questions in the
25 future.

February 21, 2023

Page 39

1 CHAIRMAN FINE: Thank you. And like I
2 said, I appreciate all of you, and we will get to
3 questions at the end.

4 Before we move to our two non-
5 professor/doctors, she is not here, but I did want
6 folks to know that we had invited sort of one of the
7 most publicly public advocates, medical
8 professionals who's done this. Her name's
9 Dr. Sidhbh Gallagher. She has 280,000 TikTok
10 followers where she promotes this. She dubs herself
11 Dr. Teetus Deletus. That is her name, not mine.
12 And she proudly has done 400 to 500 gender -- what
13 she calls gender affirmation surgeries a year,
14 including 13 on minors.

15 And we did invite her to come. I mean,
16 she's willing to talk about it on TikTok. We
17 figured she might be willing to talk about it to the
18 Florida Legislature, but I guess platforms that
19 reach more than children just aren't that
20 interesting.

21 So we will move on to our nonmedical
22 professions. And next, we're going to now hear from
23 Ms. Chloe Cole, who's here to tell us about her
24 personal experience with this type of supposed
25 medical care. Ms. Cole, you are recognized.

February 21, 2023

Page 40

1 CHLOE COLE: Excuse me. I'm an 18-year-old
2 de-transitioned woman from the Central Valley of
3 California, and I commend California -- I commend
4 Florida for stepping up for the rights and safety of
5 our children and preventing what happened to me as a
6 child to happening -- from happening to other
7 children.

8 I transitioned and de-transitioned all
9 while I was a minor when I was in middle and high
10 school. And at roughly the age of 12, I started
11 feeling that after years of being a tomboy, being a
12 more masculine girl, and a misfit amongst all the
13 other girls, I was, in fact, a boy this whole time.
14 And I began cutting my hair and wearing boys
15 clothing to reflect this belief.

16 And I experimented with new names, and
17 eventually, I wrote a letter to my mom and dad
18 telling them that I wanted to be their son. And
19 they were concerned because they knew very little
20 about the subject, and they certainly didn't expect
21 to hear such a thing from their own daughter. And I
22 don't think any parent really does.

23 So they decided to send me to a therapist.
24 And their expectation was that they would get to the
25 bottom of my distress and where it was stemming

February 21, 2023

Page 41

1 from, and that in therapy, my feelings would be
2 resolved. But this did not happen. This is far
3 from what happened.

4 When they voiced their concerns to my
5 doctors, they were immediately shot down, and
6 immediately the therapist, and eventually the gender
7 specialist, their approach was only to affirm my
8 identity, and there was no questioning. There was
9 not a proper psychological evaluation done.

10 But my mom and dad were told that children
11 are already confident in their gender identities
12 from early childhood, that I knew exactly what I
13 wanted, and if I were not affirmed, it was very
14 likely that I would kill myself. The doctors, it
15 was life or death, and Mom and Dad were not given
16 any other option but to allow me to transition. And
17 so I was put onto the path of medical transition,
18 starting with puberty blockers and testosterone at
19 13.

20 A few months after starting testosterone, I
21 was sexually assaulted by a classmate of mine. And
22 out of fear of the assault happening a second time
23 and of being recognized as my biological sex ever
24 again, I started to use a compression device called
25 a chest binder. And by the time that I entered my

February 21, 2023

Page 42

1 freshman year, my voice was already considerably
2 deeper, and I looked just like pretty much any other
3 boy my age.

4 I passed considerably well as the opposite
5 sex throughout high school, but I still lived with
6 great anxiety of being discovered as a biological
7 female, especially because I was still using male
8 restrooms and locker facilities. One day after
9 coming home from school, I started feeling a dull
10 sensation that started turning into stabbing pains
11 in my lower abdomen. And I realized that these were
12 uterine cramps. And they were worse than any period
13 cramps I had ever had in my life, and I figured that
14 it was because I was experiencing atrophy of my
15 reproductive organs. And so this atrophy was
16 treated with topical estrogen, and for the most
17 part, these cramps disappeared. They lessened.

18 But in the middle of my sophomore year,
19 after years of using the binder and wearing this
20 thing for anywhere from around 8 to 12 hours on
21 weekdays and whenever I went out to work out or swim
22 or whenever I had guests over at home, I was sick of
23 it. And I thought of myself to be like any other
24 boy my age, and I wanted my body to reflect that.

25 And so I spoke to my therapist about my

February 21, 2023

Page 43

1 desire to get my breast removed, and then I was
2 referred to a gender specialist, who then gave me a
3 letter of recommendation to a surgeon. And several
4 appointments with a surgeon later, about a month
5 before my 16th birthday, I went under the knife.

6 And initially, when I woke up from the
7 surgery, I was happy. I was very happy. I mean, it
8 was a big -- to me, it was a major milestone in my
9 transition and a big step in the right direction.
10 And it was an outpatient surgery. So I was
11 immediately sent home pretty much as soon as the
12 medication wore off, and I was conscious.

13 And my mom had to take a few weeks off from
14 work to take care of me while I was recovering
15 because it was a major surgery in the upper area of
16 my body, and I had very little range of motion. I
17 couldn't even lift my arms up until about two or
18 three months afterward.

19 But after about a week or so, I had to get
20 my stitches taken out, and it was the most
21 disgusting feeling I had ever had in my life. The
22 sensation was there, but it was very numb and very
23 dull. And it made me nauseous, and I nearly threw
24 up a few times. And once I was sent home, I started
25 having to regularly change my dressings after every

February 21, 2023

Page 44

1 shower. And during every shower, I had to look down
2 at this wounded area of my body.

3 And it wasn't really the scars that
4 bothered me so much. But the type of incision that
5 I was given was called a double mastectomy with
6 nipple grafts, meaning that they excised into the
7 breast and took out the tissue. But they also cut
8 around my areolas, and they did a deep scrape on an
9 area of my chest and then put the areolas onto that
10 area of scraped skin to simulate a more masculine
11 positioning of the nipples.

12 And because during this process the blood
13 supply was cut off, the top layer of skin was now
14 completely dead, and it was black. And I was told
15 that this would be part of the process, but nothing
16 really would have prepared me for it until I
17 actually went through it. And with every shower, I
18 watched this dead skin slowly fall off, and it was
19 hard to watch that happening to my own body.

20 After a while, I started to actually
21 realize that I missed being feminine. I miss things
22 like wearing makeup and having my hair long and
23 wearing skirts and dresses. And there are other
24 things that I missed about being a woman as well.

25 Socially, as a male, it's not easy. I

February 21, 2023

Page 45

1 mean, there's a lot less room for expressing
2 yourself either in the way you present yourself or
3 even just talking about your feelings and emotions.
4 And I found that a lot of my relationships with my
5 peers, with my friends, with both boys and girls,
6 and even within my family were a lot less
7 emotionally fulfilling, and I felt very alone.

8 And I started to go down an emotional
9 downward spiral into my junior and senior years, and
10 my grades dropped. I had a very low GPA by this
11 point in time. I was hardly even attending my
12 classes sometimes.

13 But in my junior year in an online class, I
14 was taking a psychology class, and part of the
15 psychology -- towards the end of the class, there
16 were lessons on things like parenting and childhood
17 development.

18 And, I mean, during my consultations with
19 the endocrinologist and the surgeon, I was told
20 things like I may not be able to have children as an
21 adult if I were to go on blockers or hormones, and
22 that if I were to get my breast removed, I would
23 never be able to breastfeed. And, I mean, at the
24 time, none of this really meant anything to me
25 because I was still a kid. I was still being taken

February 21, 2023

Page 46

1 care of by my parents, and I didn't know what it
2 meant. I didn't know the importance of eventually
3 deciding to have a family of my own.

4 And it was only when I was in that class,
5 when I was learning about this, that I realized that
6 I had a maternal instinct, and I wanted to have
7 children down the line. And I knew that because of
8 the decision I made to medically transition as a
9 kid, that may never be possible, and I really
10 couldn't take it anymore. I couldn't keep lying to
11 myself that I was something that I wasn't, and I
12 stopped transitioning cold turkey.

13 I'm only 18. My life is just beginning.
14 I'm far too young to feel like I am a broken woman,
15 but it's hard to look in the mirror. It's hard to
16 look at what has become of my body, and I have to
17 live my entire adulthood knowing I'll never have
18 breasts. I'll never be able to breastfeed my
19 children, and it's possible I might not ever be able
20 to carry a child. And sometimes, I have episodes
21 where I still see a boy in the mirror, and it makes
22 me panic.

23 But the emotional turmoil and regret are
24 far from the worst parts about my story. All of
25 this was a huge failure on the part of my medical

February 21, 2023

Page 47

1 practitioners. My mom and dad and I were lied to.
2 We weren't given any other option or informed fully
3 of the potential consequences of medical transition.
4 And my parents did sign off, but it was under the
5 false pretense that my life depended on it. And I,
6 a 13 year old, was expected to know exactly what I
7 needed and to know the consequences.

8 I had several comorbidities that the
9 doctors failed to rule out or address. I was
10 previously diagnosed with ADHD, but it actually
11 turned out later that I'm actually on the spectrum.
12 And it was actually the gender specialist, the same
13 one who referred me to surgery, who about a year
14 afterward told me that I had some pretty key
15 symptoms of autism, that I should be screened for
16 it. And even if I was diagnosed with autism, my
17 doctors still would have transitioned me.

18 To this day and throughout the process of
19 medically transitioning, I've faced several
20 complications. From the blockers, while I was on
21 them, because I was already about three to four
22 years into puberty, it essentially put me into a
23 state of artificial menopause. And while I was on
24 them, I started experiencing some hot flashes and
25 itching all over my body, not too unlike what women

February 21, 2023

Page 48

1 in their 40s to 50s, 60s tend to experience. But
2 after going off of them years later, I've started
3 getting some joint pains, namely in my limbs and my
4 hands and my finger, but I also get shooting pains
5 up my back, and these are pretty sporadic. They
6 don't happen very often, but they've been starting
7 to become more frequent and more painful and more
8 disruptive.

9 And from the testosterone, I mean, some of
10 the most visible changes would be to my bone
11 structure. Like I have larger shoulders and smaller
12 hips than most women, and I have more defined
13 features in my face. But I also have some issues
14 with my urinary tract. Like I have to use the
15 restroom rather frequently. I'm often dehydrated
16 because of that, and I'm prone to infections.

17 For a while, it actually got to the point
18 that I would get blood clots in my urine and
19 sometimes little bits of tissue even. But I'm also
20 experiencing sexual dysfunction, and my fertility is
21 questionable. I am getting periods, and they are on
22 -- I do have a fairly regular cycle. But I don't
23 know if I'm ovulating, or even if I am able to
24 conceive, if I'll be able to safely carry.

25 But the worst complications might be from

February 21, 2023

Page 49

1 the surgery. I mean, I'll never be able to
2 breastfeed my kids, as I said, and I have some
3 issues with the sensation. I have no -- I have very
4 little erogenous sensation, and sometimes I get the
5 feeling of phantom breasts. Sometimes when I'm
6 walking, like going up a flight of stairs, I'll feel
7 them move, even if they're not there, even though
8 they're not there.

9 And the graphs, at first, they seem to be
10 healing fairly well, other than the fact that on
11 top, the area of skin was very dehydrated. But
12 about two years post-op, they've started to fail.
13 The top area of skin is almost not there, but it's
14 just -- it's leaking fluid. I have no idea why. I
15 don't know what the fluid is, but I have to bandage
16 my chest daily. I've tried to reach out to my
17 surgeon for help with this, and all I got was just
18 put some Vaseline on it. That was his response,
19 which actually gave me a temporary skin infection.

20 So I can't trust my doctors who helped me
21 get into the situation in the first place to help me
22 now. But it's worth noting that most of the serious
23 complications that I'm facing now, I was not
24 informed of, and it's very likely that my young age
25 played a part in the onset of many of them.

February 21, 2023

Page 50

1 With all that being said, what is it that
2 we can do to help gender dysphoric children? The
3 best and the most obvious solution is to prevent
4 minors from going on these treatments, from taking
5 hormones and blockers and going under the knife in
6 the first place.

7 And conservatives are constantly reacting
8 to the most obvious and immediate dangers, but we
9 fall short when establishing a vision. And right
10 now, the conservative movement is largely just about
11 combating the vision of the left. But my question
12 for the DeSantis administration, and more broadly,
13 the conservative movement, is what is your vision
14 for the future? What is your vision for helping
15 people suffering with gender dysphoria, for helping
16 the children, parents, and families in need?

17 I've traveled to many states to testify on
18 these bills, and I've noticed a glaring problem.
19 These bills are trying to take away something
20 without replacing it with anything else. And we
21 have thousands of individuals who regret their
22 transitions, who want to go off these treatments and
23 detransition, but they have no idea how.

24 There's an epidemic approaching of children
25 and young adults who regret or have been harmed by

February 21, 2023

Page 51

1 transition, and we are at the very beginning of the
2 exponential curve. And the Florida government is in
3 uniquely positioned to not only end the affirmative
4 care model in children, but also to provide a model
5 of care that actually helps gender dysphoric
6 patients of all ages.

7 Right now, de-transitioners are their own
8 doctors. We have not a clue about how the endocrine
9 system works, but somehow, we have to navigate it
10 without proper blood tests or treatment. The first
11 month after I stopped transitioning, I was tested
12 for my hormone levels. But my endocrinologist gave
13 me the guidelines for the average hormone levels of
14 teenage males.

15 Questions that I've asked my doctors but
16 never have gotten a proper answer for are: how do
17 you taper off testosterone? Are my hormones stable?
18 Am I fertile? Why are my skin grafts failing and
19 leaking fluid two years after surgery? I've had --
20 I'm still trying to figure all this out on my own.
21 I can't trust my doctors to help me. I've reached
22 out, and I've gotten absolutely nothing. I almost
23 committed suicide several times while trying to
24 detransition.

25 So how do you provide mental health

February 21, 2023

Page 52

1 services for a child who's lost her breasts to a
2 political ideology? We need answers now. No doctor
3 knows how to provide care for de-transitioners, but
4 the WPATH has standards of care for dysphoric
5 patients that every major medical institution in
6 North America follows like it's the Bible. But we
7 need standards of care for de-transitioners now.

8 There is no science supporting gender-
9 affirming care for minors, and we need to replace it
10 with something else. Florida needs to step up and
11 do the right thing. Thank you.

12 CHAIRMAN FINE: Thank you. And I'm sorry
13 for what you've gone through.

14 Finally, we're going to hear from
15 Mr. Leatherwood, who represents the Florida chapter
16 of Gays Against Groomers.

17 Mr. Leatherwood, you are recognized.

18 MR. LEATHERWOOD: Thank you.

19 The modern trans movement is using the LGBT
20 community as a shield to push their radical agenda
21 of mutilation, sterilization, and indoctrination of
22 minors, and as a gay man who represents the
23 organization Gays Against Groomers, I'm here to make
24 it loud and clear. The LGBT community is sick of
25 being used as a scapegoat for these destructive

February 21, 2023

Page 53

1 practices that are ruining kids' lives before they
2 ever even had a fighting chance.

3 For years, the LGBT community has fought
4 valiantly for tolerance and acceptance in American
5 society, and in the year 2023, we have achieved
6 that. Now, all our progress is being erased because
7 our community has been hijacked by trans terrorists.

8 The LGBT community is being used like a
9 Trojan horse by extremists in a death cult to ruin
10 the future generation of our country by destroying
11 their bodies, creating irreversible damage, and
12 lifelong medical patients before these kids ever
13 reach puberty.

14 And make no mistake, the radical trans
15 movement has become a death cult. Their most recent
16 mantra is death before detransition. They're
17 possessed by a sick obsession with bodily
18 mutilation, self-harm, identity destruction, and
19 pure hatred for anyone who dares to question this
20 dangerous ideology.

21 America is a free society, and as a
22 patriot, I stand for the freedom of all individuals
23 to make their own decisions about their own lives.
24 But where we draw the line is children, minors who
25 cannot consent. Yet that is exactly the demographic

February 21, 2023

Page 54

1 that these terrorists are targeting with their
2 culture war. It's your kids.

3 They say, if you don't bend the knee and
4 submit to their demands of gender-affirming care,
5 which is the nice way of saying mutilation and
6 sterilization, you are a bigot or a transphobe, and
7 now LGBT acceptance in America is down for the first
8 time in years.

9 It's because people know that something is
10 wrong, and they're not on board with what's
11 happening. It only takes a caring parent with a
12 little common sense and gut instincts to know that
13 permanently mutilating their child's body is much
14 worse than being labeled anti-LGBT. Many now wear
15 that label proudly. They say, if being against the
16 medicalization of minors means I'm anti-LGBT, then
17 fine. Call me anti-LGBT because good parents care
18 more about the lives and safety of their children
19 than catering to these rainbow terrorists.

