The Dangers of “Gender-Affirming Care” for Minors

July 9, 2025

Jon Schweppe:

Good morning, everyone. Let's go ahead and have a seat if we can. Folks, we're going to get our program started in a minute if everybody could have a seat. Good morning and welcome to the Federal Trade Commission's workshop, the dangers of so-called gender-affirming care for minors. My name is Jon Schweppe. I'm a senior policy advisor in the chairman's office. We have an incredible program for you today with 33 guest speakers plus Chairman Ferguson and Commissioners Holyoak and Meador. Our approach to this workshop is simple. We want to hear from a wide variety of people all over the political spectrum about this issue. Our speakers today include medical, ethicists, physicians, whistleblowers, parents and survivors. We have Republicans, Democrats, conservatives, progressives, even feminists, who are concerned about a profit-seeking industry pushing to medicalize and in some cases sterilize gender dysphoric minors at younger and younger ages. Before we get started today with our substantive program, I need to go over some administrative details.

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right. So let's get started with the program. Please welcome to the stage the Chairman of the Federal Trade Commission, Andrew Ferguson.

Andrew Ferguson:

Good morning. Welcome to the Federal Trade Commission. Thank you all for being here, and thank you, Jon, for that introduction. Just over a year ago, the New York Times reported that the Biden administration had pressured the World Professional Association for Transgender Health or WPATH to remove age minimum requirements for cross-sex hormones and other sex change surgeries from their forthcoming guidelines on the care of transgender youth. Why did the Biden administration object to age minimum requirements? According to emails provided to the New York Times and the state of Alabama in its suit against the Biden administration, the Biden health agencies worried that including minimum age requirements in the guidelines would "result in devastating legislation for trans care." The Biden administration's concern was not that age minimum requirements were unscientific, unreasonable, or unhelpful to doctors, therapists, parents and children experiencing gender dysphoria. Science was beside the point.

Instead, their concern was political. They worried that age minimum requirements gave too much ammunition to critics of gender-affirming care. The Biden administration didn't care about the parents and kids who might've relied on those requirements when deciding whether to consent to expensive hormone treatments and sex change surgeries. They didn't care about the parents and kids who might've been spared a lifetime of pain and regret if their doctors, therapists and surgeons had observed those requirements. They cared about politics, they didn't care about people. Today, by contrast is not about politics. It's about the parents and kids the Biden administration chose to ignore. It's about our nation's children, who stand most in need of our love, protection and support. It's about their parents, whose selfless and fruitful love is the foundation of our nation and of every nation. It is about caring for the most vulnerable among us and protecting them from manipulation, deception, and abuse.

It is about healing the wounds that proponents of gender-affirming care may have inflicted on our nation's children and parents, and preventing the potential for future harm. Today is about people, not politics. So I want to focus on some of the courageous young people we have with us today. While each person's story is unique and you will hear from them, they do share some features in common, and I want to highlight those features because they speak to recurring patterns of potential deception in gender-affirming care. As chairman of the Federal Trade Commission, Congress has entrusted me with protecting citizens from deceptive acts and practices. And one of the reasons we are here today is examine whether some of the practices in gender-affirming care are deceptive and require greater scrutiny by the FTC. Let's start with Prisha Mosley. You'll hear from Prisha herself at 14 years old was a victim of sexual assault.

By age 16, she suffered depression, obsessive compulsive disorder and anorexia. After a concerning episode of self-harm, a pediatrician was recommended to help Prisha address her eating disorder. After a brief consultation, the pediatrician concluded that Prisha was actually a boy and recommended a therapist specializing in transgender care. Prisha recalls that the therapist assured Prisha that she could cure her depression, obsessive compulsive disorder and anorexia by making her body more masculine through testosterone injections. Just a few months later, Prisha secured a letter from a mental health counselor, stating that the surgical removal of her breasts was a clinical necessity. One month later, Prisha's breasts were removed. What had begun two years earlier as a referral to a pediatrician for treatment of anorexia ended on a surgeon's table and the removal of her breasts. Claire Abernathy will describe her similar experience. After experiencing a traumatic sexual assault, she began identifying as a boy when she was just 11 years old.

A year later, she met with a therapist who specialized in transgender care. Claire explains that this therapist recommended that she realize her male identity through hormone injections and sex change surgeries. Although Claire's mother was not confident in this diagnosis, she was told that affirming Claire's identity as a boy was necessary to prevent Claire from committing suicide. The takeaway for Claire's mother was clear. The only way to heal Claire, the therapist explained, was to take the chemical and surgical steps necessary to make Claire's body more masculine. And so what happened that in the summer following her eighth grade graduation, Claire's breasts were removed. Soren Aldaco too identified as a boy when she was just 11 years old, although she did so at the instigation of an older girl she met online. Four years later, Soren had a severe mental health breakdown that required hospitalization. There she met a psychiatrist, who Soren recalls told her that transitioning to become a boy was a medically legitimate form of treatment for mental health challenges.

After a short appointment, Soren was prescribed testosterone. After a year of testosterone, social isolation brought on by government-mandated COVID lockdowns and a difficult breakup, Soren decided she wanted to remove her breasts. Although Soren's therapist knew Soren had expressed reservations about this, she still wrote a letter recommending the surgical removal of her breasts. $25,000 later, Soren's breasts removed. These are not stories of liberation but of desperation. After years of intense mental health struggles, these girls and their parents were looking for any path that might lead them to genuine healing, and they encountered physicians, therapists and surgeons, who purported to provide them with one. Their pitch was simple. The children's problems were not due to the trauma of sexual assault, depression or anorexia. Instead, the real problem was the fact that they were boys trapped in girls' bodies. Taking chemical and surgical steps necessary to look more like a boy would relieve their symptoms, but they weren't cured.

Indeed, their mental health continuously declined over the course of their treatment. By the time they realized that their medical transition had not solved their mental health issues, permanent and irreversible changes had been made to their bodies. They say they were never informed that testosterone injections would affect permanent changes in their voices, their faces, their hormone levels, and their fertility. Far from making them whole, this gender-affirming care left them in the words of Prisha, "Broken with extreme physical injuries and without their body parts." Unfortunately, these stories are common. The path to puberty blockers, hormone injections, and sex change surgery often begins with a young person struggling with various mental health issues who recently underwent a personal crisis. At a loss for how to help their child helpless parents seek the advice of medical specialists who believe they will provide objective evidence-based guidance. After a brief meeting with the child, the specialist may proclaim that his or her problems can be solved by undergoing a medical transition. Parents may be told they should affirm their children's identity lest they put their child at a greater risk of suicide.

Parents are thus confronted with a terrifying choice. Either consent to gender-affirming care or their child may die. As one of the most public champions of these therapies exclaimed more than a decade ago, "We often ask parents, would you rather have a dead son than a alive daughter?" Confronted with this terrifying choice, parents sometimes are told that puberty blockers will give their child time to think, and make an informed decision about transitioning. What parents often aren't told however is that puberty blockers don't delay puberty, they suppress it entirely, and that most children on puberty blockers move on to sex hormone injections.

In such cases, puberty blockers do not buy a child or his parents' time to think. They are a gateway drug to a lifetime of expensive hormone injections and sex change surgeries. The stories we will hear today paint a troubling picture. Lured by the promise of a fail-safe cure for their mental health problems and kept in the dark about the permanent and irreversible effects of medical transitioning, these young

people and their parents say they were coaxed to open their minds, their hearts and their wallets to the miraculous healing powers of puberty blockers, hormone injections, and sex change surgeries.

