Jane Doe

vs.

Joseph Ladapo

Taped Transcription

February 21, 2023

Doe Pls' Trial Ex.
27

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

TRANSCRIPTION OF VIDEO RECORDING
HOUSE HEALTH AND HUMAN SERVICES
FEBRUARY 21, 2023

TRANSCRIBED AUDIO RECORDING BY:
Julie Thompson, CET

Job No.: 322529

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

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

Sabrina, please call the role.

THE CLERK: Chair Fine.

CHAIRMAN FINE: Here.

THE CLERK: Representatives Persons-Mulicka.

VICE-CHAIR PERSONS-MULICKA: Here.

THE CLERK: Representative Salzman.

REPRESENTATIVE SALZMAN: Here.

THE CLERK: Skidmore.

REPRESENTATIVE SKIDMORE: Here.

THE CLERK: Amesty.

REPRESENTATIVE AMESTY: Here.

THE CLERK: Anderson.

REPRESENTATIVE ANDERSON: Here.

THE CLERK: Baker.

REPRESENTATIVE BAKER: Here.

THE CLERK: Clemons.

Cross.

REPRESENTATIVE CROSS: Here.

THE CLERK: Dunkley.
REPRESENTATIVE DUNKLEY: Here.
THE CLERK: Edmonds.
REPRESENTATIVE EDMONDS: Here.
THE CLERK: Gantt.
REPRESENTATIVE GANTT: Here.
THE CLERK: Grant.
REPRESENTATIVE GRANT: Here.
THE CLERK: Koster.
REPRESENTATIVE KOSTER: Here.
THE CLERK: Massullo.
REPRESENTATIVE MASSULLO: Here.
THE CLERK: Plakon.
REPRESENTATIVE PLAKON: Here.
THE CLERK: Rizo.
REPRESENTATIVE RIZO: Here.
THE CLERK: Snyder.
REPRESENTATIVE SNYDER: Here.
THE CLERK: Trabulsy.
REPRESENTATIVE TRABULSY: Here.
THE CLERK: Woodson.
REPRESENTATIVE WOODSON: Here.
THE CLERK: Yarkosky.
REPRESENTATIVE YARKOSKY: Here.
THE CLERK: A quorum is present.

CHAIRMAN FINE: Thank you, Sabrina.

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Ackerman, you are recognized.

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

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

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

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

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

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

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

to a woman who has a vagina.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you. Thank you, Chair.

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

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

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

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

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

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

Professor Biggs, you're recognized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So Dr. Laidlaw, you are recognized.

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

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

DR. LAIDLAW: Okay.

CHAIRMAN FINE: -- you have your -- and

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

DR. LAIDLAW: Okay.

CHAIRMAN FINE: -- start.

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

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

CHAIRMAN FINE: There you go.

DR. LAIDLAW: Okay. Can everyone see that?

CHAIRMAN FINE: All right. There we go. Thank you, sir.

UNIDENTIFIED FEMALE: Yes.

CHAIRMAN FINE: Thank you, Dr. Laidlaw.

DR. LAIDLAW: Okay. Thank you very much. And thank you, Chair and all, for having me here.

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

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

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

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

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

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

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

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

Just to have a look at one good long-term

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

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

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

obviously sterilized.

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

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

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

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

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

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

To move on to surgeries, referred to

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

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

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

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

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

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

sample of physicians and others who created this document.

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

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

anywhere else in my opinion.

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

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

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

questions. That was an excellent presentation.

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

Dr. Levine, you are recognized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And the 11th idea is that teens, young

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And so I spoke to my therapist about my

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But the worst complications might be from

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

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

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

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

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

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

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

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

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

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

So how do you provide mental health

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

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

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

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

Mr. Leatherwood, you are recognized.

MR. LEATHERWOOD: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

It's funny. They call a group like Gays

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

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

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

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

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

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

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

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

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

CHAIRMAN FINE: You are recognized.

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

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

REPRESENTATIVE MASSULLO: Thank you.

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

REPRESENTATIVE ANDERSON: Thank you, Mr. Chair.