20 I'm here to tell you now, standing up
21 against these bullies and wanting to protect your
22 children is not anti-LGBT. In fact, the majority of
23 LGBT individual are against it too, like me and like
24 our entire organization, Gays Against Groomers. And
25 we are fighting for visibility to reclaim our

February 21, 2023

Page 55

1 community from the trans extremists, to stand up
2 against this evil and destructive ideology, to stand
3 in solidarity with parents, and to give a voice to
4 everyone who knows on a gut level that this is not
5 right but is too afraid to speak out in fear of
6 being smeared or labeled a bigot. It is not bigoted
7 to want to protect children from elective
8 experimental medicalization. It is common sense, it
9 is compassionate, and it is scientific.

10 The gay left, in collusion with gay media
11 and gay advocacy groups like GLAAD and HRC, are
12 promoting a narrative that the LGBT community
13 supports the medicalization of children, but that is
14 a lie. The LGBT community at large does not support
15 this. It's only fringe radicals. This lie is
16 funded by donor dollars brought to you by Big
17 Pharma.

18 That's right. These organizations are
19 sponsored by corporations like Pfizer, Johnson &
20 Johnson, UnitedHealth Group, and other medical
21 corporations who have a vested interest in turning
22 your kids into lifelong medical patients because
23 they don't see an innocent child with a bright
24 future. They see dollar signs.

25 It's funny. They call a group like Gays

February 21, 2023

Page 56

1 Against Groomers an anti-LGBT hate group, but the
2 ideology of gender-affirming care is actually very
3 homophobic. The truth is the majority of gender
4 nonconforming kids grow up to be gay. So in effect,
5 they are erasing gays.

6 Telling a masculine girl she's trans and
7 needs to start puberty blockers deprives that girl
8 of the right to explore her identity. What if she's
9 a lesbian? What if she's just a tomboy? And
10 telling a feminine boy he's meant to transition to
11 female simply because he prefers playing with
12 Barbies over trucks is outright sexist.

13 At GAG, see ourselves in these kids. Stop
14 trans and gay youth. Stop gay eraser. Save the
15 tomboys. Stop the sexism. Stop using the LGBT
16 community as a scapegoat for hurting children. This
17 is a nonpartisan issue. Protect our kids. We are
18 Gays against Groomers, and we stand firmly against
19 the elective medicalization of minors.

20 CHAIRMAN FINE: Okay. Members, that was a
21 lot, and that concludes all of our panelists. We
22 will now entertain questions from our members. I
23 know since he is a doctor and a Representative, I'm
24 going to let Representative Massullo go first. And
25 if you would like to ask questions, just sort of

February 21, 2023

Page 57

1 look down towards me, and I will put your name on a
2 list.

3 REPRESENTATIVE MASSULLO: Thank you,
4 Mr. Chair. And I want to thank you and your staff
5 for putting together such a fine panel of experts on
6 this subject who were very thorough in going over --
7 and I won't say side effects -- but I will say
8 consequences of this type of -- and I hate to use
9 the word, but I will because it's associated with it
10 -- affirming care.

11 I have two real quick questions. One, I'll
12 actually answer myself. There is a thing that all
13 physicians take called the Hippocratic oath, and one
14 of the chief tenets of that oath is to do no harm.
15 In any procedure in medicine, we are required to
16 give informed consent. It is impossible to give
17 informed consent to someone that is not of the age
18 to give consent.

19 My question is for you, Dr. Ackerman. How
20 do we, in this state of Florida, allow healthcare
21 providers to continue having a license that provide
22 this type of care? And ignorance is not an excuse.
23 Ignorance of what they're doing to these individuals
24 is not an excuse. How do we continue to allow them
25 to practice medicine? And it is almost like, do we

February 21, 2023

Page 58

1 allow -- and we do -- frontal lobotomies for people
2 that are depressed or anxious. No one does it, but
3 it's still legal in some states.

4 CHAIRMAN FINE: You are recognized.

5 DR. ACKERMAN: Thank you. Well, that's
6 exactly the rule we put forth, and the rule we put
7 forth says that the following therapies and
8 procedures performed for the treatment of gender
9 dysphoria minors are prohibited. So any physician
10 that does sex reassignment surgery or other surgical
11 procedures that alter the primary or sexual
12 characteristics will potentially lose her license.
13 Any physician that provides puberty-blocking hormone
14 treatment or hormone agonist therapies could
15 potentially lose their license.

16 And so that's what we've put forth in our
17 rule, and that's what is being put through the
18 system and should be into place within the next
19 month, both the Board of medicine and the Board of
20 osteopathic medicine.

21 REPRESENTATIVE MASSULLO: Thank you.

22 CHAIRMAN FINE: Representative Anderson,
23 you recognize for a question.

24 REPRESENTATIVE ANDERSON: Thank you,
25 Mr. Chair.

February 21, 2023

Page 59

1 And thank you, everyone, for your
2 presentations today. It was very informative, very
3 eye opening. I especially need to commend Ms. Cole
4 for your courage. I can't imagine how difficult
5 this is for you and appreciate your advocacy.

6 CHLOE COLE: Thank you.

7 REPRESENTATIVE ANDERSON: My question, I
8 believe, is likely for maybe more than one member of
9 the panel, but I'm interested to know what kind of
10 numbers are we talking about for minors versus
11 adults that are currently being treated or have
12 previously been treated for gender dysphoria? And
13 how does that compare in our state versus nationwide
14 and perhaps in Europe as well?

15 CHAIRMAN FINE: Anybody like to answer --
16 did you have that question for anyone in particular,
17 or are you just opening it up to the panel?

18 REPRESENTATIVE ANDERSON: Whoever can
19 handle that one.

20 CHAIRMAN FINE: Okay. Does anybody want to
21 take a crack at it, either here or -- how many was
22 the question.

23 DR. LEVINE: Well --

24 CHAIRMAN FINE: You are recognized. Go
25 ahead.

February 21, 2023

Page 60

1 DR. LEVINE: I think I can answer that
2 definitively as we don't know the answer to your
3 question. However, in the last 25 years, the
4 movement has been and the activity in clinical
5 centers has not been with well-established adults as
6 it was before the turn of the century. It has been
7 with youth, and by youth, I mean teenagers.

8 And by teenagers, what we mean is that the
9 number of -- say, in 1995, throughout the world,
10 there were about three boys who wanted to be girls
11 for every girl who wanted to be a boy. And more
12 recently, since the turn of the century, in
13 particular, in the last 10 years, I would say 15
14 years, the ratio has reversed. And in some centers,
15 there are seven girls presenting for every boy who
16 presents now.

17 So we really think this is like an -- I
18 don't know -- epidemic is not the right word, but
19 there is a tsunami of teenage girls who are
20 responding to early puberty changes in their bodies
21 by going on the internet and then declaring
22 themselves to be lesbian, bisexual, eating
23 disordered, and then trans.

24 Now, I don't want to emphasize that there
25 is a paucity of boys who want to be girls. I think

February 21, 2023

Page 61

1 there's been an increase in all youth who want to
2 transition, but the sex ratio has changed. I've
3 been running a gender clinic for -- it's hard to
4 believe -- but since 1974, and in the first 25, 30
5 years, we saw an occasional teenager, a rare child,
6 and most people were in their 30s and 40s.

7 And I recently had a 60-year-old man come
8 to see me, and that was the first adult who's come
9 to see me in year. But I've seen a lot of
10 teenagers. So when you ask state by state, I have
11 no idea. When I look at what is published in the
12 literature, I've just summarized what is published
13 in the literature, and I think really what's
14 happened in the trans movement, it's about trans
15 youth, not about trans adults.

16 I think when we approach the adult, say the
17 25 year old or the 50 year old or the 43 year old,
18 we don't have the controversies because, in part,
19 they're cognitively mature enough to make their own
20 bad decisions. And so we don't have as much
21 internal angst about the treatment, and there is not
22 that much controversy. And it would be interesting
23 to see if, in fact, adults, having seen the
24 controversies that are being discussed in the media
25 today, they are perhaps not willing to undergo this

February 21, 2023

Page 62

1 as often as they did in the past. But that's a wild
2 speculation.

3 PROFESSOR BIGGS: I just got information
4 from the Tavistock, which was the largest pediatric
5 gender clinic in the world and has just been sort of
6 closed down. So it was started in 1989, and in the
7 first decade, from all over England, it had 14
8 individuals a year. The last year, we have data for
9 over 6000, and that's even with a massively long
10 waiting list. So the numbers have increased
11 massively all over the world, and obviously, the
12 United States will be the same, all over the
13 English-speaking world and Western Europe.

14 And, indeed, there was a survey that came
15 out from pediatrics of schools in Pittsburgh, which
16 suggested that 9 percent of school students were
17 identified as trans, and that said it was important
18 that they would all be given, if they wanted it,
19 gender-affirming care.

20 Now, I think their numbers were
21 exaggerated. I would estimate it at 7 percent from
22 that survey, and probably some of those students
23 were just, you know, weren't really trans. They
24 were just ticking the box because they thought it
25 would be fun. But even so, the very fact that in

February 21, 2023

Page 63

1 Pediatrics, a leading medical journal, they can
2 entertain that 1 in 10, as they say it in the sort
3 of editorial, 1 in 10 kids need to go through the
4 same process that Chloe Cole had gone through,
5 that's really extraordinary. It gives you an idea
6 of the magnitude.

7 DR. ACKERMAN: Can I address it as well?

8 CHAIRMAN FINE: Absolutely.

9 DR. ACKERMAN: Unless someone else wants
10 to go ahead.

11 CHAIRMAN FINE: No.

12 DR. ACKERMAN: So what we found out from
13 the Florida Board of Medicine when we asked the
14 different providers of care from around the state to
15 come speak to us, and specifically we had the team
16 from the University of Florida in Gainesville, the
17 pediatric endocrinologists come, they're very cagey
18 about their numbers. They weren't very -- they
19 didn't disclose their numbers to us. When pressed,
20 we had a very hard time getting answers about those
21 numbers.

22 And specifically, we were asking questions
23 about the ages of the patients, et cetera, et
24 cetera. And we weren't getting straight -- we
25 weren't getting answers. I'm not saying we weren't

February 21, 2023

Page 64

1 getting straight answers. We had a hard time
2 getting any answers.

3 If you read in the back of tab -- of the
4 last tab, the article that was published a few weeks
5 ago by Jamie Reed, she quotes in here that according
6 to Reuters, the number of pediatric gender clinics
7 in America have gone from 0 15 years ago to more
8 than 100 today. So that may give you a perspective
9 as well.

10 And we also heard from physicians who spoke
11 to us -- and, remember, we had three meetings about
12 this -- different physicians speak to us. We heard
13 that the demand and the inquiries to the clinics and
14 the volume of the clinics had been going up over the
15 past few years.

16 CHAIRMAN FINE: Just a follow-up from me on
17 that.

18 DR. ACKERMAN: Yes.

19 CHAIRMAN FINE: If this is a great thing
20 and all scientifically valid and good, good, good, I
21 mean, why would someone be cagey about the numbers?
22 Why wouldn't they cheer from the rafters about how
23 many of these they're doing? What's your belief as
24 to why they were cagey?

25 DR. ACKERMAN: Well, frankly, you know, I

February 21, 2023

Page 65

1 called them out on this, that we weren't getting
2 straight answers. And we had a woman who spoke to
3 us from Yale about it, and when I personally
4 questioned her about the numbers that she was seeing
5 -- because, remember, we've gone through this very,
6 very thoroughly, and we looked at hormone blocking
7 agents. We looked at hormone affirming agents,
8 right? So you block the hormones first, then you
9 give a woman -- a girl testosterone or a guy
10 estrogen, and then you do surgery. And that's a
11 continuum.

12 And I asked the woman from Yale -- I can't
13 remember her name right now, but I mentioned it
14 before -- how many patients go in each of those
15 stages. Because as I said to her, I'm an
16 oncologist. I do radiation, but my patients
17 sometimes need chemo or surgery. And those are all
18 part of doing appropriate cancer care.

19 And so when pushing and asking her how many
20 go on to have surgery, because I think that's the
21 most -- I personally think that's the most
22 aggressive of the three -- she said that none of her
23 patients has she recommended surgery for, but it
24 wasn't easy to get that answer out of her. It was
25 question, question, question.

February 21, 2023

Page 66

1 So they were cagey about it, and the
2 reason, Representative Fine, I think they're
3 disingenuous. That's my personal opinion. That's
4 not the Board of Medicine's official word, but
5 that's my personal opinion. I think they're
6 disingenuous.

7 CHAIRMAN FINE: And just for the record --

8 DR. ACKERMAN: And I think that they want
9 to treat these kind of patients because that's --
10 because in academia, you get promoted, and you get
11 recognized better when you have a greater amount of
12 work like that.

13 CHAIRMAN FINE: And just, for one data
14 point, Dr. Gallagher says that she did 13 top
15 surgeries on minors last year. That's one provider.

16 CHLOE COLE: Excuse me.

17 CHAIRMAN FINE: Yes, Chloe. Go ahead.

18 CHLOE COLE: I'd like to add to that.

19 Kaiser, which is my healthcare provider, they
20 actually released a study recently on minors who
21 underwent a double mastectomy and the regret rate.
22 And in the study, there were about 200 or so minors,
23 and it's likely that -- the study was conducted
24 between, I think, 2013 to 2021. And I actually
25 wasn't included in this.

February 21, 2023

Page 67

1 It said that out of 200 or so of these
2 girls, only 2 of them regretted it. And the 2
3 patients were 15 and 16 at the time, I think. And I
4 reported -- even though I reported to my healthcare
5 providers, my endocrinologist and the surgeon, that
6 I regretted it, I was not included in the study.

7 And I know at least three other people who
8 went through the same provider, through the same
9 hospital, and got the same surgery and were not
10 included in the study. So it's likely that, even in
11 these studies, that the numbers are being stifled.

12 And other than that, the figures are about
13 -- it's 2000 percent to 4000 percent increase in
14 minors, mostly young girls, who have been referred
15 to gender clinics in the past decade.

16 And this is just a little anecdote, but I
17 didn't know anybody else who was transgender until I
18 was in -- in person until I was in my sophomore year
19 of high school, when I noticed that other biological
20 girls my age were also starting to identify as boys.
21 And it was only girls.

22 UNIDENTIFIED FEMALE: Thank you.

23 CHAIRMAN FINE: And members, we've got
24 about 35 minutes, and we've got 8 more members with
25 questions, just so people know.

February 21, 2023

Page 68

1 Whip Salzman, you're recognized for a
2 question.

3 REPRESENTATIVE SALZMAN: Thank you,
4 Mr. Chair. And thank you to each of you for
5 presenting to us today. I appreciate hearing your
6 insight on this.

7 I just have a question, and if more than
8 one of you want to answer it, that's great. I'm
9 interested in knowing how much it costs per year to
10 take these medications, these testosterone and hormone --
11 these hormone drugs per year. And then I also would
12 like to know, is the state covering any of the costs
13 of this treatment?

14 CHLOE COLE: Yeah. So in the state of
15 California, actually, gender-affirming care is
16 actually required by law to be covered by insurance.
17 So everything other than copays for like visits to
18 doctors was covered by insurance.

19 CHAIRMAN FINE: Okay. Any, you know,
20 again, I think there were two questions there. How
21 much did the drugs cost per year? And does anybody,
22 you know, whoever's paying for them, whether it's
23 the government or the insurance company or the
24 person? And then again, the second point would be
25 in Florida. Do any of you know, you know, what's

February 21, 2023

Page 69

1 paid for today?

2 DR. LAIDLAW: I can give you a rough idea
3 of the general cost of something like Lupron, a
4 puberty blocker. I sent something to our state a
5 few years back, but it's something like \$1000 a
6 month. It could be more, less for something like
7 that, and they may take it for one year or two years
8 or four or five years.

9 Testosterone is going to be cheaper because
10 it's generic. If it's given in liquid form, maybe
11 you could get it, a cash price, \$100 a month,
12 something like that. And estrogen or estradiol
13 tablets or patches are probably -- I don't know
14 exactly -- but maybe \$50, \$60 a month.

15 So the most expensive cost would be puberty
16 blockers, and, of course, surgeries are on the
17 orders of, you know, thousands or tens of thousands
18 of dollars.

19 CHAIRMAN FINE: But so, to be clear, the
20 puberty blockers could be, you know, whoever's
21 paying for them, more than \$10,000 a year. So good
22 business, I guess.

23 DR. LAIDLAW: Yeah.

24 CHAIRMAN FINE: Yeah. Rep. Salzman, you're
25 recognized.

February 21, 2023

Page 70

1 REPRESENTATIVE SALZMAN: Thank you,
2 Mr. Chair. I just have a follow-up. Earlier in one
3 of the presentations, I believe it was the first or
4 second presentation, you said 96 percent of the
5 children who are on these hormone blockers in the
6 beginning continue to permanent treatment. How much
7 does it cost to stay on the treatment lifelong
8 usually, right.

9 CHAIRMAN FINE: Is it -- do you have to
10 take the \$12,000 drug for the rest of your life, or,
11 you know, or do you get to stop after a certain
12 amount of time?

13 PROFESSOR BIGGS: So --

14 CHAIRMAN FINE: You know, if you stop
15 puberty, you know, maybe it starts again. But, I
16 mean, how long do you have to stay on these?