There is only one problem. It isn't true. And that isn't me saying it. That is a quote from The Atlantic written by the same reporter who previously accused the Trump administration of carrying out a nasty campaign on this issue. Europeans have a few decades of empirical experience to offer us on this. A 2024 report on gender identity services commissioned by the UK's National Health Service called the CAS report after its author found no evidence to support the claim that puberty blockers improved a child's body image or gender dysphoria, no evidence to support the claim that gender-affirming treatment or sex hormone injections reduced a child's risk of suicide, and no evidence to support the claim that social transition in children led to positive mental health outcomes. Most importantly, the report did not find sufficient evidence to support the claim that gender-affirming care, puberty blockers or sex hormone injections had a positive effect on the psychological well-being of patients.

The report criticized many of the most popular clinical guidelines for recommending medical transition in spite of insufficient evidence about the risks and benefits of medical treatment in adolescents, particularly in relation to long-term outcomes. More specifically, the CAS report notes that the most influential clinical guideline published by WPATH overstates the strength of evidence in recommending medical transition for adolescent children. The shocking disjunction between the science behind these treatments and the claims made about them is hardly limited to Europe. Just last year, the New York Times ran a lengthy expose about how one of the leading advocates of these treatments refused to publish the study, the results of a nearly ten-year study that suggested that "puberty blockers do not lead to mental health improvements in children diagnosed with dysphoria." She refused to publish the studies of her results because she worried they might provide support to state governments who were regulating this care.

You heard me right. She refused to publish the results of her scientific study because of her politics. This disjunction played out before the Supreme Court of the United States just months ago. During oral arguments in United States against Skrmetti, the Biden administration's solicitor general attacked Tennessee's regulation of gender-affirming care for children because it failed to "take into account the significant health benefits that can come from providing gender-affirming care, including reduced suicidal ideation and suicide attempts." But just a few minutes later, the lawyer representing the private plaintiffs attacking the law made a shocking admission in response to Justice Samuel Alito's question about the CAS report. "There is no evidence in the studies that this treatment reduces completed suicide." This had been the whole premise behind the push for gender-affirming care, a choice between hormones and sex change surgery or suicide, but there is no evidence to support that premise.

Indeed, the state of Alabama's brief filed in the same case revealed in gruesome details the length to which the Biden administration went to deny this reality for fear of political consequences. Now, why does all of this matter to the Federal Trade Commission? As chairman, I am not charged with passing moral judgment on anyone's ideology, lifestyle, or medical choices. I am charged, however, with protecting my fellow citizens from unfair or deceptive trade practices. And experience has taught us that the more vulnerable the population, the more likely they are to be targeted with deception. For example, people who suffer from chronic or terminal diseases are more prone to be deceived by healthcare scams. Taking advantage of their desperation, modern snake oil salesmen promise them the moon, an affordable and scientifically proven cure that will succeed where all conventional medical treatments have failed. Of course, the cure is not scientifically proven to be effective. The salesman just presents it as though it were.

The FTC's statutory mandate is to protect vulnerable people from deceptive claims about health and cures. Now, I have heard it argue that the commission ought not to address today's topic at all because

the commission does not regulate the practice of medicine and because the topic is politically controversial. Both arguments are categorically wrong, and I reject them. First, the FTC is the federal government's guardian against false and deceptive health claims. We have brought dozens of enforcement actions against false and misleading health claims from shyster snake oil salesmen to powerful pharmaceutical companies. We have won actions against individuals selling everyday herbs and spices as cures to cancer, organizations overstating the effectiveness of their products in preventing COVID-19, and medical centers making unsubstantiated claims about their efficacy in treating chronic diseases. Time and time again, we have enforced the FTC act against businesses and individuals who have made claims about their health products and services that were not backed by scientific evidence.

Just last year, we won a judgment against a company that "tricked people, who needed real help into buying expensive and unproven stem cell therapy." This was the deceptive medical care aimed at vulnerable people, the elderly and the disabled. We won another judgment against the makers of a popular supplement, who made claims about the mental health effects of the supplement "without competent and reliable scientific evidence." It's taken directly from the district court judgment in that case. The Biden Administration's chief consumer protection enforcer publicly warned after the victory that "companies should take note and remember that health claims need to be backed up by reliable scientific evidence." I agree. The Biden administration FTC also put out 40 pages of guidance on what the FTC Act requires for businesses making health claims, noting that the FTC Act applies to all claims about medical products and cures, and that claims that consumers cannot easily assess on their own must meet an incredibly high standard of scientific substantiation. The issue we address today is no different than the health claims we have addressed for many decades. Second, I acknowledge that many people feel passionately about this issue, but if a medical claim is false or misleading, it is the commission's sworn duty to protect American citizens from that claim no differently than it would for any other false or misleading claim. Refusing to investigate these health claims and the potential consumer harm to parents and children, merely because one political party supports those claims as a matter of its ideology would be the politicized choice. And that is why we are here today, to ensure that parents and children seeking professional help in a period of intense distress do not make potentially life-altering choices under veil of deception, misinformed about the risks and benefits of gender-affirming care. We are not here to pass judgment on anyone. We are here to ensure that those who make claims about gender-affirming care are held to the same standard we apply to everyone else who engages in commerce.

We are here to ensure that everyone can make an informed choice about their own path to healing without fear of being deceived by those who stand to profit from certain medical interventions. Considering our common goal today, I want to outline briefly the FTC's perspective on what counts as a deceptive trade act or practice. For an act of practice to be deceptive, it must satisfy three elements. First, the act of practice must be likely to mislead the consumer. And this can be done either through commission, for example, making a false or misleading claim, or through omission, for example, failing to disclose certain information that would prevent a claim from being misleading to a reasonable consumer. Second, the act of practice must be likely to mislead a reasonable consumer acting in similar circumstances. In the case of acts or practices that target specific groups, for example, children or vulnerable parents, the test is whether the act is likely to mislead a reasonable member of that specific population. And third, the act of practice must be material to the consumer's decision to purchase the service.

For example, if a child or his or her parents would not have chosen puberty blockers had they been aware of the risks associated with those drugs, the omission of this fact by medical practitioners may be considered material. The purpose of today's workshop then is clear. The FTC must understand what sorts of claims are being made about these treatments, what sort of science supports them, what the

risks associated with those treatments are, and whether vulnerable populations may have been subject to deception in the administration of these treatments. They're the same sorts of questions we would ask about any health claim, no matter how politically charged. Americans have a right to health claims substantiated by reliable scientific evidence, they have a right to be informed about information that would be material to their decision to accept hormone therapies or sex change surgeries. The FTC's mandate is to protect those rights in this context as it does in every other healthcare context.

While not everyone who undergoes gender-affirming care will necessarily experience the same painful loss and regret that Prisha, Claire and Soren have experienced. Every young boy and girl, every concerned parent and guardian has the right to be informed of all the material information about the risks of these procedures. I promise that our agency will do everything in its power to achieve that end. Finally, a brief note on what comes next. Following the conclusion of today's workshop, the commission will issue a public request for information on the various topics that we are discussing today. We will issue it sometime next week after we have had time to digest everything we learned today and can tailor our request for information based on what we learn. The public will have 60 days to respond to that request and encourage every single person here to submit a response. We will also provide a mechanism for individual members of the public to submit information they wish the commission to keep confidential. Thank you very much for your attention, and I look forward to today's conversations. So next we have a panel of parents and survivors of these treatments that I will moderate for about a half hour. And while they're coming up here and I'll briefly introduce them, but really the goal of this panel is to let them tell you and the American people their stories. I want to give a quick word of thanks to Jon Schweppe, a policy advisor in my office, who put together today's workshop. Jon has worked on these issues sometimes quietly and subject to great criticism. Before we brought him onto the commission, he has been a tireless advocate for people who have suffered in this industry. And we could not have put on today's event without Jon. So Jon, thank you.