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

CHLOE COLE: Thank you.

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

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

REPRESENTATIVE ANDERSON: Whoever can handle that one.

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

DR. LEVINE: Well --

CHAIRMAN FINE: You are recognized. Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

DR. ACKERMAN: Can I address it as well?

CHAIRMAN FINE: Absolutely.

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

CHAIRMAN FINE: No.

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

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

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

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

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

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

DR. ACKERMAN: Yes.

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

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

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

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

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

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

CHAIRMAN FINE: And just for the record --

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

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

CHLOE COLE: Excuse me.

CHAIRMAN FINE: Yes, Chloe. Go ahead.

CHLOE COLE: I'd like to add to that. Kaiser, which is my healthcare provider, they actually released a study recently on minors who underwent a double mastectomy and the regret rate. And in the study, there were about 200 or so minors, and it's likely that -- the study was conducted between, I think, 2013 to 2021. And I actually wasn't included in this.

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

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

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

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

UNIDENTIFIED FEMALE: Thank you.

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

Whip Salzman, you're recognized for a question.

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

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

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

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

paid for today?

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

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

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

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

DR. LAIDLAW: Yeah.

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

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

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

PROFESSOR BIGGS: So --

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

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

CHAIRMAN FINE: Okay. So a long time.

Representative Woodson, you're recognized for a question.

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

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

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

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

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

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

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

DR. LEVINE: May I respond to your question?

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

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

their aesthetic appearances by age 18.

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

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

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

And I just want to pick up on what

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

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

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

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

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

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

CHAIRMAN FINE: Yeah. Go ahead. Sure.

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

CHAIRMAN FINE: Yes, sir.

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

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

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

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

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

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

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

CHAIRMAN FINE: Thank you.

Representative Snyder --

DR. LEVINE: I think we have to --

CHAIRMAN FINE: Sorry?

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

CHAIRMAN FINE: Oh, okay.

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

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

And I think they don't understand what the

13 points that I made and the other speakers made. They just don't understand. Our medical -- our psychiatric professions have been brainwashed.

CHAIRMAN FINE: Thank you. So we've got five members left who wish to ask questions.

So Representative Snyder, you're recognized for a question.

REPRESENTATIVE SNYDER: Thank you, Mr. Chairman, and thank you again to the presenters, you know.

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

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

potentially in that direction?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REPRESENTATIVE SKIDMORE: That would be great.

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

Representative Cross, you're next.

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

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

CHAIRMAN FINE: You are recognized.

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

REPRESENTATIVE CROSS: Yes.

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

hormones of very high doses or blocking normal puberty.

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

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

But, first, Representative Rizo, you are recognized.

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

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

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

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

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

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

unless I really have to.

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

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

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

REPRESENTATIVE SKIDMORE: Mr. Chair, thank you.

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

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

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

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

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

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

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

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

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

DR. LEVINE: No.

DR. ACKERMAN: No.

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

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

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

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

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

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

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

CHAIRMAN FINE: Okay. Go ahead.

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

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

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

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

Dr. Biggs, excuse me, you talked

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

CHAIRMAN FINE: You are recognized.

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

CHAIRMAN FINE: Okay. All right. Representative Edmonds -- that was quick. Representative Edmonds, you are recognized.

REPRESENTATIVE EDMONDS: Thank you.

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

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

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

REPRESENTATIVE EDMONDS: Yes.

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

REPRESENTATIVE EDMONDS: And related to

this topic.

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

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

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

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

DR. ACKERMAN: It was unanimous.

CHAIRMAN FINE: Thank you.

REPRESENTATIVE EDMONDS: Thank you.

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

REPRESENTATIVE TRABULSY: Thank you, Mr. Chair.

My question is for Chloe. I would like to

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

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

CHLOE COLE: Okay.

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

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

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

CHAIRMAN FINE: Well, thank you.

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

question, but I have a couple of closing comments.

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

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

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

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

With that, Representative Amnesty moves we rise.

(END OF VIDEO RECORDING)

CERTIFICATE OF TRANSCRIPTIONIST

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

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

Julie Thompson, CET-1036

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