17 PROFESSOR BIGGS: So for girls, girls, once
18 they start taking testosterone, they can stop
19 puberty blockers. For boys, they need to -- because
20 testosterone is so powerful, you don't need anything
21 to block the estrogen. For boys, they will need to
22 stay on puberty blockers or something like that
23 until they have their testicles removed in order to
24 suppress testosterone. It's not simply enough to
25 take estrogen.

February 21, 2023

Page 71

1 CHAIRMAN FINE: Okay. So a long time.

2 Representative Woodson, you're recognized
3 for a question.

4 REPRESENTATIVE WOODSON: Thank you, Chair
5 Fine, for the recognition.

6 Chloe, I'm sorry for what you went through.
7 As legislators, we are tasked to look at all angles
8 because we have parents from different sides calling
9 out to us as well because they have their children
10 that they feel need this type of therapy.

11 Before I even came, I did some research,
12 and I looked to the National Institute of Health,
13 the NIH. And basically, they did research in 2022,
14 actually, that was one, and there were some that was
15 done before that. And they say research proves that
16 gender-affirming care improves the mental health and
17 overall well-being of gender diverse children and
18 adolescents.

19 My question to you: are you suggesting that
20 the state provide mental health services in place of
21 gender-affirming care? And what should the state do
22 in order to mitigate the increase in mental health
23 if we have a ban on this type of therapy?

24 CHLOE COLE: Yeah. I absolutely think that
25 in place of gender-affirming care in children, there

February 21, 2023

Page 72

1 should be psychotherapy instead because most of
2 these children actually have some sort of
3 comorbidity. Like I was on the spectrum. I was --
4 and part of that was, I think, I mean, due to my
5 autism. I believe that it was one of -- that
6 because I'm autistic, I naturally tend to have some
7 more masculine tendencies, like being more objective
8 oriented than people oriented, for example.

9 But a lot of these kids have like either
10 like a learning disorder, personality disorder,
11 depression, anxiety, or a severe like familial
12 trauma or sexual trauma. And that needs to be
13 sorted out before the dysphoria is treated because
14 oftentimes that is what causes the onset of the
15 dysphoria.

16 DR. LEVINE: May I respond to your
17 question?

18 CHAIRMAN FINE: Absolutely. Yes, sir. Go
19 ahead.

20 REPRESENTATIVE WOODSON: You're referring
21 to a study that was just published in the New
22 England Journal of Medicine last month, which was a
23 two-year prospective study of 315 teenagers, average
24 age 16. And what they found is that the vast
25 majority of those children were very happy with

February 21, 2023

Page 73

1 their aesthetic appearances by age 18.

2 They also looked at the depression and the
3 anxiety scores of those kids, and they found that
4 that was all over the place. The mean was slightly
5 significant, but there was enormous variability in
6 whether the hormones increased or decreased
7 depression, increased or decreased anxiety. They
8 had a number of suicides in the -- I think 2
9 suicides in the 315 kids, and they didn't talk
10 anything about the medical problems like obesity or
11 the development of diabetes or bone troubles. They
12 didn't provide anything like that.

13 So I think we didn't need a study that
14 teenagers are happy who want to transition in the
15 short term, that they're happy with their
16 appearance, you see, but the issue has always been,
17 what is the long-term outcome of these kids in terms
18 of the parameters that we've made reference to
19 already in the presentations today?

20 And the answers are unknown, but we have a
21 lot of indications it's not very good. And so I
22 just say that in answer, the real question you're
23 asking is: what is Florida to do or what is the
24 state and what is the medical profession to do?

25 And I just want to pick up on what

February 21, 2023

Page 74

1 Ms. Cole said, and that is these children deserve a
2 thorough psychiatric evaluation, which cannot be
3 accomplished in 1 hour and cannot be accomplished by
4 just talking to the kid because the kid doesn't know
5 what happened to that child in the first four years
6 of life.

7 And so the evaluation bleeds into a
8 psychotherapeutic relationship between the parents,
9 the child, and the mental health professional. And
10 that requires time, you see, and that will
11 inevitably lead to what can we do to help this
12 child's source of distress other than changing their
13 gender presentation?

14 And that requires a commitment and the
15 training of mental health professionals who believe
16 that treating a gender child is just like treating
17 any other psychiatric problem with a child. They
18 need a thorough evaluation. They need a trusting
19 relationship with one person who's knowledgeable and
20 who can address the underlying problems, whether
21 it's autism or bedwetting or learning disabilities,
22 whatever it may be, you see.

23 So there is an alternative. It is the
24 traditional alternative. It is the traditional
25 approach to psychiatric problems in children. We've

February 21, 2023

Page 75

1 made a special exception of the gender child, and as
2 the 6th speaker spoke about, if you leave these kids
3 alone, most of them are going to grow up to be gay.
4 And we're not trying to remove gayness from the
5 world by creating trans, or if we are trying to do
6 that, that's a terrible thing.

7 CHLOE COLE: I'd like to add to that.

8 CHAIRMAN FINE: Yeah. Go ahead. Sure.

9 CHLOE COLE: There is not a single other
10 psychiatric issue that we treat with cosmetic
11 interventions. We don't give -- we don't refer
12 patients with anorexia to liposuction. And if a
13 cosmetic surgeon has a patient who presents to them
14 with body dysmorphia, they turn them away because
15 they know it's not right.

16 CHAIRMAN FINE: Yes, sir.

17 MR. LEATHERWOOD: I think Chloe's case is a
18 perfect example and a response to your question.
19 When she was taken to the doctor's office, they
20 jumped straight to gender-affirming care, you know.
21 It's like do not like collect \$200. Do not pass GO.
22 Just go all the way. Jump to the end game. You're
23 being medicalized.

24 At Gays against Groomers, we actually have
25 a lot of transgender members that are part of our

February 21, 2023

Page 76

1 organization, and gender dysphoria is obviously a
2 real condition. And a lot of them have chosen to
3 transition just after they are grown adults, and
4 they're capable of consenting to make that decision.

5 Treating these cases psychologically, I
6 think, is a smart idea and should be promoted by the
7 state as a first course of action, you know. The
8 answer should not just be jumping to medicalizing
9 children, and the problem right now that we're
10 seeing is the societal and cultural pressures that
11 is being put on these kids in school, you know.

12 There's a colloquial term. We call them
13 trans-trenders. But a lot of people, these young
14 kids that are just experiencing the normal growing
15 pains of life and growing up, they're uncomfortable
16 with their bodies because that's normal going
17 through puberty. They are confused, and it's, you
18 know, not cool to be normal. It's trendy to
19 explore, you know, changing their gender or being
20 gender nonconformist.

21 The solution should not be jumping straight
22 to medicalization, and if there are serious issues,
23 it should be psychologically evaluated first. And
24 if a person does have gender dysphoria and they
25 believe that medically transitioning is the best

February 21, 2023

Page 77

1 option for them, they should be able to make that
2 decision after they are a grown adult able to
3 consent to that decision and not while they're a
4 young, impressionable child.

5 CHAIRMAN FINE: Thank you.

6 Representative Snyder --

7 DR. LEVINE: I think we have to --

8 CHAIRMAN FINE: Sorry?

9 DR. LEVINE: I'm sorry. I think we have to
10 face --

11 CHAIRMAN FINE: Oh, okay.

12 DR. LEVINE: -- the very fact that it's
13 very hard to find mental health professionals who
14 have not been indoctrinated that the best way to
15 treat trans people is to affirm them and to get them
16 what they want.

17 We have to take our hats off to WPATH
18 because they have convinced the American mental
19 health professionals, including their organizations,
20 that science has already delivered the verdict that
21 this is the best treatment, and young mental health
22 professionals are coming out of graduate schools
23 being taught that the only thing to do for these
24 kids is to transition them and to affirm them.

25 And I think they don't understand what the

February 21, 2023

Page 78

1 13 points that I made and the other speakers made.

2 They just don't understand. Our medical -- our

3 psychiatric professions have been brainwashed.

4 CHAIRMAN FINE: Thank you. So we've got

5 five members left who wish to ask questions.

6 So Representative Snyder, you're recognized

7 for a question.

8 REPRESENTATIVE SNYDER: Thank you,

9 Mr. Chairman, and thank you again to the presenters,
10 you know.

11 Last week in this Committee, we talked
12 about just some of the harmful impacts of social
13 media and just some of the disturbing trends we're
14 seeing with just again the mental health crisis in
15 our country.

16 Mr. Leatherwood, you kind of touched on
17 just some of the societal pressures on this. I was
18 curious, you know, kind of from the nonmedical
19 perspective and then also the medical perspective,
20 you know, if you can talk about just the
21 intersection that social media plays in this uptick,
22 you know. I'm curious if the opinion is, you know,
23 is this a great awakening in today's youth that
24 they're now realizing they have these issues, or are
25 they're getting drawn into this and steered

February 21, 2023

Page 79

1 potentially in that direction?

2 CHAIRMAN FINE: And again we've got about
3 20 minutes left. So if you've got something to say,
4 please say it. But if not, I want to try to get to
5 every member's questions.

6 MR. LEATHERWOOD: Well, it's definitely
7 become trendy. It's definitely become what's cool.
8 I'm not a kid today going through school.
9 Obviously, Chloe did it more recently, but people
10 like Dr. Gallagher, who was mentioned earlier, who
11 is targeting her propaganda directly to the younger
12 generation through social media platforms like
13 TikTok, is incredibly dangerous.

14 And I find it shocking to this day that she
15 is able to just get away with what she's doing on
16 platforms like TikTok, you know. She's making these
17 trendy videos. She's bragging about the joys and
18 wonders of gender reassignment surgery and double
19 mastectomies and posing with children after they've
20 had these surgeries. And to me, it's horrifying.

21 But that type of content is targeted
22 towards that demographic, and I think, you know,
23 there's a lot going on in today's society. This
24 idea that it's not cool to be straight, that that's
25 normie, and that that's boring. And, you know, I

February 21, 2023

Page 80

1 know, like I said, I'm obviously not a kid going
2 through school now, but when I was a kid -- and I'm
3 sure we all experienced this, you know -- you don't
4 want to just be normal, you know. You want to be
5 cool. You want to -- you want to fit in.

6 And this is -- I mean, the percentage of
7 the younger generation who now identify as part of
8 the LGBT -- I call it the rainbow spectrum -- has
9 exponentially increased from the time I was in
10 school or the, you know, generation beyond me.

11 I mean, and I think now we're seeing what
12 Chloe was talking about, the uptick in de-
13 transitioners, it's going to be horrifying. And she
14 just warned us all. This is just the beginning.
15 All these kids, they think that they're trans now.
16 They're jumping all in on this. In five, ten years,
17 oh my gosh, and it's already happening in England.
18 All these gender clinics are shutting down because
19 they're being hit with these lawsuits. It's
20 horrifying.

21 CHAIRMAN FINE: Okay. If anybody wants to
22 add anything. Or --

23 DR. ACKERMAN: I'll just say something very
24 quick. So from the Board of Medicine, I'm not a
25 social scientist. I really can't speak to that.

February 21, 2023

Page 81

1 But I can tell you that the past two issues we've
2 had the past couple of years, this is a current
3 issue that we've been dealing with, and recently
4 we've been dealing with the Brazilian butt lift
5 issues we've had with that with safety associated
6 with Brazilian butt lift surgery.

7 And both of these, we've seen an increase
8 in number of procedures, transgender procedures and
9 Brazilian butt lift procedures, because -- what
10 we've heard is a lot of this is through social
11 media. But again I'm not a social scientist, and
12 the word of medicine isn't in that business.

13 CHAIRMAN FINE: Ranking Member Skidmore,
14 you're recognized for a question.

15 REPRESENTATIVE SKIDMORE: Mr. Chair, my
16 question is for Dr. Levine, who doesn't seem to be
17 there.

18 CHAIRMAN FINE: Do you want me -- that
19 wasn't planned. Do you want me to come back to you?

20 REPRESENTATIVE SKIDMORE: That would be
21 great.

22 CHAIRMAN FINE: Okay. We have a couple
23 other members. And I was going to do a Democrat
24 next.

25 Representative Cross, you're next.

February 21, 2023

Page 82

1 REPRESENTATIVE CROSS: Thank you for
2 recognizing me, Mr. Chair.

3 My question is for Dr. Laidlaw. In your
4 slides, you used a definition that states that
5 gender dysphoria is a discomfort with one's sex and
6 perceived gender leading to significant distress or
7 impairment of functioning lasting at least six
8 months. My question is: can you discuss some of the
9 potential effects of banning gender-affirming
10 therapies that are being sought specifically to
11 ameliorate significant distress or impairment in
12 trans patients?

13 CHAIRMAN FINE: You are recognized.

14 DR. LAIDLAW: So just to clarify, so you're
15 saying if this medical treatment and surgical
16 treatments aren't available, what will happen to the
17 kids with gender dysphoria? Is that --

18 REPRESENTATIVE CROSS: Yes.

19 DR. LAIDLAW: Can you hear me? Okay.
20 Well, one thing to recognize, that I'm an
21 endocrinologist. Gender dysphoria is not an
22 endocrinologic condition. It has nothing to do
23 actually with hormones or problems with hormones or
24 glands in most of the cases. It only becomes an
25 endocrine condition once you start providing these

February 21, 2023

Page 83

1 hormones of very high doses or blocking normal
2 puberty.

3 So really, this originated in the realm of
4 psychological disorders. So I've listed the harms
5 that can happen from this treatment. The
6 alternative is going back, like Dr. Levine said, to
7 traditional psychological treatments to help these
8 kids. It's really not an endocrine condition until
9 people like Chloe have been harmed by these
10 treatments.

11 CHAIRMAN FINE: I promise. But we are --
12 some of the folks who've put their hands up late,
13 we may not have time. But I will take you next,
14 Representative Skidmore.

15 But, first, Representative Rizo, you are
16 recognized.

17 REPRESENTATIVE RIZO: Thank you very much,
18 Chair. Thank you to everyone that presented, and
19 especially the final two speakers. Thank you so
20 much for coming here today and just showing, you
21 know, your intelligence and also just your
22 willingness to speak your mind.

23 My first question, Chair, I have two.
24 First of all, speaking about puberty suppression,
25 how reversible is this? How permanent is this?

February 21, 2023

Page 84

1 When are we undergoing this treatment, does it
2 become irreversible? And if so what are the long-
3 term effects?

4 CHAIRMAN FINE: Anybody who wants -- yeah.
5 Go ahead.

6 DR. ACKERMAN: We've heard at the Board of
7 Medicine that from the physicians involved in this
8 sort of care, that these treatments are reversible,
9 that these are a way to put puberty on hold. But we
10 also heard from other experts that, no, it's not --
11 there are side effects of these treatments that are
12 not reversible. When you put someone on Lupron --
13 this is a testosterone blocking drug -- it
14 demineralizes the bones. There's calcium lost in
15 the bones, and that may never come back.

16 As I mentioned before, I'm an oncologist.
17 I actually prescribe Lupron, this hormone blocking
18 drug. I treat men who have metastatic prostate
19 cancer with that drug. It blocks testosterone, and
20 we do it all the time. And there are side effects
21 with that. And I try to minimize the dose of
22 testosterone I give men because it causes
23 osteoporosis, which is irreversible. It also causes
24 early onset of dementia, Alzheimer's. And so I try
25 not to have men on that more than a few months

February 21, 2023

Page 85

1 unless I really have to.

2 And so those same -- we heard from other
3 experts that in the adolescence, that there are the
4 similar irreversible side effects of those hormone-
5 blocking drugs. They're not to be taken lightly.
6 That's not the sort of thing you just put a little
7 pause on and then take off, and that there are long-
8 term effects of those drugs.

9 CHAIRMAN FINE: Okay. I'm not -- maybe.
10 But I want to make sure that Ranking Member Skidmore
11 has time. So and she may, depending on how long it
12 takes, be the last question.

13 So Ranking Member Skidmore, you are
14 recognized for a question.

15 REPRESENTATIVE SKIDMORE: Mr. Chair, thank
16 you.

17 My question is to Dr. Levine. In your
18 comments earlier, you said that it made more sense
19 to let adults make any bad decision that they
20 wanted. Is it your opinion that it is always a bad
21 decision to receive transgender care at any age?

22 DR. LEVINE: No. That is not my opinion.
23 I just think adults are able to weigh the pros and
24 the cons of the decision. They're able to recognize
25 their own internal ambivalence, that is, they feel

February 21, 2023

Page 86

1 both attracted to and worried about it, whereas
2 teenagers can't tolerate the concept that they have
3 ambivalence. They present themselves as absolutely
4 certain.

5 And you and I, as adults, know that human
6 beings are not absolutely certain about anything,
7 and we don't trust certainty in medicine at all. So
8 there are people who have the right to make this
9 decision, and for them, because they're an expert in
10 their suffering and in their developmental history
11 and when they convince me that this is a prudent
12 thing, I certainly open the gate for them to make
13 this decision or give them my blessing, so to speak.

14 But I'm very hesitant to give my blessing
15 to hormones to anyone who's not of the age of
16 majority and who is certain. Certainty is not to be
17 trusted in any field.