So I'm going to briefly introduce the panel before we begin. We are joined by Simon Amaya Price and his father Gareth, Claire Abernathy of whom I talked in the speech, Elvira Syed and Kayla Lovdahl. Okay, so I don't think anyone here wants to hear from me anymore, so what I'd like to do is go down the panel and we'll start here with you, Simon. Tell us your story about your experience with gender-affirming care. And once we've heard from each of you about your experiences both as patients and as parents, I'm going to then ask what do you wish you had been told early on in the process before treatment began? But why don't we start, Simon, with you and your story?

Simon Amaya Price:

Yeah. First of all, I want to thank you for that amazing presentation. I think that was a very balanced, very apolitical and really great, so thank you for inviting us. Thank you for everybody who's here in the room, and thank you for everybody at home who's watching either live or after the facts. So as mentioned, my name is Simon Amaya Price. And I wrote something ahead of time and then I didn't like it and then I wrote another thing and then I didn't like that either, so I'm just going to speak from the heart here. When I was 14 years old, I was going through a really tough time. I was at a new high school, and I had been ostracized by a group of friends. And shortly after I was sexually assaulted by an older boy at my high school. After this, I sought out a therapist at Boston Children's Hospital at their Waltham location with a combination of what I had been exposed to in school and my conversations with my therapist and obsessive Googling as any kid in my situation would do.

I concluded that I was transgender, that I was really a girl inside. I told my therapist this, and she immediately affirmed me. She said that I'm so brave. She told me not only that I'm brave, but at the same time that she had given instruction to my father to count all the knives in the drawer because I was at risk of self-harm. She encouraged me to go behind my parents' backs to attend transgender

support groups. I was referred to the gender clinic by her, my psychopharmacologist and my pediatrician. Around my 15th birthday, I remember meeting with my pediatrician, sharing with him my transgender identity, and my gender dysphoria diagnosis. I told him that my dad was refusing to take me to the gender clinic. The pediatrician then asked my dad in front of me, would you like a dead son or a living daughter? This isn't just a line used by activists. This is a line used in healthcare settings by the doctors that your kids are seeing in your communities all across this country.

I'm one of the lucky ones. I only socially transitioned. I only lost a couple of years of my life. I didn't lose any body parts. I thank God every day, whether or not he exists, that I'm whole and I'm here today. I was lied to by the medical professionals. I was supposed to trust the same medical professionals who gave me antibiotics, when I had strep. I was told that changing my name, my pronouns, socially transitioning, taking cross-sex hormones, undergoing surgeries would fix me. That was all a lie. And I'm here telling you that today. If I were there again, I really wish that my doctors would've asked me about any history of sexual assault. Maybe if they would've talked about the two years of homophobic bullying I endured in seventh and eighth grade, where kids threatened to kill me and called me the F-slur on a near daily basis.

Maybe that would've helped. Instead of telling me I was really a girl inside and reaffirming my delusions. I wish they told me that I was born in the right body, that I am perfect just the way I was because nobody told me that, nobody I paid attention to at least. Wanted to put that in there for you, dad. And I'm lucky, and look, I could have gotten hormones when I was 16, but COVID happened and I was out in Western Massachusetts for college. And my dad worked as a statistician at Raytheon, so an expert in evaluating methodology and statistical relevance. He read up on all of the science. He is the only reason I am here in front of you today full in one piece, unharmed. Please give him a round of applause. We cannot expect every parent to be a trained statistician, and that's why we are here today. What else do you want to know?

Andrew Ferguson:

That was great, Simon. Thank you.

Simon Amaya Price:

Thank you.

Andrew Ferguson:

Thank you for speaking from the heart. Gareth, tell us what this is like as a parent.

Gareth Amaya Price:

Well, I'm going to stick to my prepared remarks. Hello, I'm the father of a 21-year-old man. He was born male 21 years ago, and he's been male every day since. Even when he and medical professionals told me he wasn't anymore, they were wrong, and the proof is right next to me. In the spring of 2019 when my son was 14 in the ninth grade, he began seeing a therapist and psychopharmacologist at Boston Children's Hospital in Waltham because he was in great distress, suffering from anxiety, depression, confusion, and intrusive thoughts. Our son had already told my wife and me that he believed he was really a girl inside, after which I embarked on weeks of research about the nature and social manifestation of trans ideation in adolescence, all of which validated my instinctive response that it was delusional. Our son did not always have a happy childhood, in part because of the confusion caused by undiagnosed autism, and puberty was traumatic for him.

He cried if a gas station closed. His own body changing, upset him profoundly. He was a target of bullying both by boys physically and by girls socially. The boys threatened him and called him homophobic slurs and the girls shunned him mostly for not acting like they thought a boy was supposed to. The psychiatrist and psychopharmacologist at Boston Children's were supposed to be treating him for anxiety and depression, but when he told them both, he believed he was really a girl in a boy's body. They repeatedly suggested to me that I should take him to Boston Children's Gender Center GeMS. I deflected these suggestions and encouraged them to refocus on his anxiety and depression.

I already knew then what is public knowledge now that GeMS universally agreed kids were the wrong gender and only gave a cursory assessment before recommending medical intervention. The psychiatrist did not like it that I did not take my son to GeMS. I felt I had to walk on eggshells to avoid her recommending to child services that my son be taken away from our family by CPS. She had already suggested he be put in an inpatient facility. I believed that his trans ideation was caused by his anxiety and depression, not vice versa. And that concretizing this delusion through medicalization was a terrible idea. I was right, but I had to keep quiet. At the same time that I was instructed to keep our son under close watch for self-harm, the psychiatrist at Boston Children's was telling him behind my back, to sneak away from home and go to a transgender support group. I was counting knives in the drawers and checking on him every half hour, and she was telling him to lie to me and escape my supervision. That June at his annual pediatric visit, my son told his doctor who had known us for several years that he was really a girl inside. The doctor immediately agreed and offered to refer him to GeMS. I told the doctor I thought that was absurd, as I had known the boy his entire life, and that transgenderism was a phase he would get over, a temporary result of his adolescent misery. I knew then that research supported my view and now hindsight does too. The pediatrician told me he sent every kid who said he was transgender to GeMS.

When I told the pediatrician I didn't intend to take him to GeMS, he asked me in front of my son whether I would like a dead son or a living daughter. That was emotional blackmail and in my opinion malpractice. I chewed the pediatrician out thoroughly for that abuse and we never saw him again. He quit the practice. I think he should have quit the profession, but he just moved one town over and manages a practice there now. I shudder to think how many kids he's medicalized by now.

Later that spring, the Boston Children's psychiatrist and Psychopharmacologist refused to keep treating my son and referred us to a private pay facility. I can't say the name of that facility, because they did a good job treating his anxiety and depression. And treating a child with transgender ideation in any other way than so-called affirmation therapy is illegal in Massachusetts. As I suggested to the several medical professionals who tried to get me to chemically castrate my son, he eventually outgrew the idea that he was really female on the inside and reconciled himself with his sex. Here he is today a happy and healthy man.

Chairman Andrew Ferguson:

Claire, tell us your story.

Claire Abernathy:

[inaudible 00:36:13]. Is this on? Hi friends. First, I want to a little disclaimer, that I wear my heart on my sleeve, so please don't mind my voice shaking while I speak. I want to thank the Federal Trade Commission for inviting me to speak today. I'm grateful for the chance to share my story, because I believe that what happened to me and what's still happening to so many others is an urgent matter of consumer protection and fraud. My name is Claire and I'm a detransitioner. A week after I turned 14 years old, I was put on testosterone by Dr. May Lau at Cook Children's Hospital in Dallas, Texas. Six

months later, Dr. Alan Dulin with the American Institute for Plastic Surgery in Plano, performed a double mastectomy on me.

I was too young... Sorry. I was too young to get a tattoo. I was too young to drive. I hadn't even learned... Thank you. Thank you, Jamie. I hadn't even learned algebra in high school yet, but I was old enough to choose to have healthy parts of my body electively amputated. I was sold a product, medical transition, by professionals and institutions who told me that it would fix my distress and save my life. I was told that if I didn't do this, I would probably end up dead.

But here's what they didn't tell me. They didn't tell me that taking cross-sex hormones and undergoing major surgery at 14 years old could leave me with pelvic floor dysfunction and urinary incontinence, problems I have to manage now as a young adult. I'm only 20 years old. They didn't tell me that these complications are common enough to be known risks, and yet they were hidden from me at an age where I didn't even understand what these terms meant, let alone the impact they would have on my daily life, and it doesn't stop there.

When I tried to warn others by leaving honest reviews on my surgeon's websites, describing my regret, the complications, the lack of real informed consent, my reviews were deleted. Think about that. A surgeon permanently altered my healthy body when I was a middle school student and then erased my negative feedback to protect his reputation. If that doesn't sound like fraud, I don't know what does. In any other context, selling a medical product in this way with half-truths and hidden side effects would be considered fraud. If a pharmaceutical company pushed a drug on children without disclosing the lifelong damage it can cause, they would be sued out of existence. If a cosmetic surgeon buried evidence of complications, they would be shut down. But when it comes to gender medicine, it's not just allowed, it's celebrated. And anyone who asks questions is called hateful.

Every week I hear from more young men and women like me, people who are convinced as kids or as teenagers, that the only way to survive was to become a lifelong medical patient. We now live with the irreversible consequences, the scars, the side effects, the pain and the grief, and we watch helplessly as the same professionals and clinics keep selling the same product to the next generation of vulnerable kids while silencing those of us who speak out. Let me be clear, it is not in my wheelhouse to say that no one should ever transition. I'm here to say that when you sell a product, especially one that removes healthy body parts and alters your life forever, the consumer deserves the whole truth. They deserve honest disclosure of all of the risks, possible outcomes like regret, and alternative treatment options. They deserve the right to share their negative experiences without being censored.

At 14, I trusted the adults who were supposed to protect me. Instead, they sold me a dream that turned out to be a nightmare. That's not healthcare. It's blatant consumer fraud. I want to thank the FTC and those in the audience again for giving people like me a seat at the table. Please hold these providers and pharmaceutical companies to the same standards as any other industry. We need real informed consent. We need oversight, and we need to make sure that no more kids are sold a product they can't return. Thank you for listening.

Chairman Andrew Ferguson:

Thank you for your tremendous courage, Claire. Elvira, let's hear from you.

Elvira Syed:

Good morning everyone. First, I want to thank FTC for having me here and giving me this opportunity to share the tragic story of our family. My name is Elvira Syed, and I lost my... I'm sorry. I lost my 17-year-old daughter, Ilene, to gender ideology and the system that failed her at every step. Ilene was exceptional, despite being on autism spectrum, she spoke four languages, played five instruments, held

two black belts in martial arts and earned a full tuition scholarship to Rider University. But behind all those accomplishments was a young woman silently battling anxiety, depression, trauma, and self-harm, especially after losing her father to cancer at age 12.

During the pandemic, like many other kids, she spent too much time online and after cycling through several LGBTQ labels, she finally declared she was transgender. Before college, she began seeing a therapist who immediately affirmed her identity, no question asks, no effort to understand her trauma or mental health, no curiosity about why this identity emerged so suddenly. When she got to campus, things got worsened. She cut me off and at the age of 17, at that point, she was introduced to a transgender pastor from Metropolitan Community Church in Hartford, someone who barely knew her but filed a complaint against me with the Department of Children and Families. Why? Because I refused to accept my son's identity.

The goal was to remove me so the state could step in and give Ilene all the care she supposedly needed. From that moment, I lost any access to my daughter. I would like to thank Project Veritas for taking a deeper investigation and finding out that that pastor who filed that complaint against me was providing free binders to minors behind their parents' back. In January 2024, Ilene began therapy at the Pride Center referred by Rider University. The therapist there, a transgender man, also affirmed her. And I have to wonder, was this therapist affirming Ilene solely because that's what modern guidelines encourage, or was it also because of her own subjective viewpoint, her personal identity? Was this care or ideology disguised as therapy?

In a therapist's own notes, she documented Ilene's history of self-harm, suicidal ideation, and autism spectrum disorder. On one entry she wrote, "The client stated that most of the time he's feeling blank when he zones out or can't remember, and other times it is like he's watching himself through a screen." To me, this is a massive red flag, dissociation, detachment, instability, but no follow-up was done. No second opinion, no attempt to contact me, her only living parent. Instead, the therapist reinforced Ilene's belief that I was unsafe to be around and referred her to an endocrinologist.

When I finally saw the endocrinologist's notes after Ilene's death, they mentioned only anxiety and depression, nothing about suicidal thoughts, nothing about trauma, nothing about self-harm. Her visit was marked as a well visit. There was no physical exam, no mention of the visible scars on her arms, no signs that her condition was truly assessed and absolutely no indication of an endocrine disorder that would justify a prescription for hormones.

And when talking about side effects, the only side effect discussed was fertility. On that very first visit, Ilene was given a prescription for 40 milligrams of testosterone per week and the referral for double mastectomy on that very first visit. In that referral letter, the doctor or APRN falsely claimed that Ilene had dreamt of being a boy since age eight. That was never true. My insurance was charged for this against my will. When I saw this pharmacy alert, I was horrified. Testosterone can increase aggression, emotional numbness, and suicidal thoughts, especially in a vulnerable unstable teen. But no one stopped to ask if it was safe.

On just her second visit, APRN increased her dose to 60 milligrams per week, even though her chart noted worsening side effects like acne and bleeding, her testosterone level at that point was 289. For reference, the normal female range does not exceed 45. In October 2024, my daughter died by suicide. She overdosed on Benadryl, her body lay in her dorm for four days before anyone found her. The school waited another day to call me. During that time, they were celebrating national coming out day. The autopsy revealed new self-harmed wounds on her thighs. According to the detective report, her friend said Ilene's depression was getting worse. She was struggling and she was having difficulty with transition.

Those entrusted with her care didn't treat her depression. They didn't explore what was underneath the identity. They didn't even tell me what was going on. They treated her ideology, not her illness. What she got instead was a fast-track prescription and an ideology that told her pain was proof she needed to keep going down that path. Ilene deserved better. Every child does. And answering your question, Chairman Ferguson, what would I wish was different? I wish Ilene had met the very true therapist who would really care about her, not about promoting an ideology on a vulnerable teen, because therapy is not identity validation. It's a life-and-death guidance and if done poorly, it leads to the irreversible, sometimes fatal consequences.

Chairman Andrew Ferguson:

Thank you so much, Elvira. Kayla, let's hear from you.

Kayla Lovdahl:

Hello, and good morning to everyone here. My name is Kayla Lovdahl. I go by Layla Jane online, and I am a survivor of gender medicine or a detransitioner. I am someone who has been dosed with Lupron and testosterone starting at 12, I received a bilateral mastectomy just one month after my 13th birthday. I went straight from training bras to binding, straight to the operating table at 13. The reason why, is because I had undiagnosed autism and unaddressed childhood sexual trauma. I was scared to become a woman. I was getting unwanted male attention, which made me fearful of being victimized again. I had sensory issues I didn't know how to cope with when I began menstruating and needing bras.

I learned about transgenderism at 11, and I thought maybe that was the reason I was so uncomfortable. I brought the idea to the therapist I'd been seeing, and she immediately affirmed me, gave me a diagnosis of gender dysphoria. And once I told my parents, she began writing referrals for doctors specializing in pediatric transition care. Never along the way did anyone question why I suddenly wanted to become a boy. They didn't comprehensively screen me for mental health disorders or ask me about any prior trauma.