18 So the simple answer to your question is
19 absolutely no. I'm not opposed to everyone under
20 these circumstances forever having these kind of
21 treatments. I am very much in favor of the
22 scientific approach to this. That is a controlled
23 study, as Dr. Biggs talked about.

24 CHAIRMAN FINE: Ranking Member Skidmore,
25 you can ask a follow-up, but just so you know, there

February 21, 2023

Page 87

1 are two Democrats and one Republican that haven't
2 asked a question yet.

3 REPRESENTATIVE SKIDMORE: Mr. Chair, my
4 question is also to Dr. Levine or Dr. Ackerman. Is
5 there any regimen or procedure that has no risks or
6 side effects in your profession, in your specialty?

7 DR. LEVINE: No.

8 DR. ACKERMAN: No.

9 CHAIRMAN FINE: All right. Okay. In the
10 order they asked, Representative Koster, you are
11 recognized. You've been waiting a while.

12 REPRESENTATIVE KOSTER: Thank you, Chair.
13 And I guess I just want to try to break this down to
14 its simplest form, in my understanding, and if I've
15 got it wrong, somebody will correct me.

16 We've got a DSM-recognized mental health
17 disorder, mental health condition, but we don't have
18 a recognized standard of care or standard of
19 treatment or something. And I sort of see some
20 nodding. So I'm going to assume that, at its
21 simplest form, that's what we're dealing with here.

22 And I guess my question is sort of for
23 Chloe or for Dr. Ackerman. Chloe, like you talked
24 about wanting to see regulation in terms of de-
25 transitioning and more standards there, but what

February 21, 2023

Page 88

1 would you have wanted to see on the front end as
2 somebody struggling with gender dysphoria as a
3 teenager? What would you have wanted to see in
4 hindsight then now?

5 And then, you know, for Dr. Ackerman, sort
6 of should the standard of care just be what the
7 standard of care is for other mental health
8 conditions? I know with like schizophrenia, we used
9 to incarcerate people. Obviously, the more we've
10 learned about schizophrenia, we clearly know that
11 that's not the solution. So, I mean, as we're
12 studying this, how do we come up with a nationalized
13 standard of care? So whoever wants to take that
14 very compound question.

15 CHLOE COLE: I really wish that during my
16 screening for gender dysphoria, they went more into
17 my background and treated the underlying conditions
18 that led to the onset of it. But I also really wish
19 that it wasn't pushed as the only option, that I
20 was, I guess you could say, gatekept more and not
21 allowed to undergo these treatments while I was
22 still a minor, especially because, I mean, it was --
23 they directly interfered with my physical and
24 psychiatric and cognitive development in doing so.

25 CHAIRMAN FINE: Okay. Go ahead.

February 21, 2023

Page 89

1 DR. ACKERMAN: So you're correct. There is
2 a DSM diagnosis of gender dysphoria, and I think in
3 medicine, there's a number of things where there's
4 no consistent or no generally accepted standard of
5 care. We have standards of care for lots of things,
6 diabetes, and most cancers that I deal with, we have
7 standards of care. But just again looking at what I
8 do in cancer, there's a lot of unusual cancers that
9 aren't very frequent where there's really no
10 standard of care developed yet.

11 One standard of care in gender dysphoria,
12 psychological support, is certainly a well-accepted
13 standard of care. People are trying different
14 things, hormones and surgery. People are trying
15 that, but we felt, from the perspective of the Board
16 of Medicine, that there wasn't a generally widely
17 accepted, agreed upon standard of care. And so
18 that's why we felt uncomfortable allowing that sort
19 of care to be given to minors in the state of
20 Florida.

21 Representative Gantt, you are recognized
22 for a question. This may be the last one.

23 REPRESENTATIVE GANTT: Thank you for your
24 recognition, Mr. Chair.

25 Dr. Biggs, excuse me, you talked

February 21, 2023

Page 90

1 extensively about the physical effects of hormone
2 therapy. Just for clarification, you are a doctor
3 in sociology and not a medical doctor, correct?

4 CHAIRMAN FINE: You are recognized.

5 PROFESSOR BIGGS: Yes. That's correct.
6 But I've also published now, over the last couple of
7 years, my own research in medical and psychological
8 journals.

9 CHAIRMAN FINE: Okay. All right.
10 Representative Edmonds -- that was quick.

11 Representative Edmonds, you are recognized.

12 REPRESENTATIVE EDMONDS: Thank you.

13 CHAIRMAN FINE: You might put your name tag
14 down so people can see you.

15 REPRESENTATIVE EDMONDS: Dr. Ackerman, in
16 the Board of Medicine last meeting, when discussing
17 these rules, were they in support or against these
18 rules, and how many people were in support versus
19 against?

20 DR. ACKERMAN: Who are you referring to,
21 the Board members?

22 REPRESENTATIVE EDMONDS: Yes.

23 DR. ACKERMAN: In the last meeting the
24 Board of Medicine had --

25 REPRESENTATIVE EDMONDS: And related to

February 21, 2023

Page 91

1 this topic.

2 DR. ACKERMAN: -- related to this topic,
3 we had a -- it was a petition to the Board to look
4 at the rules, and so the Board did not make any
5 change to the rule.

6 REPRESENTATIVE EDMONDS: So were they in
7 support or against? Do you have a number or a
8 count?

9 DR. ACKERMAN: Yes. They were all --
10 because we didn't have a vote at the last meeting.
11 So let me just get this -- my notes. Give me a
12 second to get my notes together here for a second.

13 CHAIRMAN FINE: I think he's asking what
14 the vote was when you adopted the proposed rule,
15 what your vote was.

16 DR. ACKERMAN: It was unanimous.

17 CHAIRMAN FINE: Thank you.

18 REPRESENTATIVE EDMONDS: Thank you.

19 CHAIRMAN FINE: All right. Well, Rep.
20 Trabulsy, I think if you're quick, you can ask your
21 question. And everyone who wanted to ask one will
22 have been able to.

23 REPRESENTATIVE TRABULSY: Thank you,
24 Mr. Chair.

25 My question is for Chloe. I would like to

February 21, 2023

Page 92

1 think when a child has a dysphoria or something of
2 your nature, that it the whole family would be
3 treated, right, because it's something that you're
4 all going through. And you did all go through this,
5 and you had, although it be negative treatment,
6 how's your family doing? What is the collateral
7 damage there with your family?

8 CHAIRMAN FINE: And I ask you to keep the
9 answer relatively brief --

10 CHLOE COLE: Okay.

11 CHAIRMAN FINE: -- because we have to end
12 on time.

13 CHLOE COLE: I mean, it was really hard on
14 my family. I had a lot of family who disagreed, but
15 they felt like they couldn't really speak up. And
16 the ones who did, I mean, my relationship with them
17 suffered, obviously, because I thought they were
18 wrong. I thought they were being ignorant.

19 And now that I'm speaking out, not all my
20 family necessarily agrees with what I'm doing now.
21 But for the most part, after I've stopped, my
22 relationship with the majority of my family, and
23 especially my parents, has been much better.

24 CHAIRMAN FINE: Well, thank you.

25 I have a couple -- I'm not going to ask a

February 21, 2023

Page 93

1 question, but I have a couple of closing comments.

2 First, I want to say I'm incredibly
3 grateful, both to the panel -- all of you both came
4 from far and near to participate. It's a very, very
5 emotional subject for people, and I appreciate it.
6 I will tell you. I think in my seven years in the
7 legislature, this has been the least looking at cell
8 phones among legislators maybe that I have seen. I
9 think people were mesmerized by what all of you had
10 to say. I also want to thank the members for how
11 you comported yourself today, and I want to thank
12 the audience. We were very concerned about not
13 being able to get through this in a professional
14 way, and I could not hear anyone breathe. And so I
15 thank you for that.

16 When I hear these comments -- so you all
17 know I'm Jewish, and I study the Holocaust. And
18 it's been an impactful part of my life, and I will
19 tell you that when I hear this discussion, when I
20 hear this discussion, when I hear these medicine,
21 when I hear this, I think of Dr. Mengele, who was
22 another doctor.

23 And so I will tell you this. I say these
24 panels are oftentimes a predicate for what's to
25 come. That's exactly what today was. And I promise

February 21, 2023

Page 94

1 you, you will like the bill that is coming. I'm
2 sorry.

3 With that, Representative Amnesty moves we
4 rise.

5 (END OF VIDEO RECORDING)

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February 21, 2023

Page 95

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Julie Thompson

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Julie Thompson, CET-1036

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February 21, 2023

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\$10,000	13	16:22	280,000
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\$100	15,20 34:4,17	2	28th
69:11	38:17 39:14	<hr/>	10:23 12:3
\$1000	41:19 47:6	2	<hr/>
69:5	66:14 78:1	26:20 29:20	3
\$12,000	14	67:2 73:8	<hr/>
70:10	29:16 62:7	20	30
\$200	14th	17:21 79:3	23:2 26:1,4
75:21	12:21	200	61:4
\$50	15	66:22 67:1	300
69:14	9:11 17:16	2000	27:15
\$60	20:14 23:20	67:13	30s
69:14	29:17 60:13	2010	61:6
<hr/>	64:7 67:3	15:23	315
0	150	2013	72:23 73:9
<hr/>	27:10,11	66:24	32
0	15th	2014	17:24
26:4 64:7	14:13	17:19	324
<hr/>	16	2017	26:2
1	29:17 67:3	30:20	35
<hr/>	72:24	2018	67:24
1	16th	15:23 29:14	<hr/>
18:8 63:2,3	14:9 43:5	2021	4
74:3	18	66:24	<hr/>
10	20:4 46:13	2022	4
6:18 27:5	73:1	8:4,11 21:16	26:22
29:9 60:13	18-year-old	71:13	40
63:2,3	40:1	2023	27:10 37:16
100	19	53:5	400
27:17 64:8	26:8 37:17,18	20th	39:12
1000	1974	10:23	4000
27:12,15	61:4	23	67:13
10th	1989	28:18	40s
12:25	62:6	24th	48:1 61:6
11th			
37:25			

February 21, 2023

2

43 61:17	<hr/> 7 <hr/>	71:24 72:18 86:3,6,19	action 13:20 76:7 95:7,8
44 18:22	7 29:9 62:21	abuse 28:17 32:6 34:16	actions 6:25
46 28:12	70 17:19 18:7,8	academia 66:10	actively 11:4,22
4th 12:9,12	76 30:11	academic 5:24	activity 60:4
<hr/> 5 <hr/>	<hr/> 8 <hr/>	acceptance 53:4 54:7	add 8:25 66:18 75:7 80:22
5 8:11	8 28:21 42:20 67:24	accepted 89:4,17	addition 5:25
50 24:18 27:5 61:17	<hr/> 9 <hr/>	accomplished 74:3	address 47:9 63:7 74:20
500 39:12	9 62:16	accumulating 21:13	ADHD 47:10
50s 48:1	96 70:4	accumulation 20:8	administered 16:23 18:22
<hr/> 6 <hr/>	98 24:19	accurate 9:21 95:3	administration 50:12
6 27:17	<hr/> A <hr/>	achieve 16:13	Administrative 12:21 14:11
60-year-old 61:7	abdomen 28:4 29:4 42:11	achieved 53:5	adolescence 35:7,11 85:3
6000 62:9	ability 29:7,8	Ackerman 5:8 6:20,23 7:3,4,12 15:3 57:19 58:5 63:7,9,12 64:18,25 66:8 80:23 84:6 87:4,8,23 88:5 89:1 90:15,20,23 91:2,9,16	adolescents 33:13 71:18
60s 48:1	abnormality 35:16	acknowledge 18:5	adopt 21:21
64B15-14.014 13:25	abnormally 17:6 20:10		adopted 91:14
64B8-9.019 13:24	absence 15:20		adopting 25:21
6th 75:2	absolutely 51:22 63:8		adoption 14:6,8,15

February 21, 2023

3

adult 26:18 27:4 45:21 61:8,16 77:2	65:7	ahead 59:25 63:10 66:17 72:19 75:8 84:5 88:25	anabolic 28:17
adulthood 22:3 24:18 46:17	afflicted 34:7	all-cause 26:7	analogous 17:2
adults 32:16 33:13 37:4 50:25 59:11 60:5 61:15,23 76:3 85:19,23 86:5	afraid 55:5	allowed 14:15 88:21	Anderson 58:22,24 59:7,18
advance 34:7	afternoon 7:8,9	allowing 32:22 89:18	anecdote 67:16
advocacy 30:23 55:11 59:5	afterward 43:18 47:14	alter 58:11	angles 71:7
advocates 35:13 39:7	age 17:4,8,15,21 20:4,14 31:15,18,21 40:10 42:3,24 49:24 57:17 67:20 72:24 73:1 85:21 86:15	alternate 36:13,14	angst 61:21
aesthetic 73:1	agenda 52:20	alternative 36:9 74:23,24 83:6	anorexia 75:12
affect 13:8	agents 65:7	Alzheimer's 84:24	answers 52:2 63:20,25 64:1,2 65:2 73:20
affirm 33:12 41:7 77:15,24	ages 51:6 63:23	ambivalence 85:25 86:3	anti-lgbt 54:14,16,17, 22 56:1
affirmation 39:13	aggressive 65:22	ameliorate 82:11	anxiety 21:10 42:6 72:11 73:3,7
affirmative 11:10 12:5,15 25:19 33:23 36:10,21 37:6 38:7,18,19 51:3	agonist 58:14	amend 13:20	anxious 58:2
affirmed 41:13	agonists 16:9	America 16:11 52:6 53:21 54:7 64:7	anymore 46:10
affirming 52:9 57:10	agree 9:24	American 11:8 19:4,8 53:4 77:18	anytime 24:20
	agreed 89:17	Amnesty 94:3	apolitical 7:22
	agreement 10:2,6	amount 27:6,7 66:11 70:12	apologize 5:17
	agrees 92:20		apparently 33:21

February 21, 2023

4

appearance 73:16	arrives 17:6	attending 45:11	20
appearances 73:1	article 6:3,6,10 16:21 64:4	attention 5:25	balance 24:5,7,9
appeared 17:25	artifact 18:1	attorney 6:9 95:6	ban 71:23
apply 31:13,14	artificial 47:23	attracted 35:10 86:1	bandage 49:15
appointments 43:4	assault 41:22	attrition 19:11	banning 82:9
approach 36:14 41:7 61:16 74:25 86:22	assaulted 41:21	audience 22:22 93:12	Barbies 56:12
approaches 36:9,13	assert 33:24 38:11	augmentation 9:7	basic 25:8
approaching 50:24	asserted 35:4,19	August 8:11	basically 71:13
approved 12:17	assertions 38:18	autism 32:6 47:15,16 72:5 74:21	basis 30:16
approving 12:7	assessment 32:18	autistic 72:6	bedwetting 74:21
Archives 16:2	associate 5:9 15:14 27:6	average 37:16 51:13 72:23	began 34:11 40:14
area 23:21 29:22 30:20 43:15 44:2,9,10 49:11,13	assume 87:20	awakening 78:23	beginning 16:24 46:13 51:1 70:6 80:14
areolas 44:8,9	assumption 37:13	<hr/> B <hr/>	begun 38:9
argue 21:22	astonishing 20:24	back 24:4 28:14 38:15 48:5 64:3 69:5 81:19 83:6 84:15	Behavior 16:3
argument 13:3	atrophy 42:14,15	background 7:20 88:17	beings 34:8 86:6
arms 43:17	attached 29:24	bad 61:20 85:19,	belief 40:15 64:23
	attempt 18:19 36:17		believed 33:17
	attempts 36:15		belong 30:18,22

February 21, 2023

5

bend 54:3	25:8	65:6 83:1	bone 20:8,10,16 48:10 73:11
benefit 19:17 38:20	biopsy 24:24 25:3	84:13,17 85:5	
Bernie 6:5	birthday 43:5	blocks 84:19	bones 84:14,15
bias 35:1	bisexual 60:22	blood 24:23 27:24 28:1,10 44:12 48:18 51:10	boring 79:25
biased 30:25	bit 7:20 14:16,17 18:12 22:12 25:8	board 5:8 6:24 7:1, 15,21,25 8:10,11 10:8, 10,13,16,17, 24 13:1,14, 19,21 14:5 21:21 54:10 58:19 63:13 66:4 80:24 84:6 89:15 90:16,21,24 91:3,4	born 29:2
Bible 52:6	bits 48:19		bothered 21:1 44:4
big 34:5 43:8,9 55:16	black 44:14		bottom 8:23,24,25 9:2 40:25
Biggs 5:9 15:5,11, 12 22:6 25:23 26:11 29:18 62:3 70:13,17 86:23 89:25 90:5	bleeds 74:7		box 62:24
bigot 54:6 55:6	blessing 86:13,14	Board's 7:16	boy 24:11 40:13 42:3,24 46:21 56:10 60:11, 15
bigoted 55:6	blind 21:25		boys 40:14 45:5 60:10,25 67:20 70:19, 21
bill 94:1	block 26:20 65:8 70:21	boards 7:21,24 8:5 10:16,18 12:8,10,11, 17,25 13:23	bragging 79:17
bills 50:18,19	blocked 26:22	bodies 7:22 53:11 60:20 76:16	brain 25:2
binder 41:25 42:19	blocker 69:4	bodily 53:17	brainwashed 78:3
biologic 34:21,23	blockers 15:23 16:8 17:1,13 19:14 20:25 25:22 26:12,23 41:18 45:21 47:20 50:5 56:7 69:16,20 70:5,19,22	body 24:14 27:19 28:3,22 38:14 42:24 43:16 44:2,19 46:16 47:25 54:13 75:14	brand 16:11
biological 41:23 42:6 67:19	blocking		Brazilian 81:4,6,9
biology			break 87:13

February 21, 2023

6

breast 9:7 28:11 43:1 44:7 45:22	calcium 84:14 California 11:17 22:11 23:19 40:3 68:15	26:8 31:4,5, 6,12 32:13 33:12,23 34:6 35:3,21 36:10,21 37:6 38:7,18,19 39:25 43:14 46:1 51:4,5 52:3,4,7,9 54:4,17 56:2 57:10,22 62:19 63:14 65:18 68:15 71:16,21,25 75:20 84:8 85:21 87:18 88:6,7,13 89:5,7,10,11, 13,17,19	27:24 93:7 cemetery 37:10 centers 9:4,6,9 60:5, 14 Central 40:2 century 18:18 60:6,12 certainty 86:7,16 CERTIFICATE 95:1 certify 95:2,5 CET-1036 95:13 cetera 63:23,24 chair 5:8 7:15 14:4 22:14 23:17 57:4 58:25 68:4 70:2 71:4 81:15 82:2 83:18,23 85:15 87:3,12 89:24 91:24 Chairman 7:5 14:21 22:5,18,25 23:5,10,12,15 32:24 39:1 52:12 56:20 58:4,22 59:15,20,24 63:8,11 64:16,19
breastfeed 29:7,8 45:23 46:18 49:2	call 26:16 29:3 54:17 55:25 76:12 80:8 called 5:15 30:23 36:18 41:24 44:5 57:13 65:1	caring 54:11 carry 46:20 48:24 case 19:25 33:6 75:17 cases 76:5 82:24 cash 69:11 castration 16:13 catering 54:19 caused 21:8 34:21 cavity 29:22 cell	
breasts 17:5 28:2 29:5 46:18 49:5 52:1	calling 71:8 calls 39:13 campaign 18:25 campaigned 15:25 cancer 16:15 24:24, 25 28:1,11 65:18 84:19 89:8 cancers 89:6,8 capable 76:4 capacity 20:21 cardiovascular 27:22 care 8:1 9:18,20 10:5 11:10		
breathe 93:14 bridge 25:17 bright 55:23 bring 24:4,6 27:15 British 19:8 broadly 50:12 broken 46:14 brought 11:2 55:16 bullies 54:21 business 69:22 81:12 butt 81:4,6,9			
<hr/> C <hr/>			
cagey 63:17 64:21, 24 66:1			

February 21, 2023

7

66:7,13,17 67:23 68:19 69:19,24 70:9,14 71:1 72:18 75:8,16 77:5,8,11 78:4,9 79:2 80:21 81:13, 18,22 82:13 83:11 84:4 85:9 86:24 87:9 88:25 90:4,9,13 91:13,17,19 92:8,11,24 challenge 14:10 chance 53:2 change 22:10 43:25 91:5 changed 14:16 61:2 changing 74:12 76:19 chapter 52:15 characteristics 58:12 cheaper 69:9 cheer 64:22 chemical 16:13 chemo 65:17	chest 41:25 44:9 49:16 Chicago 11:16 chief 10:2 57:14 child 17:7,10 35:6 36:11,18 37:10,11 40:6 46:20 52:1 55:23 61:5 74:5,9,16,17 75:1 77:4 92:1 child's 54:13 74:12 childhood 35:7 41:12 45:16 children 7:2 15:17 16:6,16 17:13 24:16 31:19 33:13 36:6 39:19 40:5,7 41:10 45:20 46:7,19 50:2, 16,24 51:4 53:24 54:18, 22 55:7,13 56:16 70:5 71:9,17,25 72:2,25 74:1, 25 76:9 79:19 Children's 11:15,24,25 12:1	Chloe 5:12 39:23 40:1 59:6 63:4 66:16, 17,18 68:14 71:6,24 75:7, 9 79:9 80:12 83:9 87:23 88:15 91:25 92:10,13 Chloe's 75:17 chose 12:2 19:9 chosen 76:2 circumstances 86:20 claim 17:1 clarification 90:2 clarify 82:14 class 16:8 35:2 45:13,14,15 46:4 classes 45:12 classmate 41:21 clear 18:4 52:24 69:19 clinic 15:22,25 18:20 61:3 62:5	clinical 5:24 11:6,8 15:9 22:9 30:20 33:5 60:4 clinically 33:21 clinicians 20:25 21:14 clinics 64:6,13,14 67:15 80:18 closed 62:6 closer 19:15 closing 93:1 clothes 25:20 clothing 40:15 clots 28:10 48:18 clue 51:8 coercive 37:8 cognitive 21:7,12 88:24 cognitively 61:19 cohort 11:5,7 18:14 cohorts 11:2 cold 46:12
---	--	--	--

February 21, 2023

8

Cole 5:12 39:23,25 40:1 59:3,6 63:4 66:16,18 68:14 71:24 74:1 75:7,9 88:15 92:10, 13	12:3,11 78:11 common 16:10 27:8 54:12 55:8 communication 26:14 community 52:20,24 53:3,7,8 55:1,12,14 56:16 comorbid 32:4 comorbidities 47:8 comorbidity 72:3 company 68:23 compare 59:13 compared 22:1 26:9 compassionate 55:9 complete 30:4 completed 26:2,9 completely 13:13 44:14 complication 30:10 complications 29:5,12 30:2, 12 47:20 48:25 49:23	comported 93:11 compound 88:14 compression 41:24 conceive 48:24 concept 35:19 38:16 86:2 concerned 40:19 93:12 concerns 41:4 concludes 56:21 conclusion 10:13 13:17, 19 condition 24:21 27:8 35:23 36:1 76:2 82:22,25 83:8 87:17 conditions 16:15 88:8,17 conducted 66:23 confident 41:11 confronted 33:18 confused 76:17 cons 85:24	conscious 43:12 consensus 31:23 consent 31:19 53:25 57:16,17,18 77:3 consenting 76:4 consequence 18:11 20:5 consequences 24:1 27:19 47:3,7 57:8 conservative 50:10,13 conservatives 50:7 considerably 42:1,4 consideration 12:8 consistent 89:4 constantly 50:7 consultations 45:18 content 22:16 79:21 context 21:19 continue 17:13 22:2 33:2 57:21,24 70:6
--	--	--	--

February 21, 2023

9

continuing 17:14 21:14	cosmetic 75:10,13	create 31:11	cutting 40:14
continuum 65:11	cost 68:21 69:3,15 70:7	created 20:1 30:22 31:1	CVS 5:23
contradiction 31:22	costs 19:19 20:18 68:9,12	creating 53:11 75:5	cycle 48:22
contrast 17:8	counseling 32:11	creation 30:7	<hr/> D <hr/>
control 21:24 22:1	counselors 32:9	crisis 78:14	D.o 10:17
controlled 21:8 86:22	count 91:8	criteria 28:19 38:5	dad 40:17 41:10, 15 47:1
controversies 61:18,24	countered 33:17	Cross 81:25 82:1,18	daily 49:16
controversy 61:22	countries 15:10	cross-sex 17:10,14,15 20:19 25:23	damage 53:11 92:7
conversion 36:16,18	country 29:15 53:10 78:15	crossed 25:18	damaging 34:11
convince 86:11	counts 27:24	CT 25:2	danger 31:24
convinced 77:18	couple 12:24 81:2,22 90:6 92:25 93:1	cult 53:9,15	dangerous 27:12,16 31:19 53:20 79:13
cool 76:18 79:7,24 80:5	courage 59:4	cultural 76:10	dangers 50:8
copays 68:17	covered 68:16,18	culture 54:2	Dania 10:24
copy 6:8	covering 68:12	curious 78:18,22	dares 53:19
corporations 55:19,21	crack 59:21	current 11:6 81:2	data 11:6 15:20 21:15 22:3,9 26:1 62:8 66:13
correct 22:17 34:3 38:22 87:15 89:1 90:3,5	cramps 42:12,13,17	curtailed 20:12	daughter 40:21
correcting 34:23		curve 51:2	
		cut 44:7,13	

February 21, 2023

10

David 5:14	21,24 86:9,13	Deletus 39:11	depression 28:20 72:11
day 13:18 42:8 47:18 79:14	decisions 53:23 61:20	delivered 77:20	73:2,7
de 17:19 18:5,10 21:3	declaring 60:21	demand 64:13	deprives 56:7
de- 80:12 87:24	decline 17:25	demands 54:4	Desantis 50:12
de-transitioned 40:2,8	declined 11:20	dementia 84:24	describe 25:7
de- transitioners 51:7 52:3,7	decreased 73:6,7	demineralizes 84:14	describes 6:4
dead 44:14,18	deep 44:8	Democrat 81:23	description 14:23
deadly 28:9	deepening 28:4	Democrats 87:1	deserve 74:1
deal 89:6	deeper 42:2	demographic 53:25 79:22	desire 43:1
dealing 6:7 81:3,4 87:21	deeply 23:21	demonstrate 36:24,25	desisters 32:20
death 18:8,11 27:22 34:16 37:2,3 41:15 53:9, 15,16	defended 34:2	demonstrated 37:12	destroying 53:10
decade 62:7 67:15	defined 48:12	demonstration 34:13	destruction 53:18
decided 18:24 40:23	defining 38:12	density 20:10,16	destructive 52:25 55:2
deciding 46:3	definite 24:21 25:4	department 8:6,13,15,17, 18,21 10:12 13:14 14:11	detransition 38:8,10 50:23 51:24 53:16
decision 46:8 76:4 77:2,3 85:19,	definition 82:4	depended 47:5	detransitioners 32:20
	definitions 24:10	depending 24:17 85:11	develop 10:20 27:23, 25 28:21 35:6
	definitively 60:2	depends 24:19	developed 20:13 25:10 89:10
	dehydrated 48:15 49:11	depressed 58:2	developing 17:5 25:15
	delaying 17:6		

February 21, 2023

11

development 20:20 21:7 25:12 26:17, 18 45:17 73:11 88:24	disadvantage 19:18	disruptive 48:8	doses 28:8,15,19 32:18 83:1
developmental 86:10	disagreed 92:14	distress 24:15 40:25 74:12 82:6,11	double 44:5 66:21 79:18
device 41:24	disappeared 42:17	disturbing 78:13	downward 45:9
diabetes 24:22 73:11 89:6	disclaimer 31:3	divergence 25:14	draft 12:7,13 21:16
diagnosed 36:6,8 47:10, 16	disclose 63:19	diverse 71:17	dramatically 26:5
diagnosis 24:22 89:2	discomfort 24:12 82:5	divorce 32:7	drastically 20:12
diagnostic 38:5	discovered 15:23 32:5 42:6	DOA 14:10	draw 5:25 53:24
differences 9:14,22	discriminatory 36:5	doctor 5:16,18 52:2 56:23 90:2,3 93:22	drawn 78:25
differing 10:25	discuss 82:8	doctor's 75:19	dressess 44:23
difficult 59:4	discussed 61:24	doctors 5:21 30:25 31:17 33:23 41:5,14 47:9, 17 49:20 51:8,15,21 68:18	dressings 43:25
difficulties 29:11	discussing 90:16	document 31:2,23	dropped 26:4 45:10
digital 95:3	discussion 93:19,20	dollar 55:24	drug 70:10 84:13, 18,19
Dimaggio 12:1	disease 27:22,25	dollars 55:16 69:18	drugs 16:9,11,13,14 68:11,21 85:5,8
direction 43:9 79:1	disgusting 43:21	donor 55:16	DSM 89:2
directly 79:11 88:23	disingenuous 66:3,6	dose 84:21	DSM-RECOGNIZED 87:16
disabilities 74:21	disorder 72:10 87:17		dubious 19:12
	disordered 60:23		
	disorders 83:4		

February 21, 2023

12

dubs 39:10	85:18	55:7 56:19	51:12 67:5
due 27:22 32:7 34:16 36:5 72:4	early 17:6 19:14,20 20:4,18 25:17 26:17,20 41:12 60:20 84:24	elevated 37:3	82:21
dull 42:9 43:23	easy 44:25 65:24	embryologic 34:23	endocrinologist s 11:3 63:17
Dutch 17:19 18:13, 20 19:7 20:3, 4 21:2	eating 60:22	embryology 25:12,17	endocrinology 8:16 16:4 24:2
dysfunction 27:25 28:6,12 48:20	eavesdropped 33:25	emotional 21:6 36:4 45:8 46:23 93:5	endogenous 27:18
dysmorphia 75:14	editorial 63:3	emotionally 12:4 45:7	endorse 11:9
dysphoria 5:5 7:18 8:9 9:17 10:4,5 11:4 12:19 14:2 16:7,17 17:9,25 18:3 19:3 24:12 35:9,22 36:7 38:6 50:15 58:9 59:12 72:13,15 76:1,24 82:5, 17,21 88:2,16 89:2,11 92:1	Edmonds 90:10,11,12, 15,22,25 91:6,18	emotions 45:3	England 62:7 72:22 80:17
dysphoric 50:2 51:5 52:4	educate 15:16	emphasize 29:13 32:12 33:11 60:24	English 21:15
<hr/> E <hr/>	effect 21:6,11 56:4	employee 95:6	English-speaking 62:13
earlier 22:12 29:1 70:2 79:10	effective 14:9 36:9	encourage 6:3,12	enormous 73:5
	effects 21:1 28:16 57:7 82:9 84:3,11,20 85:4,8 87:6 90:1	end 6:11 10:8 13:23 14:18 20:9 39:3 45:15 51:3 75:22 88:1 92:11 94:5	entered 41:25
	effort 14:22	endocrine 11:20 26:19 27:8,10 30:18 51:8 82:25 83:8	entertain 56:22 63:2
	efforts 7:16	endocrinologic 82:22	entire 46:17 54:24
	egg 25:11	endocrinologist 5:11 11:17 23:19 45:19	epidemic 34:11 50:24 60:18
	elective		episodes 46:20
			Equal 8:13
			erased 53:6

February 21, 2023

13

eraser 56:14	eventually 18:25 36:7 40:17 41:6 46:2	expensive 69:15	45:1
erasing 56:5		experience 6:7 39:24 48:1	extended 11:19
erogenous 49:4	evidence 17:17 20:18 21:13 25:4 31:7,8 32:19	experienced 5:13 80:3	extensively 90:1
erotic 30:4	evil 55:2	experiencing 16:7 42:14 47:24 48:20 76:14	extraordinary 63:5
essentially 47:22	evolution 35:11	experimental 55:8	extreme 31:23
establish 12:17 31:4	exaggerated 62:21	experimentally 32:17	extremely 31:18
established 26:21 34:18 38:20	exceeding 18:8	experimented 40:16	extremists 53:9 55:1
establishing 50:9	excellent 33:1	expert 23:23 31:23 86:9	eye 59:3
estimate 62:21	exception 75:1	expertise 11:6	<hr/> F <hr/>
estradiol 69:12	excised 44:6	experts 5:5 8:14,21 10:2,25 11:1 13:7 57:5 84:10 85:3	face 28:4 29:3 48:13 77:10
estrogen 26:15 28:7,8 42:16 65:10 69:12 70:21, 25	excuse 40:1 57:22,24 66:16 89:25	explain 18:12	faced 47:19
et al 17:19 18:5,10	exemption 13:16,22	explore 56:8 76:19	facilities 42:8
Europe 9:16 59:14 62:13	exist 31:12 36:10	exponential 51:2	facing 49:23
European 15:9	existing 21:17	exponentially 80:9	fact 18:2 21:2 40:13 49:10 54:22 61:23 62:25 77:12
evaluated 76:23	expect 40:20	exposing 37:19	fail 49:12
evaluation 41:9 74:2,7, 18	expectation 40:24	expressing	failed 47:9
	expected 47:6		failing 51:18