I saw Susanne Watson in Kaiser Oakland's Pride Clinic, and within 90 minutes she signed off for me to receive testosterone and meet with a surgeon named Winnie Tong. The mastectomy was explained to me at 12 using watered down terms like top surgery. I was told I would never be able to chest feed. I was told I might lose sensation, but to me, at 12, that equated to numbness. But today I deal with nerve pain, extreme slicing sensations, electrical zaps and itchiness. I could scratch my skin until I bleed, but with no relief, because the skin is numb and doesn't register touch, however, the nerves underneath are erratic.

I'm nearing eight years post-op this September. As you can probably all tell, my voice is permanently lowered from the testosterone I took from 12 to 17. I do have a slight Adam's apple. I can't raise my voice for long periods of time. I can't scream if I'm in danger. Mind you, I'm a pretty small person standing at about 4' 11". I still grow facial hair that I have to deal with. I have atrophy and urinary issues. Testosterone also damaged my liver. I've had fatty liver disease since about 14.

The Lupron essentially put my body in menopause. I gained weight. My psychiatric issues flared up. I experienced intense hot flashes, which made it really difficult to focus on my seventh grade homework. Today I live with chronic joint pain. I'm only 20. At no point along the way was I offered an off-ramp. I didn't even know what detransition was until I was almost 18 and began to taper myself off the hormones, scared to go back to the doctors. Even at 18, I called member services and requested my name and gender marker be switched back and to receive a new insurance card to reflect that change. Weeks later, I received one in the mail with my male name. I'm here today to speak out against gender-affirming medical practices for minors. We are letting vulnerable children be irreversibly harmed by a

medical system that affirms without asking why. We need to protect children from these rushed experimental interventions. Let kids grow up whole. Thank you.

Chairman Andrew Ferguson:

I don't think anything could be added to what we just heard. And so I'm going to close with only two comments. First, I'm not sure in my life I've ever seen more courage displayed than what I just witnessed in the last 30 minutes. And second, I want you to know the FTC hears you. We hear all of you. We want to understand what's going on so that if the law is being broken, we can stop it. So thank you for being here for this today.

Jon Schweppe:

Thank you Mr. Chairman, and thank you to the parents, Gareth, Elvira and the survivors, Simon, Claire and Kayla for sharing your personal experiences. So now we're going to shift over to a presentation. So thank you, guys. Dr. Miriam Grossman, MD is board certified in child, adolescent and adult psychiatry. Her current practice focuses on youth who have distress about their sex and their parents. She's a senior fellow at donoharmmedicine.org, the author of five books, including You're Teaching My Child What? and Lost in Trans Nation. Dr. Grossman's work exposing the origin and hazards of the sexuality and gender industry has been translated into 11 languages. In fact, Dr. Grossman of her own volition, brought books here today to share with attendees, and I haven't checked, but I'm pretty sure they're in English. She has testified in Congress and lectured at the British House of Lords and the United Nations. She's featured in The Daily Wire's What is a Woman documentary, Fox Nation's The Miseducation of America, and many other documentaries and popular podcasts. Her expert psychiatric opinion is sought for witness testimony and court reports. Please welcome to the stage Dr. Miriam Grossman.

Dr. Miriam Grossman:

Good morning. Thank you, Chairman Ferguson, John Schweppe, Brandon Scholter. Thank you also to Jackie, Simon, Maria, Laura, Prisha, Kayla, Beth, and Forrest for sharing your medical documents with me. And actually the books that are out there, my Lost in Trans Nation, that's thanks to Do No Harm. So thank you very much, Do No Harm. Section five of the FTC Act says, as you heard, that fraud and deceptive practice means representing as facts, things that are entirely unproven or demonstrably false, thereby misleading the consumer in a material way. When I examine gender-affirming care and the history that led up to it, I see fraud and deceptive practice everywhere. Going back decades, I see it in the landmark experiment on Bruce Reimer when he was a toddler and John Money instructed his parents to socially and medically transition him. This was to be Dr. Money's proof for a concept he'd come up with in 1966 called Gender Identity. Dr. Money announced to the world that the experiment was a resounding success. And for years, the world believed it. But in fact, it was a catastrophe from the start. Decades after Dr. Money, consumers were misled again when gender specialists took the results of one tiny Dutch study, whose subjects were carefully chosen and led parents to believe that every child distressed about their sex could benefit from that model of care.

And now, families are told there's a consensus among clinicians about the best way to help these children, but there is no consensus. What there is, is the silencing of opposition. There are many more examples that you're going to hear about today, but I think it's fair to say that the fraud is wide and it's deep. I decided to focus on three topics, deceptive practice in language, in medical records, and in therapist's letters for support of hormones and surgeries. But first, before discussing fraud and deception, I'll remind you of what's true.

Humanity is divided into two biological categories. Male and female are established at conception. While there are many ways of being male or female, sex does not change and cannot be changed. These are universally acknowledged facts, but gender-affirming care is based on their denial. The premises of gender-affirming care are every person knows best who they are, regardless of their age, development, or mental health. All gender identities should be rubber-stamped by parents, doctors, therapists, and teachers. Medical interventions, including the removal of healthy organs, must be available on demand.

Gender Affirming Care's denial of biological facts is right in front of us. We don't need to make any FOIA requests to see it. All we need to do is examine the language. Look how aggressively the proponents of gender-affirming care compel the language of doctors. This is from a course given by a Doctor Erica Metz, medical director of transgender health for Kaiser Permanente in San Francisco. In this course, doctors learn that there are acceptable and unacceptable terms. For example, sex change operation is not acceptable. Doctors must say gender-affirming surgery. Born male is unacceptable. The proper term is assigned male at birth. Here's another slide from the same course. Always use the pronouns the patient asks you to use, regardless of what they look like to you or what their name is. And the red highlight, I didn't do that. That was from the original.

Why is it so critical to Kaiser to control their doctor's speech? Well, they know what George Orwell taught us. Language is an instrument. It can be shaped for a particular purpose. It can change the way we think. I'm going to go through some of the vocabulary of gender-affirming care and demonstrate how this language is designed to change the way that we think about male and female and to mislead consumers in a material way. So basically, what I'm suggesting today is that all of these terms are Section 5 violations.

Gender identity. We are told that whether we know it or not, we all have an inner sense of being male, female, both or neither. And that's represented by the brain in this slide, which by the way, comes from a sex education course. And we're told that that sense not only is untethered to material reality, but it overrides it, which is the body there. The brain overrides the body. You can have, for example, a girl's brain in a boy's body, and that boy is actually a type of girl, a trans girl. This belief is the cornerstone of gender-affirming care. It's represented as factual. It's not up for discussion.

Now, science studies the material world, the world that can be directly observed, measured and verified. The proponents of gender-affirming care declare that a person's inner sense, something that cannot be directly observed, measured, or verified, is more authentic than the material world. Now, what would you call that? Is that a philosophy? Is that a religion? I'm not sure, but I am sure that the idea is entirely unproven and unprovable in the same way that we can't prove the existence of a soul, even though we might believe in one. There is no objective evidence of being born in the wrong body and saying so misleads and takes advantage of consumers, and it impacts their medical decisions.

I know from my patients and many others, that when young people hear the idea that their feelings are more consequential than their bodies, and when they hear this idea endorsed with great certainty by therapists and doctors, echoed by professional organizations and government agencies, they believe it. They believe that this is bona fide science and that they have a medical condition whose only cure is pharmaceuticals and surgeries. Here's Dr. Gallagher, our favorite Miami surgeon. Girls see the language on her website, female to male procedures, and they genuinely believe that Dr. Gallagher can turn them into boys. And here's Johns Hopkins telling boys they can get female genitals. Boys see this and they think they can get an actual vagina and be a woman just like any other. But Johns Hopkins and Dr. Gallagher cannot do these things. Their claims are demonstrably false. They deceive and exploit vulnerable and misinformed consumers and their families.