February 21, 2023

14

failure 21:14 46:25	feeling 24:11 40:11 42:9 43:21 49:5	filed 14:10	48:4
failures 20:15		final 26:17 83:19	Finland 11:15
fairly 27:4 48:22 49:10	feelings 8:2 41:1 45:3	finally 38:8 52:14	firmly 33:16 56:18
fall 44:18 50:9	felt 9:19 45:7 89:15,18 92:15	financially 95:8	fistulas 30:3,11
false 47:5	female 23:14 25:11 27:4,18 29:2 32:14 42:7 56:11 67:22	find 5:23 25:2 77:13 79:14	fit 80:5
familial 72:11		finding 18:1	flashes 47:24
families 50:16	females 9:11 25:13,16 26:16,18 27:5,7,20,23 35:3 37:15	fine 7:5 14:21 22:5,18,25 23:5,10,12,15 32:24 39:1 52:12 54:17 56:20 57:5 58:4,22 59:15,20,24 63:8,11 64:16,19 66:2,7,13,17 67:23 68:19 69:19,24 70:9,14 71:1, 5 72:18 75:8, 16 77:5,8,11 78:4 79:2 80:21 81:13, 18,22 82:13 83:11 84:4 85:9 86:24 87:9 88:25 90:4,9,13 91:13,17,19 92:8,11,24	flawed 19:10
family 32:7,11 36:18 45:6 46:3 92:2,6,7,14, 20,22	feminine 44:21 56:10		flight 49:6
fasciitis 18:6	fertile 51:18		Florida 5:8 7:14,15, 19,24 8:9,15, 22 9:4,9,11 11:2,13,23 12:20 14:15 21:21 31:25 39:18 40:4 51:2 52:10,15 57:20 63:13, 16 68:25 73:23 89:20
favor 86:21	fertility 26:21 48:20		
favoring 17:18	fertilized 25:10		
FDA 32:18	field 86:17		fluid 49:14,15 51:19
fear 41:22 55:5	fighting 53:2 54:25		focus 16:6
features 48:13	figure 51:20		folks 5:1 22:22 39:6 83:12
February 12:25 14:8,13	figured 39:17 42:13		follow 22:2 32:10
feel 34:1 46:14 49:6 71:10 85:25	figures 67:12	finger	follow-up 37:21 64:16

February 21, 2023

15

70:2 86:25	53:21		25 18:20 19:3
followers	freedom	G	21:16 24:10,
39:10	53:22		12,13 25:1,5,
force	frequent	GAG	19 34:25
15:25	48:7 89:9	56:13	35:8,9,16,17,
forced	frequently	Gainesville	22 36:7 38:6
18:25	48:15	63:16	39:12,13
forces	freshman	Gallagher	41:6,11 43:2
34:21	42:1	5:18 39:9	47:12 50:2,15
forearm	friends	66:14 79:10	51:5 56:3
30:8,14	45:5	gallstones	58:8 59:12
foregoing	fringe	28:10	61:3 62:5
95:2	55:15	game	64:6 67:15
forever	front	75:22	71:17 74:13,
86:20	33:4 88:1	Gantt	16 75:1 76:1,
form	frontal	89:21,23	19,20,24
35:16,17	58:1	gate	79:18 80:18
38:15 69:10	fulfilling	86:12	82:5,6,17,21
87:14,21	45:7	gatekept	88:2,16 89:2,
formal	fully	88:20	11
11:19,21	47:2	gave	gender-
21:19	fun	43:2 49:19	52:8
forward	62:25	51:12	gender-
7:10 32:25	function	gay	affirming
fought	36:22	52:22 55:10,	54:4 56:2
53:3	functioning	11 56:4,14	62:19 68:15
found	19:2 20:20	75:3	71:16,21,25
9:2,8,10,19	82:7	gayness	75:20 82:9
18:23 26:6	funded	75:4	general
27:23 28:17	55:16	gays	6:9 8:12
33:11 45:4	funny	5:15 52:16,23	10:11 69:3
63:12 72:24	55:25	54:24 55:25	generally
73:3	future	56:5,18 75:24	9:3 27:13
fourth	38:2,25 50:14	gender	89:4,16
35:15	53:10 55:24	5:5 7:18 8:8	generation
frankly		9:17 10:4,5	53:10 79:12
64:25		11:4,9 12:18	80:7,10
free		14:2 15:18,22	generic
		16:7,17 17:8,	69:10
			genetic

February 21, 2023

16

25:3	64:20 69:21	group	handful
genital	73:21	18:9 22:1	19:4
19:21	gosh	30:24 55:20,	handle
genuine	80:17	25 56:1	59:19
38:3	government	groups	hands
girl	51:2 68:23	55:11	48:4 83:12
9:7 16:25	GPA	grow	happen
17:4 24:11	45:10	24:18 25:6	41:2 48:6
40:12 56:6,7	grades	56:4 75:3	82:16 83:5
60:11 65:9	45:10	growing	happened
girls	grading	76:14,15	40:5 41:3
40:13 45:5	31:7	grown	61:14 74:5
60:10,15,19,	graduate	76:3 77:2	happening
25 67:2,14,	77:22	growth	37:23 40:6
20,21 70:17	grafts	28:2 29:3	41:22 44:19
give	44:6 51:18	guarantee	54:11 80:17
6:17 23:2	granted	22:2,3	happy
27:3 34:4	8:14	guess	38:1,24 43:7
55:3 57:16,18	graphs	39:18 69:22	72:25 73:14,
64:8 65:9	49:9	87:13,22	15
69:2 75:11	grateful	88:20	hard
84:22 86:13,	93:3	guests	44:19 46:15
14 91:11	grave	42:22	61:3 63:20
GLAAD	31:24	guidelines	64:1 77:13
55:11	great	30:17,20,22	92:13
glands	37:19 42:6	31:20 51:13	harm
24:2 82:24	64:19 68:8	gut	57:14
glaring	78:23 81:21	54:12 55:4	harmed
50:18	greater	guy	25:6 50:25
Gnrh-a	66:11	65:9	83:9
16:22 18:22	greatly		harmful
20:9 21:8,18	6:15		78:12
gonadotropin-	Groomers		harms
releasing	5:15 52:16,23	hair	34:14 83:4
16:9	54:24 56:1,18	28:2 40:14	hate
good	75:24	44:22	56:1 57:8
6:9,12 25:25	grossly	halfway	hatred
30:19 32:16	28:23	18:3	53:19
38:6 54:17			

February 21, 2023

17

hats 77:17	8:16 10:19 12:12 13:1	80:19	53:9
healing 29:11 49:10	helped 49:20	hold 84:9	hospital 11:15,24,25 12:1 67:9
health 8:6,18 21:15 36:22 37:5 51:25 71:12, 16,20,22 74:9,15 77:13,19,21 78:14 87:16, 17 88:7	helping 50:14,15	Hollywood 12:1	hospitals 11:23
healthcare 31:25 57:20 66:19 67:4	helps 51:5	Holocaust 93:17	hosted 8:11 10:10
healthy 18:10	hesitant 86:14	home 42:9,22 43:11,24	hot 47:24
hear 13:7 15:5 22:8 31:5 33:4 38:2 39:22 40:21 52:14 82:19 93:14,16,19, 20,21	high 10:6 18:9 19:11 21:9 24:3,23 27:23,25 28:8,10,15,19 30:9 32:3,18 40:9 42:5 67:19 83:1	homophobic 56:3	hour 74:3
heard 13:18 64:10, 12 81:10 84:6,10 85:2	high-quality 10:3,7	Hopkins 11:24	hours 42:20
hearing 8:21 12:24 13:1,4,6,11 33:3 68:5	higher 27:9,11,18	hormone 16:9 24:3,5 51:12,13 58:13,14 65:6,7 68:10, 11 70:5 84:17 90:1	how's 92:6
Hearings 14:11	hijacked 53:7	hormone- 85:4	HRC 55:11
heart 27:24	hinders 20:7	hormones 16:12 17:10, 14,15 20:19 24:3,8 25:23, 24 26:2,23 27:2,3,14 28:23 31:21 45:21 50:5 51:17 65:8 73:6 82:23 83:1 86:15 89:14	huge 46:25
held	hindsight 88:4	horrifying 79:20 80:13, 20	human 25:9 34:8 86:5
	Hippocratic 57:13	horse	hurting 56:16
	hips 48:12		<hr/> I <hr/>
	hirsutism 28:2 29:4		idea 27:3 35:15,25 37:4,25 49:14 50:23 61:11 63:5 69:2 76:6 79:24
	history 34:9 86:10		ideas 33:11,20 38:17,21
	hit		ideation 37:7

February 21, 2023

18

identical 13:24	importance 46:2	increasingly 38:10	informed 47:2 49:24
identified 32:8 62:17	important 26:21 62:17	incredibly 18:9 79:13	57:16,17
identify 67:20 80:7	impossible 19:23 57:16	93:2	informing 37:22
identities 34:20 41:11	impressionable 77:4	independent 34:25	infrequently 9:5,8
identity 24:10 25:1,5 34:18,25 35:16,17 41:8 53:18 56:8	improve 19:2	indications 73:21	inherent 35:25
ideology 52:2 53:20 55:2 56:2	improvement 17:22	indirect 20:5	initially 25:13 43:6
ignorance 57:22,23	improves 36:21 37:4 71:16	Indiscernible 17:1	initiate 8:7 10:9,14
ignorant 92:18	incarcerate 88:9	individual 32:11 54:23	injury 30:3,15
illnesses 32:4	inches 29:9	individuals 17:24 26:2 50:21 53:22 57:23 62:8	innocent 55:23
imagine 30:10 59:4	incision 44:4	indoctrinated 77:14	inpatient 26:8
immediately 20:2 41:5,6 43:11	include 30:2,13	indoctrination 52:21	inquiries 64:13
immutable 34:19	included 66:25 67:6,10	inevitably 74:11	inside 29:23
impactful 93:18	including 37:11 39:14 77:19	infarction 27:22	insight 68:6
impacts 78:12	incorrect 33:22	infection 30:3 49:19	instances 9:10
impairment 24:15 82:7,11	increase 29:25 61:1 67:13 71:22 81:7	infections 30:13 48:16	instinct 46:6
implies 36:1	increased 27:21 28:9,12 62:10 73:6,7 80:9	infertility 26:24 28:6,13	instincts 54:12
		information 62:3	Institute 71:12
		informative 59:2	institution 52:5
			insurance 68:16,18,23

February 21, 2023

19

intelligence 83:21	inverted 29:23	Jamie 6:4 64:5	jurisdictions 36:20
intended 8:7 16:19 22:10	invertng 19:24	Jewish 93:17	justification 34:22 36:23
interest 55:21	invitation 11:19,21 15:13	Joe 11:25	juvenile 16:20
interested 59:9 68:9 95:8	invitations 11:21	Johns 11:24	<hr/> K <hr/>
interesting 21:4 39:20 61:22	invite 10:24 11:11 39:15	Johnson 55:19,20	Kaiser 66:19
interfered 88:23	invited 11:5,7 39:6	joining 6:22 15:6 22:11 33:7	key 47:14
internal 24:11 61:21 85:25	involved 84:7	joint 10:18,23 12:9,11 13:1 48:3	kid 45:25 46:9 74:4 79:8 80:1,2
international 31:11	IQ 21:12	Joseph 8:12	kids 25:5 32:2,14 49:2 53:12 54:2 55:22 56:4,13,17 63:3 72:9 73:3,9,17 75:2 76:11,14 77:24 80:15 82:17 83:8
internet 60:21	IRB 13:22	journal 16:3,4 63:1 72:22	kids' 53:1
intersection 78:21	irreversible 53:11 84:2,23 85:4	journals 16:2 90:8	kill 41:14
intervention 16:6 17:18 35:24 38:21, 22	issue 7:24 12:6,16 15:8 56:17 73:16 75:10 81:3	joys 79:17	killed 18:6 20:3
interventions 75:11	issues 6:7 8:2 48:13 49:3 76:22 78:24 81:1,5	Julie 95:13	kind 59:9 66:9 78:16,18 86:20
interview 21:3	itching 47:25	Jump 75:22	Kits 16:25
intestine 20:1	<hr/> J <hr/>	jumped 75:20	
intestines 20:2		jumping 76:8,21 80:16	
introduce 16:22	Jacksonville 7:14	June 8:4	
		junior 45:9,13	

February 21, 2023

20

knee 54:3	large 9:15 11:8 30:14 55:14	17,18 75:17 78:16 79:6	72:16 77:7,9, 12 81:16 83:6
knew 40:19 41:12 46:7	largely 50:10	leave 75:2	85:17,22 87:4,7
knife 43:5 50:5	larger 48:11	led 25:11 88:18	LGBT 52:19,24 53:3,8 54:7, 23 55:12,14 56:15 80:8
knowing 46:17 68:9	largest 15:21 62:4	left 6:5 50:11 55:10 78:5 79:3	liberally 34:12
knowledge 18:16	lasting 24:15 82:7	legal 58:3	libido 20:21 21:4
knowledgeable 74:19	lastingly 36:21	legislative 10:19	license 57:21 58:12, 15
Koster 87:10,12	late 83:12	legislators 71:7 93:8	licensed 11:2 16:14,17
<hr/> L <hr/>	law 14:16 68:16	legislature 39:18 93:7	lie 55:14,15
label 54:15	lawsuits 80:19	lesbian 6:4 56:9 60:22	lied 47:1
labeled 54:14 55:6	layer 44:13	lessened 42:17	life 17:11 20:11 41:15 42:13 43:21 46:13 47:5 70:10 74:6 76:15 93:18
lack 10:3,6 18:15 37:12	lead 21:2 74:11	lessons 45:16	lifelong 53:12 55:22 70:7
Ladapo 8:12	leading 63:1 82:6	letter 6:8 40:17 43:3	lift 43:17 81:4,6, 9
Laidlaw 5:11 22:8,13, 14,24 23:4,8, 11,15,16,18 33:10 69:2,23 82:3,14,19	leads 24:14	level 27:16 55:4	lightly 85:5
Laidlow 36:13	Leakage 20:2	levels 21:9,10 24:3, 5 27:4,15,18 51:12,13	limbs 48:3
language 10:21 12:7, 13,17,20,22	leaking 49:14 51:19	Levine 5:12 18:4 32:3 33:5,9 59:23 60:1	
	learned 88:10		
	learning 46:5 72:10 74:21		
	Leatherwood 5:14 52:15,		

February 21, 2023

21

limited 16:5 38:15	long-term 25:25 32:15	lowered 31:15	making 14:22 30:17
liposuction 75:12	36:25 37:23	luck 6:9	79:16
liquid 69:10	longer 18:16	Lupron 16:10 69:3	male 25:11,15
list 57:2 62:10	longitudinal 17:18 19:5	84:12,17	29:3,20 32:13
listed 83:4	looked 26:1 42:2	lying 46:10	42:7 44:25
literally 16:14	65:6,7 71:12	<hr/> M <hr/>	male's 37:18
literature 15:18 33:12	73:2	M.D. 7:13 10:16	males 16:12 19:20
34:1 61:12,13	lose 29:6,7 58:12,15	made 43:23 46:8	25:13,15
live 46:17	loss 29:10 30:4	73:18 75:1	26:15,18
lived 42:5	losses 20:15	78:1 85:18	27:7,21 28:7
liver 27:25	lost 52:1 84:14	magnitude 63:6	35:2 51:14
lives 53:1,23 54:18	lot 45:1,4,6	major 8:19 9:3,5,9	man 9:7 52:22
living 36:5	56:21 61:9	28:19,20	61:7
lobotomies 58:1	72:9 73:21	43:8,15 52:5	mania 28:20
locker 42:8	75:25 76:2,13	majority 24:16,18	manifest 21:9
London 15:22 18:20	79:23 81:10	54:22 56:3	manifestation 35:8
long 5:1 37:20	89:8 92:14	72:25 86:16	mannerisms 25:22
44:22 62:9	lots 89:5	92:22	mantra 53:16
70:16 71:1	loud 14:25 52:24	make 23:3 24:23	March 14:9
85:11	low 20:10 24:5	32:13 38:1	Marital 16:3
long- 84:2 85:7	26:15 31:7	52:23 53:14,	marriages 32:7
	32:19 45:10	23 61:19 76:4	masculine 40:12 44:10
	lower 42:11	77:1 85:10,19	56:6 72:7
		86:8,12 91:4	mass
		makes 19:21 46:21	
		makeup 44:22	

February 21, 2023

22

20:8	35:23 36:1	Medicines	78:14 87:16,
massively	39:7,25 41:17	10:13	17 88:7
62:9,11	46:25 47:3	meeting	mention
Massullo	52:5 53:12	8:11,20 10:8,	18:10
56:24 57:3	55:20,22 63:1	14,22,23	mentioned
58:21	73:10,24	11:18 12:2,3,	21:3 65:13
mastectomies	78:2,19 82:15	10,11,12,15	79:10 84:16
9:12 29:16	90:3,7	13:17,19,23	mesmerized
79:19	medicalization	38:5 90:16,23	93:9
mastectomy	54:16 55:8,13	91:10	met
9:6 29:1 44:5	56:19 76:22	meetings	10:10 28:19
66:21	medicalized	33:17,18	Metabolism
maternal	75:23	64:11	16:4
46:6	medicalizing	member	metastatic
matter	76:8	6:19 59:8	84:18
10:25 11:1	medically	81:13 85:10,	methods
95:4	46:8 47:19	13 86:24	19:12
mature	76:25	member's	Miami
61:19	medication	79:5	5:18 11:24
meaning	43:12	members	mice
44:6	medications	5:4 7:6,25	21:8,9
means	32:17 68:10	14:23 22:19	Michael
17:5,9 19:24	medicine	35:2,10	5:9,11 23:18
54:16	5:9 6:24 7:1,	56:20,22	middle
meant	15,21,22 8:5	67:23,24	35:7 40:9
45:24 46:2	10:10,16,17	75:25 78:5	42:18
56:10	13:1,15,19,21	81:23 90:21	milestone
measures	14:6,13 15:18	93:10	43:8
17:22,23 18:2	21:21 34:9,12	men	mind
19:6,9 21:12	57:15,25	16:15 84:18,	28:22 83:22
media	58:19,20	22,25	mine
55:10 61:24	63:13 72:22	Mengele	39:11 41:21
78:13,21	80:24 81:12	93:21	minimize
79:12 81:11	84:7 86:7	menopause	84:21
medical	89:3,16	47:23	minimum
5:21 7:1 9:3,	90:16,24	mental	31:21
5,9,15 16:14	93:20	36:22 37:5	minimums
24:1 30:24,25	Medicine's	51:25 71:16,	31:16
33:3 34:8,10	8:10 66:4	20,22 74:9,15	
		77:13,18,21	

February 21, 2023

23

minor 40:9 88:22	modern 52:19	mutilating 54:13	needed 47:7
minors 5:7 7:19 9:3, 5,9,17 11:4 12:19 14:2 31:24 39:14 50:4 52:9,22 53:24 54:16 56:19 58:9 59:10 66:15, 20,22 67:14 89:19	modifications 25:24 mom 40:17 41:10, 15 43:13 47:1 month 43:4 51:11 58:19 69:6, 11,14 72:22 months 8:4 24:16 41:20 43:18 82:8 84:25 monument 38:18 mood 28:19 morning 7:9 mortality 26:7 motion 12:7 13:21 43:16 move 6:19 22:20 27:2 28:25 39:4,21 49:7 movement 50:10,13 52:19 53:15 60:4 61:14 moves 94:3 multiple 9:21 30:1	mutilation 52:21 53:18 54:5 myocardial 27:21 <hr/> N <hr/> name's 39:8 names 40:16 narrative 55:12 narrow 27:5 natal 29:2 National 21:15 71:12 nationalized 88:12 nationwide 59:13 naturally 72:6 nature 92:2 nauseous 43:23 navigate 51:9 necessarily 38:4 92:20 necrotizing 18:6	negative 12:6,16 21:13 92:5 nerves 30:4,15 newly 20:1 nice 54:5 Nicklaus 11:24 NIH 71:13 ninety-eight 17:12 Ninety-six 17:12 nipple 29:10 44:6 nipples 44:11 nodding 87:20 non- 39:4 non-academics 5:21 nonconforming 56:4 nonconformist 76:20 Nonetheless 33:16,23 nonmedical 39:21 78:18

February 21, 2023

24

nonpartisan 56:17	<hr/> O <hr/>	20:8	5:15 30:23,24
normal 14:14 17:7,9 19:23 20:8 26:14,16 28:23 29:10 76:14,16,18 80:4 83:1	oath 57:13,14	online 45:13	31:11,13 52:23 54:24 76:1
normie 79:25	obesity 73:10	onset 49:25 72:14 84:24 88:18	organizations 55:18 77:19
North 52:6	objective 72:7	open 86:12	organs 25:15 26:14, 25 42:15
note 5:20	obsession 53:17	opening 6:18 59:3,17	orgasm 20:21 21:4
notes 91:11,12	obvious 50:3,8	opinion 9:25 32:1 66:3,5 78:22 85:20,22	orientation 34:24,25 35:12
notice 6:21 8:6	occasional 61:5	opioid 34:11,16	oriented 72:8
noticed 50:18 67:19	occasions 6:11	opioids 34:12	orifice 20:2
noting 49:22	October 10:22,23 12:3 21:15	opportunity 7:7	original 16:1 38:13,15
November 12:9,12,21	off-label 32:17	opposed 86:19	originated 83:3
numb 43:22	offered 9:3,5,8 21:23	opposing 8:17 9:25	osteopathic 7:21 8:5 10:10,13,17 12:25 13:15, 21 14:12 58:20
number 9:23 12:22,23 60:9 64:6 73:8 81:8 89:3 91:7	office 75:19	opposite 19:16 25:21, 24 27:2 31:21 42:4	osteoporosis 20:11,14 84:23
numbers 59:10 62:10, 20 63:18,19, 21 64:21 65:4 67:11	official 66:4	option 41:16 47:2 77:1 88:19	outcome 5:3 20:23 38:6 73:17
	oftentimes 72:14 93:24	order 17:9 27:16 70:23 71:22 87:10	outcomes 17:20 18:16 32:15 37:23
	olds 29:16,17	orders 69:17	outcry 33:19
	oncologist 7:13 65:16 84:16	organization	
	one's 82:5		
	one-third		

February 21, 2023

25

outlawed 36:17,19	37:12 56:21	pass 19:17 75:21	pediatric 8:16 11:3,23
outpatient 43:10	panels 93:24	passed 12:7 13:21	15:22 16:4
outright 56:12	panic 46:22	42:4	62:4 63:17
ovarian 27:9	papers 23:22	passionate 33:19	64:6
ovary 28:1	paradox 35:25	past 62:1 64:15	pediatricians 11:3
ovulating 48:23	parameters 73:18	67:15 81:1,2	pediatrics 8:16 62:15
ovum 25:10	parent 40:22 54:11	patches 69:13	63:1
Oxford 5:11 11:14	parenting 45:16	path 41:17	peers 45:5
15:15	parents 36:11 37:8,22	patient 18:5,14 20:4	penis 19:22,24
<hr/>	46:1 47:4	35:24 36:3	29:21,23
P	50:16 54:17	75:13	people 7:23 11:11
<hr/>	55:3 71:8	patients 17:21,24	13:7,10 14:25
packet 5:23 6:1	74:8 92:23	18:7,8 19:16	24:8 36:19
13:25 14:7,24	part 42:17 44:15	20:13,15	37:11,19
packets 22:21	45:14 46:25	29:14 38:9	38:11 50:15
paid 69:1	49:25 61:18	51:6 52:5	54:9 58:1
pain 29:10	65:18 72:4	53:12 55:22	61:6 67:7,25
painful 48:7	75:25 80:7	63:23 65:14,	72:8 76:13
pains 42:10 48:3,4	92:21 93:18	16,23 66:9	77:15 79:9
76:15	partial 30:4	67:3 75:12	83:9 86:8
panel 5:4 57:5	participate 93:4	82:12	88:9 89:13,14
59:9,17 93:3	participated 11:17	patriot 53:22	90:14,18
panelists 5:24 6:15,22	parties 95:7	pattern 29:3	93:5,9
	parts 46:24	paucity 60:25	perceived 24:13 82:6
		pause 85:7	percent 17:12 18:9
		paying 68:22 69:21	24:19 28:18,
			21 30:11
			62:16,21
			67:13 70:4
			percentage 80:6

February 21, 2023

26

perfect 75:18	petition 8:7 91:3	pituitary 26:12	population 26:10
performed 5:6 58:8	Pfizer 55:19	place 49:21 50:6 58:18 71:20, 25 73:4	portion 19:25 29:24
period 42:12	phalloplasty 30:6	plan 33:10	portions 28:3
periods 48:21	phallus 8:25	planned 81:19	posing 79:19
peritonitis 30:13	phantom 49:5	platforms 39:18 79:12, 16	position 8:13,17 10:12 12:16
permanent 28:5 70:6 83:25	Pharma 55:17	played 49:25	positioned 51:3
permanently 54:13	Phd 5:9	playing 56:11	positioning 44:11
person 6:21 29:2,6 31:25 67:18 68:24 74:19 76:24	Phds 5:20	plays 78:21	positions 12:6
person's 24:14	phenomenon 33:14 35:13	point 10:2 13:5 45:11 48:17 66:14 68:24	positive 18:23
personal 8:2 39:24 66:3,5	phones 93:8	pointing 18:4	possessed 53:17
personality 72:10	phrase 16:20	points 8:19 33:15 34:2 78:1	possibilities 28:11
personally 5:13 65:3,21	physical 25:4 32:6 88:23 90:1	policy 21:17,22	possibly 10:20
persons 30:22	physician 7:13 58:9,13	political 52:2	post-op 49:12
Persons-mulicka 7:5	physicians 11:22 31:1 57:13 64:10, 12 84:7	politically 6:5	potential 47:3 82:9
perspective 64:8 78:19 89:15	pick 73:25	polycystic 27:9	potentially 58:12,15 79:1
Petersburg 11:25	pioneered 19:7	poor 15:19	powerful 12:4 37:8 70:20
	Pittsburgh 62:15		practice 7:18 11:16 12:18 14:1 23:20 30:20

February 21, 2023

27

57:25	presentations	private	39:8 74:15
practices	15:2 59:2	11:16 23:20	77:13,19,22
53:1	70:3 73:19	problem	professions
practicing	presented	28:22 29:19	39:22 78:3
7:14 11:22	8:3 83:18	35:18 50:18	professor
23:19	presenters	74:17 76:9	5:10 15:5,11,
practitioners	78:9	problems	12,14 22:6
36:12 47:1	presenting	24:4,6 29:10	29:18 33:5
precocious	60:15 68:5	32:6,7,21	62:3 70:13,17
16:16 17:2,3	presents	36:4,8 73:10	90:5
predicate	31:24 60:16	74:20,25	professor/
93:24	75:13	82:23	doctors
predicts	pressed	procedure	39:5
38:6	63:19	29:4 57:15	profiles
prefers	pressure	87:5	32:19
56:11	28:1	procedures	progress
premature	pressures	5:6 7:2 29:25	53:6
34:16	76:10 78:17	31:20 58:8,11	prohibited
prenatal	pretense	81:8,9	58:9
34:21	47:5	proceed	prolapse
preparation	pretty	14:14	30:3
10:22	42:2 43:11	proceeds	promise
prepare	47:14 48:5	25:12	83:11 93:25
17:10	prevent	process	promoted
prepared	50:3	14:14,17	66:10 76:6
7:8 44:16	preventing	44:12,15	promotes
prescribe	40:5	47:18 63:4	39:10
20:25 84:17	prevents	produced	promoting
prescribed	20:20 37:7	29:22 30:20	55:12
5:7	previously	produces	promulgate
prescribing	36:7 47:10	19:15 33:18	7:17
34:12	59:12	production	promulgated
present	price	16:12	14:5,12
8:7 32:23	69:11	profession	prone
45:2 86:3	primarily	73:24 87:6	48:16
presentation	34:21 36:5	professional	pronounce
33:1 70:4	primary	74:9 93:13	5:17
74:13	7:22 58:11	professionals	
		5:22 33:3	

February 21, 2023

28

propaganda 79:11	provided 14:10 95:4	psychotherapy 36:15 72:1	pure 53:19
proper 21:23 32:18 41:9 51:10,16	provider 66:15,19 67:8	psychotic 28:21	purposes 35:2
properly 32:8	providers 57:21 63:14 67:5	puberty 15:23 16:7,8, 16,19,24 17:1,3,6,7,8, 9,13 18:11 19:1,13,15,20 20:5,7,12,18, 25 21:11,22 25:22 26:12, 17,23 35:7 41:18 47:22 53:13 56:7 60:20 69:4, 15,20 70:15, 19,22 76:17 83:2,24 84:9	pursuant 14:15
proposed 7:2 12:17 13:20,22,23 91:14	providing 82:25		push 52:20
proposing 26:19 27:14	prudent 86:11		pushed 88:19
pros 85:23	pseudo-penis 30:7,9		pushing 65:19
prospective 72:23	psychiatric 26:8 36:14 74:2,17,25 75:10 78:3 88:24		put 10:18 41:17 44:9 47:22 49:18 57:1 58:6,16,17 76:11 83:12 84:9,12 85:6 90:13
prostate 16:15 84:18	psychiatrist 5:12	puberty- blocking 58:13	putting 8:1 20:10 24:8 57:5
protect 54:21 55:7 56:17	psychiatrists 32:9	public 12:4,14 13:18 39:7	<hr/> Q <hr/>
protecting 7:23	psychiatry 33:6	publication 12:22	qualified 32:9
protocol 21:19	psychological 17:22 19:2,9 28:16 32:4 41:9 83:4,7 89:12 90:7	publicly 39:7	quality 15:19 19:6 31:8 32:19
protocols 15:9	psychologically 35:19 76:5,23	publish 15:25 18:24 19:1 22:3	quarter 18:18
proudly 39:12 54:15	psychologists 32:9	published 12:20 15:19 16:1,21 17:20 18:15 61:11, 12 64:4 72:21 90:6	question 21:4 34:5 50:11 53:19 57:19 58:23 59:7,16,22 60:3 65:25 68:2,7 71:3,
prove 24:25 25:1	psychology 45:14,15		
proves 71:15	psychotherapeut ic 74:8		
provide 36:15 51:4,25 52:3 57:21 71:20 73:12			

February 21, 2023

29

19 72:17 73:22 75:18 78:7 81:14,16 82:3,8 83:23 85:12,14,17 86:18 87:2,4, 22 88:14 89:22 91:21, 25 93:1 questionable 48:21 questioned 7:10 65:4 questioning 41:8 questions 6:19 13:3 14:20 15:1 33:1 38:24 39:3 51:15 56:22,25 57:11 63:22 67:25 68:20 78:5 79:5 quick 57:11 80:24 90:10 91:20 quickly 35:12 quote 21:18 quoted 37:17 quotes 64:5 <hr/> R <hr/> radiation 7:13 65:16	radical 52:20 53:14 radicals 55:15 rafters 64:22 rainbow 54:19 80:8 raise 34:5 randomized 21:7,24 range 27:5,10 28:24 43:16 ranking 7:6 81:13 85:10,13 86:24 rare 27:10 38:8,11 61:5 rate 18:8 26:7,8,9 37:16,17,18 66:21 rates 19:11 26:4 30:10 32:3 37:2,3,6 ratio 60:14 61:2 reach 39:19 49:16 53:13 reached 51:21 reacting	50:7 read 6:3,12,13 14:3,25 15:17 35:20 64:3 reading 6:10 reaffirmed 37:3 real 57:11 73:22 76:2 realize 44:21 realized 37:19 42:11 46:5 realizing 78:24 realm 83:3 reason 66:2 reassignment 37:15 58:10 79:18 receive 13:2 85:21 received 8:6 12:5,23 recent 6:25 15:9 21:7 31:15 37:2 53:15 recently 18:13 21:3 34:10 60:12 61:7 66:20	79:9 81:3 rechanged 38:14 reclaim 54:25 recognition 71:5 89:24 recognize 58:23 82:20 85:24 recognized 7:3 15:11 22:13 33:9 38:10 39:25 41:23 52:17 58:4 59:24 66:11 68:1 69:25 71:2 78:6 81:14 82:13 83:16 85:14 87:11, 18 89:21 90:4,11 recognizing 82:2 recommendation 31:22 43:3 recommended 21:20 65:23 record 66:7 recording 94:5 95:3 recovering 43:14 red 27:23 reduce 19:3
--	--	--	---

February 21, 2023

30

reduces 37:6	relating 7:17	replace 52:9	87:1
Reed 6:4 64:5	relationship 74:8,19 92:16,22	replacing 50:20	republished 14:13
refer 75:11	relationships 45:4	replicate 18:19	request 13:10
reference 73:18	relative 95:6	replicating 19:6	requested 13:4
referred 28:25 43:2 47:13 67:14	released 21:16 66:20	reported 67:4	requests 12:23 13:6
referring 72:20 90:20	remarkable 21:10	Representative 56:23,24 57:3 58:21,22,24 59:7,18 66:2 68:3 70:1 71:2,4 72:20 77:6 78:6,8 81:15,20,25 82:1,18 83:14,15,17 85:15 87:3, 10,12 89:21, 23 90:10,11, 12,15,22,25 91:6,18,23 94:3	required 57:15 68:16
reflect 40:15 42:24	remarks 6:18 7:8		requires 35:23 74:10, 14
reflection 35:18	remember 14:16 64:11 65:5,13		research 10:3,7 13:15 15:8,19,22 16:1 18:3 19:1 21:19 71:11,13,15 90:7
regimen 87:5	remotely 6:22 15:6 22:11 33:8		researcher 21:2
Register 12:21	removal 26:25	representatives 11:7,13	researchers 18:13,24 19:8 21:11
regret 38:8,11,12,16 46:23 50:21, 25 66:21	remove 13:15,22 29:5 75:4	represented 11:1	resemblance 19:16
regretted 67:2,6	removed 31:15,20 43:1 45:22 70:23	representing 8:13 10:11 12:15	Reserve 33:6
regular 8:10 48:22	removing 8:24	represents 38:16 52:15, 22	resolved 41:2
regularly 43:25	Rep 69:24 91:19	reproductive 42:15	respond 72:16
regulate 7:1	repeated 19:7	Republican	responding 60:20
regulation 87:24	repeatedly 33:25		response 49:18 75:18
related 90:25 91:2			