Preferred pronouns. If you can pick your pronouns, it means that your feelings determine who you are. And it means, again, that biology is inconsequential. Preferred pronouns are part of social transitioning,

and we know that social transitioning increases the odds that gender dysphoria will persist. Nevertheless, the captured American Association of Child and Adolescent Psychiatry instructs parents, "Use the name and pronouns your child prefers." Chicago Children's Hospital have pronoun stickers for staff, and the pressure is intense. Trust me, I've talked to a lot of people working in hospitals. The pressure is very intense for staff to wear these pronoun stickers. In my opinion, using opposite sex pronouns endorses something that can never be. It supports a patient's false belief and it impacts their medical decisions. So that's fraud right there. Sex assigned at birth. The purpose of that phrase is to lead people to think that male and female are a random designation, a doctor's whim. This is utterly false. I don't have time to discuss intersex. You're going to be hearing about it later. But the sex assigned at birth term, which we hear 24/7 everywhere, is designed to change the way that we think about male and female. Instead of it being a inherent quality of every one of the billions of cells in our body.

Cisgender and non-binary. The word cisgender was invented in 1994 by a graduate student at the University of Minnesota. The inventor explained, "There did not seem to be a way to describe people who were not transgender without inescapably couching them in normalcy and making transgender identity automatically the other." This student was unhappy, in other words, about how the transgender identity was perceived. And the goal of creating the word cisgender was to change that perception. So again, the goal was to change how we think. We are given the impression that cisgender is a scientific classification of people, but it's not.

Non-binary. We are told this is a valid identity for people who are both male and female, neither male and female, or some other combination of male and female. Kaiser Permanente provides this menu of non-binary options. We might think this is silly and it is, but to vulnerable youth, it means that they can have a new identity every day of the month. If identity is based on feelings and you feel different from day to day, then why not? Do you see why so many young people are confused? I once had a 15-year-old patient who identified as non-binary. I asked him to explain what that meant. He thought for a moment, and he gave me hands down the best definition of non-binary I have ever heard. Excuse the language. I would never speak this way, but it's refreshing to hear the truth.

Moving on. Wrong puberty. That's a disturbing one. Puberty is not a disease. You're going to hear more about that from Dr. [inaudible 01:09:01]. Using that phrase is profoundly misleading, as if someone can go through the wrong puberty.

Top and bottom surgery. These are dangerous euphemisms. They're meant to distract you from what they really are. The removal of healthy organs causing disfigurement and a laundry list of serious medical problems, as you've just heard, and you'll hear more about that from Dr. Lappert. Justice Thomas called top and bottom surgery sanitizing language. And he got that right.

Genital reconstruction. Nope. Reconstruction means that particular genitals were once there. That's demonstrably false. A surgical procedure that creates a faux vagina is not reconstruction, it's construction. Same with hormone replacement therapy. You're not replacing anything. It's not the same as giving estrogen to a post-menopausal woman, and it misleads the consumer.

And finally, chestfeed. The CDC until recently, because their site was scrubbed and this page is no longer there, it endorsed the idea that men can lactate. Well, the female body is designed to lactate. The male body is not. Men do not lactate unless they have a medical disorder or they're pumped full of drugs that cause a nipple discharge. This is altogether different from the natural process of lactation that occurs in women. The term chestfeed, aside from erasing women in a most offensive way and dehumanizing all of us, misleads boys and men.

To summarize. The language of gender- affirming care seeks to deny the primacy of biology in determining male and female. It advances the notion that feelings override the objective reality of our sexed bodies. Such beliefs can harm patients and are not consistent with science in the 21st century.

Now, fraudulent language in medical records. I'm going to tell you about this case that was reported in The New England Journal of Medicine. I'm not giving you all the details. This is a very concise review. And this article in The New England Journal called this woman a man and he.him pronouns, so I'm going to go ahead and do that, even though I normally wouldn't. 32-year-old Sam came to the emergency room. He had intermittent lower abdominal pain and high blood pressure. He told the triage nurse that he was a transgender man. His electronic medical record indicated he was male. The nurse noted that Sam was an obese man, and he was comfortable between his bouts of pain. She assessed his condition as non-urgent. Lab tests were ordered, including a pregnancy test. It took several hours for Sam to finally be seen by a physician who took a detailed history, reviewed his lab results, and did a physical exam. He determined that Sam was in labor and had pre-eclampsia, which is an emergency that can be fatal for mother and child. A heartbeat could not be found on the ultrasound. And soon thereafter, Sam delivered a stillborn baby. Though he had obviously not planned or expected the pregnancy, he was heartbroken, and the loss of his baby produced a major depressive episode.

The language of medical records must be accurate. There was once a standard way to indicate a patient's sex in medical records, but no longer. And I want to give a shout-out to Dr. Carrie Mendoza for pioneering the work on safety in electronic health records and writing a model policy. With her help, Texas passed legislation requiring not gender identity, not legal sex, but actually just sex, male or female, on medical records.

So why is it so critical to accurately indicate a patient's sex on medical records? Well, we can see from Sam's story, of course, what happened, but there's much more. The X and Y chromosome have a deep and lifelong impact on each organ system. In fact, on each cell. There are significant differences between male and female in health and disease, and there are thousands of examples of this. For example, women are more likely to develop certain heart arrhythmias. 80% of autoimmune diseases are in women. Certain drugs are more powerful in one sex than in the other. So it's potentially life-saving to have the correct sex identified on medical records. Not gender identity and not legal sex, because that can be changed. But here's what's going on, and this is from NYU Langone Hospital. In 2018, this child was identified as a female, but two years later, this same child was identified as a male. At the Oregon Health and Science University, this is a surgeon's entry for a ma,n Forrest, who you're soon going to meet, who came in for breast implants, and it says the sex is female. And even more, well, equally incredible is that this surgeon's note for purposes of insurance coverage stated that this is a woman with underdeveloped breasts who needed a more feminine shape to her breasts in order to help with her gender dysphoria. Again, this is for the insurance companies to cover the cost of the prosthetic breast insertions. And if someone wasn't careful in reviewing these records, they would've thought that this is a young woman who simply has underdeveloped breasts.

This is back to Kaiser again, Kaiser Permanente in California. This was an admission note for Layla Jane, who you just met. She came in for her bilateral mastectomy. And it's indicated here that she is a 13-year-old male.

Now, more from Kaiser Permanente. This patient is identified as non-binary. A non-binary patient. Now, this is not someone's Facebook page. This is not Instagram. This is a legal document identifying a person as non-binary. Boston Children's has something interesting, and this was given to me by Simon. You'll note it says legal sex up there on the top right. But that means that someone whose legal sex had been changed to a different sex, it would just say that up there. And then... Okay, they have something very interesting there. They have Boston Children. They have an organ inventory. An organ inventory. Now what's that? All right. You see a list of organs, okay? Breasts, cervix, ovaries, penis, testes. And what's supposed to happen here, I guess, is that I don't know if they were indicating that Simon had all these organs, or whether someone forgot to make a check mark next to the ones that he actually has. This is

not medical care. This is dehumanizing. I mean, that's a judgment call, I guess. But as a doctor, okay, this is not medical care.

Now, returning to Forrest, his records... Oh, yeah. Returning to Forrest, his records didn't say anywhere. It didn't indicate that he had gender dysphoria. Oh, I said that already. That the surgeon wrote that he suffers from a... Okay, feminine breast. I already did that. Now, I want to move on to the next thing. And this is the diagnosis endocrine disorder, not otherwise specified, and this is an example of a lab request for estrogen that was written by a Dr. Grace Evins, MD in... Where's this? North Carolina, right? South Carolina?

Audience member:

North Carolina.

Dr. Miriam Grossman:

North Caroline. Now, this is a male patient who's on estrogen, and the doctor, for probably insurance purposes, has indicated diagnosis E34.9. The lawyers in this room, take note. E34.9. I want to explain that to you. It means endocrine disorder, not otherwise specified.