February 21, 2023

31

rest 17:11 70:10	Rizo 83:15,17	run 37:20	80:2,10
restroom 48:15	robust 17:17	running 61:3	schools 62:15 77:22
restrooms 42:8	Rockland 23:19	<hr/> S <hr/>	science 7:25 38:19 52:8 77:20
result 5:7	rolled 30:8	safely 48:24	scientific 17:17 34:13 55:9 86:22
resulting 26:14	romantic 35:1	safety 40:4 54:18 81:5	scientifically 33:16,20 64:20
results 15:24 16:1 18:15,23,24 24:13	room 45:1	Salzman 68:1,3 69:24 70:1	scientist 80:25 81:11
Reuters 64:6	rough 69:2	sample 31:1	scientists 11:5
revealed 8:19 19:1	roughly 40:10	samples 19:10	scores 73:3
reversal 21:17	ruin 53:9	Sanders 6:5	Scot 5:8 7:12
reversed 60:14	ruining 53:1	satisfactory 19:22	scrape 44:8
reversible 83:25 84:8,12	rule 10:20 12:7 13:4,6,8,9, 11,16,20,22 14:5,12,16 47:9 58:6,17 91:5,14	save 36:11 56:14	scraped 44:10
rights 40:4	rulemaking 8:8 10:9,14 14:14	scan 25:2	screen 23:7
rise 94:4	rules 7:17 10:19 12:24 13:13, 24 14:7,10,24 30:17 90:17, 18 91:4	scapegoat 52:25 56:16	screened 47:15
risk 20:11 27:21, 24 28:9,11 30:1 32:18 37:20	rules-making 12:10	scarring 29:9 30:14	screening 88:16
risks 28:1 87:5		scars 44:3	screens 15:4
risky 19:21		schizophrenia 88:8,10	scrotum 29:21
		school 40:10 42:5,9 62:16 67:19 76:11 79:8	seconds 23:2
			self-harm 53:18

February 21, 2023

32

send 40:23	sexist 56:12	shower 44:1,17	44:10
senior 45:9	sexual 16:2 20:20	showing 26:11 27:3	single 9:20 75:9
sensation 29:11 30:5 42:10 43:22 49:3,4	28:5,12 32:6 34:24,25 35:2 48:20 58:11 72:12	29:14 30:6 32:21 83:20	singular 9:18
sense 54:12 55:8 85:18	sexuality 21:1	shows 35:9	sir 23:13 72:18 75:16
sensory 30:3,15	sexually 41:21	shutting 80:18	sites 11:9
separate 10:15 11:2 35:5,13	share 5:14 22:16	sick 6:12 42:22 52:24 53:17	situation 49:21
separation 19:20	sharing 23:7	side 25:15 57:7 84:11,20 85:4 87:6	Skidmore 81:13,15,20 83:14 85:10, 13,15 86:24 87:3
Service 21:15	shield 52:20	sides 71:8	skin 44:10,13,18 49:11,13,19 51:18
services 21:17 52:1 71:20	shifts 15:9	Sidhbh 5:18 39:9	skirts 44:23
set 19:9 31:15	shocking 79:14	sign 47:4	slides 22:15,21 37:2 82:4
severe 20:13 72:11	shooting 48:4	significant 9:14 20:15 24:15 29:8 73:5 82:6,11	slightly 73:4
sex 16:3,12 19:16 22:10 25:21, 24 27:2 31:21 35:10 37:15 41:23 42:5 58:10 61:2 82:5	short 50:9 73:15	signs 55:24	slowly 44:18
sexes 25:9	shortly 17:20	similar 25:13 85:4	smaller 27:7 48:11
sexism 56:15	shoulders 48:11	simple 86:18	smart 76:6
	show 38:10	simplest 87:14,21	smear 55:6
	showed 17:22 21:8 30:11	simply 56:11 70:24	Snyder 77:6 78:6,8
		simulate	

February 21, 2023

33

so-called 8:23 9:4	sorted 72:13	62:2	32:12 87:18
social 25:20 36:22 78:12,21 79:12 80:25 81:10,11	sought 82:10	speeches 33:24	88:6,7,13 89:4,10,11, 13,17
Socially 44:25	source 74:12	sperm 25:11	standards 7:17 8:1 12:18 14:1 31:12 35:3,20 52:4,7 87:25 89:5,7
societal 76:10 78:17	speak 6:2 7:7,16 55:5 63:15 64:12 80:25 83:22 86:13 92:15	spiral 45:9	standing 54:20
societies 9:15,23,24,25 11:8	speaker 75:2	spoke 42:25 64:10 65:2 75:2	start 6:20,23 7:9 17:4,13 22:17 23:5 56:7 70:18 82:25
society 11:20 26:19 30:18 53:5,21 79:23	speakers 5:19 78:1 83:19	sponsored 55:19	started 15:22 18:7 22:19,23 40:10 41:24 42:9,10 43:24 44:20 45:8 47:24 48:2 49:12 62:6
sociology 5:10 15:14 90:3	speaking 83:24 92:19	sporadic 48:5	starting 41:18,20 48:6 67:20
solidarity 55:3	special 75:1	St 11:25	starts 70:15
solution 50:3 76:21 88:11	specialist 41:7 43:2 47:12	stabbing 42:10	state 6:7 7:23 8:11 10:11 34:14 47:23 57:20 59:13 61:10 63:14 68:12, 14 69:4 71:20,21 73:24 76:7 89:19
son 40:18	specialty 87:6	stable 51:17	
sophomore 42:18 67:18	specific 25:15	staff 10:24 57:4	
sort 11:9 24:20 33:3 39:6 56:25 62:5 63:2 72:2 84:8 85:6 87:19,22 88:5 89:18	specifically 8:15 11:23 63:15,22 82:10	stage 16:23 26:20, 22 29:20	
	specification 21:16	stages 25:19 26:17 65:15	
	spectrum 47:11 72:3 80:8	stairs 49:6	
	speculation	stand 38:17 53:22 55:1,2 56:18	
		standard 9:18,20 10:5 31:4,5,6	

February 21, 2023

34

states 9:16 34:15 50:17 58:3 62:12 82:4	stopping 17:9 29:20	studying 88:12	suicides 73:8,9
statistical 19:12	story 5:14 46:24	subject 10:4,25 11:1 15:17 23:24 40:20 57:6 93:5	summarized 61:12
stay 27:20 70:7, 16,22	straight 63:24 64:1 65:2 75:20 76:21 79:24	subjects 28:18	superficially 19:17
steered 78:25	stress 21:9	submit 54:4	superiority 38:20
stemming 40:25	strictures 30:2,12	submitted 14:6,7	supply 44:13
step 43:9 52:10	strongly 34:1	subsequent 19:21	support 55:14 89:12 90:17,18 91:7
Stephen 5:12	structure 48:11	subset 17:23	supporting 52:8
stepping 40:4	struggling 88:2	substantial 9:22	supports 55:13
stereotypical 25:21	students 15:16 62:16, 22	substantive 9:14	supposed 39:24
sterilization 52:21 54:6	studied 21:5,11 28:16	suffered 92:17	suppress 70:24
sterilized 27:1	studies 19:5,10 28:18 32:21 36:24, 25 37:1,14,21 67:11	suffering 34:15 50:15 86:10	suppressed 15:24
steroid 28:17	study 17:19 18:20 21:1 24:2,17 26:1 29:13 30:11 37:2 66:20,22,23 67:6,10 72:21,23 73:13 86:23 93:17	sugar 24:23	suppression 16:8,19 17:8 18:12 19:2,15 20:6,7,12,19 21:12,23 83:24
stifled 67:11		suggested 62:16	surgeon 8:12 10:11 43:3,4 45:19 49:17 67:5 75:13
stitches 43:20		suggesting 71:19	
stop 16:12 26:13 56:13,14,15 70:11,14,18		suicidal 37:7	
stopped 46:12 51:11 92:21		suicide 26:9 37:7,16, 17,18,20 51:23	surgeries 26:24 28:25 30:1 39:13 66:15 69:16 79:20

February 21, 2023

35

surgery 8:24,25 9:2, 4,6,8 17:20 19:21 20:3 26:3 27:13 29:1,15,18 31:16 37:15 43:7,10,15 47:13 49:1 51:19 58:10 65:10,17,20, 23 67:9 79:18 81:6 89:14	syndrome 27:9 28:20 system 51:9 58:18 <hr/> T <hr/> tab 6:1 64:3,4 tablets 69:13 tag 90:13 takes 54:11 85:12 taking 6:16 28:7 45:14 50:4 70:18 talk 5:5 22:9 32:3 39:16,17 73:9 78:20 talked 31:10 78:11 86:23 87:23 89:25 talking 15:8 45:3 59:10 74:4 80:12 talks 23:23 Tallahassee 13:2 Tanner 16:23 26:16, 20,22 29:20 taper	51:17 targeted 79:21 targeting 54:1 79:11 tasked 71:7 taught 77:23 Tavistock 18:21 62:4 team 19:8 21:2 63:15 teams 19:8 technology 32:13 teenage 51:14 60:19 teenager 61:5 88:3 teenagers 17:19 18:10, 22 20:9 37:9 60:7,8 61:10 72:23 73:14 86:2 teens 37:25 38:1 Teetus 39:11 telling 38:12 40:18 56:6,10 temporary 49:19	ten 26:5 30:21 37:6 80:16 tenable 35:19 tend 48:1 72:6 tendencies 72:7 tenets 57:14 tens 69:17 term 18:16 73:15 76:12 84:3 85:8 terms 20:16 28:15 73:17 87:24 terrible 75:6 terrorists 53:7 54:1,19 test 5:3 tested 51:11 testes 26:13 testicles 70:23 testify 50:17 testing 25:3 testone 68:10
--	--	--	---

February 21, 2023

36

testosterone 26:15 27:4,6 28:14,15 41:18,20 48:9 51:17 65:9 69:9 70:18, 20,24 84:13, 19,22	thinking 25:9 Thompson 95:13 thought 42:23 62:24 92:17,18 thousands 50:21 69:17 threw 43:23 thromboembolism 28:9 throw 13:12 ticking 62:24 Tiktok 39:9,16 79:13,16 time 6:15,16 8:14 16:5 23:24 26:3 35:20 38:2 40:13 41:22,25 45:11,24 54:8 63:20 64:1 67:3 70:12 71:1 74:10 80:9 83:13 84:20 85:11 92:12 times 26:7,8,9 27:17 28:9,12 37:16,17 43:24 51:23 tiny	19:10 tissue 29:24 30:7 44:7 48:19 title 16:21 titled 14:1 today 5:4,5,7,22 6:16 7:16 37:12 38:24 59:2 61:25 64:8 68:5 69:1 73:19 79:8 83:20 93:11,25 today's 78:23 79:23 told 15:16 36:14 37:9 41:10 44:14 45:19 47:14 tolerance 53:4 tolerate 86:2 tomboy 40:11 56:9 tomboys 56:15 top 9:4,6,8 29:1 44:13 49:11, 13 66:14 topic 91:1,2	topical 42:16 touched 78:16 Trabulsy 91:20,23 tract 48:14 traditional 74:24 83:7 training 74:15 trans 34:6,18,20 37:11 52:19 53:7,14 55:1 56:6,14 60:23 61:14,15 62:17,23 75:5 77:15 80:15 82:12 trans-trenders 76:13 transcript 95:3 TRANSCRIPTIONIS T 95:1 transgender 15:17 33:13 67:17 75:25 81:8 85:21 transition 25:20 26:3 41:16,17 43:9 46:8 47:3 51:1 56:10 61:2 73:14 76:3 77:24
--	---	---	---

February 21, 2023

37

transitioned 26:6 40:8 47:17	24:1,20 27:15 30:17 34:22 36:23 51:10	trusting 74:18	UK 15:6 16:18
transitioners 80:13	58:8,14 61:21 68:13 70:6,7 77:21 82:15	truth 56:3	ultimately 11:11,12 12:6,16
transitioning 46:12 47:19 51:11 76:25 87:25	83:5 84:1 87:19 92:5	tsunami 60:19	unable 6:2
transitions 50:22	treatments 22:10 25:7 27:13 50:4,22 82:16 83:7,10	tubules 25:13	unanimous 91:16
transphobe 54:6	84:8,11 86:21 88:21	tumors 27:11,12,17	uncertain 37:5
transsexual 37:4	trends 78:13	turkey 46:12	unchangeable 34:19
transsexuals 16:20	trendy 76:18 79:7,17	Turku 11:15	unchanging 34:19
trauma 72:12	trial 21:8,24 22:2	turmoil 46:23	uncomfortable 76:15 89:18
traveled 50:17	triglycerides 28:10	turn 60:6,12 75:14	undergo 17:7 24:20 25:6 38:14 61:25 88:21
treat 16:17 24:22, 24,25 36:2 66:9 75:10 77:15 84:18	Trojan 53:9	turned 47:11	undergoing 84:1
treated 32:5,8 42:16 59:11,12 72:13 88:17 92:3	trucks 56:12	turning 42:10 55:21	undergone 9:12
treating 11:4 17:2 74:16 76:5	troubles 73:11	tweak 13:9	underlying 74:20 88:17
treatment 7:18 8:8 9:16 10:4 12:18 14:2 17:5 18:17 21:25	true 19:14 33:19 34:17,20 35:15 38:3,7, 21 95:2	two-year 72:23	underpin 38:21
	trust 38:22 49:20 51:21 86:7	type 30:16 39:24 44:4 57:8,22 71:10,23 79:21	understand 10:15 32:15 77:25 78:2
	trusted 86:17	typically 17:15	understanding 87:14
		<hr/> U <hr/>	underwent 37:15 66:21
		U.S.A. 16:18	undeveloped 19:22 29:21

February 21, 2023

38

unethical 36:16	urging 36:19	25:9	vote 91:10,14,15
unexplained 19:11	urinary 48:14	versa 32:14	voted 10:9,14
UNIDENTIFIED 23:14 67:22	urine 48:18	versions 36:16	Vries 17:19 18:5,10 21:3
uniquely 51:3	uterine 42:12	versus 59:10,13 90:18	<hr/> W <hr/>
United 9:16 34:15 62:12	utility 34:14	vested 55:21	waiting 62:10 87:11
Unitedhealth 55:20	<hr/> V <hr/>	vice 7:5 32:14	walking 49:6
University 5:10 8:14,22 11:13,14 15:15 33:6 63:16	vagina 9:1	VIDEO 94:5	wanted 13:12 38:23 40:18 41:13 42:24 46:6 60:10,11 62:18 85:20 88:1,3 91:21
unknown 20:17 73:20	vaginoplasty 18:7 19:23,24	videos 79:17	wanting 13:14 54:21 87:24
unlike 47:25	valiantly 53:4	view 34:18	war 54:2
unquestioned 9:18	valid 64:20	viewpoints 10:25	warned 80:14
untrue 33:16	Valley 40:2	visibility 54:25	watch 35:6,11 44:19
untruth 37:8	variability 73:5	visible 48:10	watched 44:18
unusual 89:8	variation 24:12	vision 50:9,11,13,14	wear 54:14
upper 43:15	Vaseline 49:18	visit 37:10	wearing 25:20 40:14 42:19 44:22, 23
uptick 78:21 80:12	vast 72:24	visits 68:17	week
urethra 30:2,11	veracity 37:13	voice 28:4 42:1 55:3	
urethral 30:12	verdict 77:20	voiced 41:4	
	verifiable 33:21	volume 64:14	
	verify		

February 21, 2023

39

10:9 14:8	woman	46:24 48:25	42:19 45:9
43:19 78:11	9:1,6 29:7	worth	47:22 48:2
weekdays	40:2 44:24	49:22	49:12 51:19
42:21	46:14 65:2,9,	wound	53:3 54:8
weeks	12	29:11	60:3,13,14
12:24 43:13	women	wounded	61:5 64:7,15
64:4	47:25 48:12	44:2	69:5,7,8 74:5
weigh	wonders	WPATH	80:16 81:2
85:23	79:18	30:23 31:10	90:7 93:6
weighed	Woodson	32:10 35:4	young
19:18	71:2,4 72:20	52:4 77:17	9:11 16:25
well-accepted	word	writings	24:8 29:14
89:12	57:9 60:18	33:24	37:25 46:14
well-being	66:4 81:12	written	49:24 50:25
71:17	wore	6:3,6 23:22	67:14 76:13
well-	43:12	33:12	77:4,21
established	work	wrong	younger
60:5	23:3 30:19	54:10 87:15	79:11 80:7
Western	42:21 43:14	92:18	youth
33:6 62:13	66:12	wrote	34:6 37:21
Whip	working	40:17	56:14 60:7
68:1	22:18 23:1		61:1,15 78:23
whistleblower	works	<hr/>	
6:6	51:9	Y	
who've	workshop	<hr/>	
83:12	10:20	Yale	
whoever's	world	11:14 65:3,12	
68:22 69:20	16:18 36:5	year	
widely	60:9 62:5,11,	26:4 29:16,17	
89:16	13 75:5	39:13 42:1,18	
widen	world's	45:13 47:6,13	
29:9	15:21	53:5 61:9,17	
wild	worried	62:8 66:15	
62:1	86:1	67:18 68:9,	
willingness	worse	11,21 69:7,21	
83:22	19:5 42:12	years	
woke	54:14	9:11 15:15	
43:6	worst	16:25 18:23	
		20:9 23:20,22	
		26:1,4,5 34:1	
		38:9 40:11	