Oh, here's another example. Sorry. Dartmouth College Health Service. Also, you see below that endocrine disorder, unspecified. Dartmouth. Oh, I messed up. Okay. And this is another one for feminizing HRT. But let me just get back to it. Wait, sorry.

Okay. What is diagnosis code E34.9? In the International Classification of Diseases, they have thousands of diagnoses. And so they've categorized all the endocrine, these are medical diagnoses are... Oh, I can see it over there. Okay. The endocrine diagnoses are between E00 and E89. These are endocrine, nutritional and metabolic diseases. So for example, there's hyperthyroidism, type 1 diabetes, polycystic ovaries. These are all medical diagnoses that are between E00 and E89. But then you have E34.9, endocrine disorder, unspecified.

What is that? So it says that this is an acceptable diagnosis when clinical information is unknown or not available for a particular condition. Okay? It's preferable to use a more specific code, but you can use that code when they accurately reflect what is known about a patient's condition. Now, all these people here, these medical records that I showed you, and I'll show you some more, these are physically healthy people. They have no medical diagnosis whatsoever. They have a psychiatric diagnosis. But this E34.9 is being used in a fraudulent way, I would say, in order to get payment for the services.

Now, this is what Planned Parenthood of Southeast Pennsylvania says. "In order to meet the needs of most insurance companies and patients, we typically use the code E34.9. We recognize that much of the language around billing for gender-affirming care is troublesome." What they mean by that is that it's called a disorder. When you say endocrine disorder, they're objecting to the word disorder. "We recognize this is medically necessary care and will work to decrease barriers to get folks the care they need." So they're explaining why they use that diagnosis. So here's... Whoops, I skipped ahead.

Okay, so what I'm going to do now is go into the fraudulent notes that are written for individuals who need letters from therapists in order to get their cross-gender hormones, opposite-sex hormones or surgeries, and how these letters are fraudulent.

So this is actually Prisha's note. You're going to meet her soon. On the first day that she saw this therapist, the therapist indicated that she had a major depressive disorder, recurrent, moderate. That is a serious psychiatric condition. It is a condition that impairs one's functioning and day-to-day life. And she also indicated that Prisha had an eating disorder, doesn't go more than two days without eating. That's a serious eating disorder if she sometimes goes two days and doesn't eat. Yet on the same day

that this therapist indicated this in her chart, she wrote a letter for testosterone saying there is an absence of problems related to mood. What? She just wrote the same day she has a major depression, an eating disorder. Yeah, like Simon's father right here. He's going like, yeah, like what? How can you do that? And she writes later on in the second paragraph, "There is no evidence of psychopathology." What? And the diagnosis, gender dysphoria, anorexia in remission. Nothing about the depression. Nothing about having not that long ago had serious self-injury and cutting, and a whole host of other mental illness diagnoses. So she writes for the testosterone the same day, day one.

She had also, this same therapist. Am I over time? Oh, I am. All right. Anyway, this is another therapist's letter for Prisha to the surgeon. And this therapist wrote, "He presents with no apparent residual psychiatric symptoms and is quite stable." Oh, no, no, no. Wait. This is Laura Becker's. Okay, I'm sorry. This is Laura Becker's, the letter that her therapist wrote to the surgeon. And Laura had been hospitalized for suicidality just two months before this letter to the surgeon for her bilateral mastectomy. Two months. You cannot say that someone that's just two months out of a serious psychiatric hospitalization has no residual psychiatric symptoms and is quite stable. It's misleading. It's misleading to the surgeon. And she also wrote that Laura demonstrated excellent insight into transition. Well, Laura was under the impression at that time, that this is the only thing that would cure her symptoms. This was the only thing that would prevent her from committing suicide. That is not excellent insight. That is not informed consent. So these letters omit critical information about the patient's mental health, information that impacts their ability to provide informed consent, and information that one would hope might make the surgeon think twice before using the scalpel.

So to wrap it up, here's what Admiral Levine said about gender-affirming care. Whoops. Oh. Oh, I messed up the letters. Well, you know what? They're all the same. They're all the same in the same bad way. So Admiral Levine said, "Gender medicine is a medical field like any other. It's all very carefully done." No, Admiral Levine, I don't think so. I don't think it's done carefully at all. I think this WPATH doctor put it more accurately. Dr. Marshall Dahl at a WPATH meeting. No audio? No audio. Okay, I'll talk for him. He said, "Not only are the medications off-label, the whole field is off-label, right? But that's all good." Well, I'm here to say, all of us are here to say that that's not good. It's not good at all. No more misleading the consumer. No more representing facts, things that are entirely unproven or demonstrably false. Families deserve much better, and today is a great start. Thank you for listening.

Jon Schweppe:

Thank you, Dr. Grossman, for that informative presentation. Let's take, I'm going to try to grab a couple of those minutes back. So let's take a quick seven-minute break and we'll be back in seven and then we will have our first panel. All right, everyone. Let's go ahead and get started again. If I can have everybody back to their seats. We're going to get started in the next one to two minutes. All right, everyone. Welcome back. Please have a seat. It is time now for our first panel, the Politicization of Science. And I'd like to introduce our moderator and attorney advisor to Chairman Ferguson here at the Federal Trade Commission, Annie Chiang.

Annie Chang:

Hi, everyone. Good morning. My name is Annie Chang and I'm a current attorney advisor to Chairman Ferguson. We've already heard firsthand this morning the accounts of the harms due to what some refer to as gender-affirming care by those truly on the front lines, the parents and the survivors. We've also heard from Dr. Miriam Grossman, pull back the curtain for us on some of the deceptive language, fraudulent medical records, and misrepresentations in letters used to support the medical and surgical procedures that amount to this type of so-called care.

Though we're speaking publicly about these things today, we should keep in mind how impossible this type of event felt not too long ago. For much of recent history, even asking the questions we are posing today was in many circles, totally forbidden. I hope by now you're thinking to yourself about the elephant in the room, how? And in my mind there's two versions of how. First and possibly most obvious, how did politics and ideology creep into and ultimately capture this area of medicine?

And second, how given the overwhelming success of that political and ideological capture are we discussing these questions today? Before we discuss those questions and hear from our panelists who will shed light, I have the honor of introducing our four panelists, Edmund LaCour, Dr. Eithan Haim, Jordan Campbell and Leor Sapir. And I'll just give a short biography of each.

Edmund LaCour is the current solicitor general of Alabama. In that role, he oversees the state's appellate and constitutional litigation. He has argued three times before the US Supreme Court and dozens of times before other courts. Before joining the Alabama attorney general's office, Edmund was a partner at the DC office of Kirkland & Ellis where he represented numerous clients before the Supreme Court, Courts of Appeals and trial courts. Before joining Kirkland, he practiced at Bancroft PLLC in Washington, DC and Baker-Botts LLP in Houston, Texas. Upon graduating from law school, Edmund clerked for the Honorable William H. Pryor, Jr. of the US Court of Appeals for the 11th Circuit. Edmund earned his bachelor's degree from Birmingham Southern College, his master of philosophy from Trinity College Dublin, and his JD from Yale Law School.

Dr. Eithan Haim is a general and trauma surgeon in a small town outside of Dallas. He attended University of South Florida for his undergraduate degree, followed by Florida Atlantic University, Schmidt College of Medicine, where he was part of the prestigious Alpha Omega Alpha and Gold Humanism Honor Societies. He completed his residency in general surgery at Baylor College of Medicine in Houston, Texas in June 2023.

During his residency, Dr. Haim was an anonymous whistleblower in a May 2023 story released by Christopher Rufo that showed Texas Children's Hospital had been lying about shutting down their transgender program. Instead of shutting down the year before, like they said, TCH continued and expanded the program behind closed wars.

The very next day the Texas Senate passed SB14, a bill to outlaw pediatric gender intervention, which received bipartisan support and in part due to Dr. Haim's anonymous whistleblowing. The Biden administration, however, had a very different response to Dr. Haim's bravery which we will discuss during this panel, and which I'm sure many of you know. Dr. Haim lives with his wife and baby daughter in a small town outside of Dallas, Texas.

Jordan Campbell is the newly appointed deputy assistant attorney general for the consumer protection branch of the civil division at the Department of Justice. Before accepting that position, Mr. Campbell co-founded the first and only law firm exclusively dedicated to representing de-transitioners and victims of radical gender ideology based out of Dallas, Texas. In that capacity, he represented plaintiffs across the country, consulted with state legislatures on proposed legislation, regulating pediatric gender medicalization, coordinated with the state attorney's general's offices, and consulted on policy. He earned his bachelor's degree from Washington and Lee University and JD from Southern Methodist University. He will soon be moving his wife and seven children from Dallas to join him here in DC.

And finally, Leor Sapir. Leor Sapir is a fellow at the Manhattan Institute. He holds a PhD in political science from Boston College and completed a postdoctoral fellowship at the program on constitutional government at Harvard University. Since joining the Manhattan Institute, Leor has become a widely recognized thought leader on topics related to pediatric gender medicine, education, policy, and culture. Leor has offered incisive analysis of the institutional dynamics at play in youth gender medicine, the lack

of incentives for evidence-based practices in this area and the growing divergence between the US and other countries in medical policy.

So I'm really excited today to learn from this group of speakers experienced on this panel's topic. And I want to start with Leor. So you've been writing and studying in this space for years now, and you've been ringing the alarm on the ways that politics have crept into medicine. As just one example, as early as 2022, you published an article on the "affirm or suicide mantra" that you described have become the central strategy of contemporary transgender activism, the empirical basis of which you explained to shoddy at best. So I'd like to hear from your perspective from a 30,000-foot view very generally, how did ideology and politics creep into medicine?

Leor Sapir:

Thank you, Annie. It's really a pleasure and an honor to be here. And I wanted to thank the FTC for organizing this event. A very important event. Before I answer your question, Annie, I do just want to say one thing in light of the context in which this event is being held, and that is that there's growing awareness and acknowledgement among professional class, liberal professional class people that something has gone very wrong in the field of gender medicine, that there is this child-led model where no assessment takes place and kids are rushed into transition.

So that's a good thing that acknowledgement exists. The problem is that that acknowledgement is always accompanied by another claim, which is that there is an alternative, a careful way to do youth gender medicine. They sometimes call it the assessment model. And so I just want to make a few very brief comments about that because I think this is where we're going to see a lot of the battle of ideas over the next couple of years.

So the first thing I want to say is that even this supposedly more conservative approach to youth gender medicine has been evaluated in systematic reviews of evidence and has been found to be based on very low quality, meaning very uncertain evidence. Number two, as the CASS review, I think very helpfully pointed out, even a diagnosis of gender dysphoria is not predictive of adult outcomes. So even if you have a therapist who does a very careful assessment, there's nothing really that assessment can tell you about what would happen to that child if they were not medicalized.

And then the third problem is even if there was good evidence for some mental health benefits in some kids, and even if a gender dysphoria diagnosis was predictive, which it isn't, it would still run into significant ethical problems involving informed consent because no 12-year-old can really understand what it means to give up fertility, sexual function to endure cognitive impairment, if that is indeed one of the consequences of pubertal suppression.

So I just want to flag here that we are moving towards a debate about the careful assessment based model, which itself has significant problems attached to it. Okay, so with that aside to get your question, this is obviously a long and complicated story, but at the heart of it, I want to argue, is a broken chain of trust. So the previous panels I think, explored this idea that medical professionals are misleading patients, misleading parents, and that's true. But I think that another crucial part of this story is that some folks in the medical community are misleading their colleagues and that has to be accounted for.

I cannot tell you how many times I've seen this, how many times I've heard this in my conversations with doctors, with people in positions of authority within the medical field who for understandable reasons say this is not my area of expertise. There are these other people that I call my colleagues who work at my hospital, and they are gender clinicians. This is their specialty. They know what they're doing. I don't want anybody to question what I'm doing. I focus on my particular area of expertise and I expect them to defer to me, so I'm going to defer to them. And modern medicine cannot work without a high level of

trust and deference because modern medicine involves high levels of specialization and compartmentalization.

And so that kind of deference is to be expected, and it's a good thing generally. But it also means that the medical profession, that the trust that makes modern medicine possible can be abused. And pediatric gender medicine is a prime example of what happens when that trust is abused. It is a classic example of a broken chain of trust. So the leading authority on gender medicine in the United States is of course WPATH, the World Professional Association for Transgender Health.

WPATH publishes a document called the standards of care, which are essentially clinical recommendations. The eighth and most recent standards of care were published in 2022, and WPATH has managed to embed its standards of care, and more broadly its approach to understanding human nature, sex, gender, gender identity, and so forth in virtually every relevant aspect of US healthcare. So state Medicaid authorities and commercial insurers incorporate WPATH standards of care in their determinations of covered benefits.

Hospitals conduct WPATH-aligned trainings, also called the Global Education Institute, and operate specialized pediatric gender clinics that rely or claim to rely on WPATH standards. Major US hospitals and medical schools integrate WPATH-aligned standards into their residency fellowship and continuing medical education programs. Around 20 medical associations, including the powerful American Medical Association have repeatedly assured state and federal regulators that WPATH standards are credible and deserving of deference.

And of course, the Biden administration, as we saw, cited WPATH standards of care in its policy memos and had its Department of Justice try to enforce those standards through litigation. In short, in the United States, gender medicine is WPATH and WPATH is gender medicine. In a few minutes, you'll hear from my co-panelist, Solicitor General LaCour about what his team found out about WPATH standards of care during the discovery phase of their litigation Boe vs. Marshall.

Let me give a very brief overview. In evidence-based medicine, systematic reviews of the evidence are the gold standard for evaluating what is known about a medical practice. Clinical practice guidelines are considered trustworthy only if they are based on systematic reviews of evidence. WPATH's previous standards of care version seven, which came out in 2012, was not an evidence-based guideline, and WPATH did not rely on systematic reviews of evidence for that guideline.

When WPATH decided to revise its standards around 2017, it resolved to do so using systematic reviews. The co-chair of the eighth standard of care revision guideline, Dr. Aseratix said at the time that the eighth version would be, "The first to be developed using an evidence-based approach."

So WPATH commissioned dozens of systematic reviews from evidence review experts at Johns Hopkins University. These included reviews of evidence for pediatric outcomes. But when WPATH leaders discovered that the evidence for pediatric transition was extremely weak, it prevented the Johns Hopkins team from publishing their results. WPATH claimed in the final guideline that a systematic review was not possible. It even told the authors of the adolescent chapter of SOC-8 that it was not possible to do a systematic review.

WPATH violated other key requirements of trustworthy guideline development. For example, it failed to manage conflicts of interest stacking the guideline panel with clinicians who are personally, professionally, and financially invested in medical transition. It eliminated age minimums for transition procedures for political reasons, and WPATH leaders privately admitted to including medical necessity statements for the purpose of insurance coverage and for winning legal battles.

In short, WPATH put its activist agenda above any concern for patient health and well-being. And the Alabama documents provide incontrovertible evidence of fraud by the leading authority on transgender

medicine in the United States. Now, the fraud WPATH committed, as I said, is not just against patients and their parents who are the end users of WPATH standards of care, though that is of course their most troubling impact. It's also against the American public, which has absorbed WPATH's messaging about the safety and efficacy of these interventions through WPATH's allies in the media and in the medical profession.

But it's also fraud, as I've been saying, against the rest of the medical community, including unsuspecting insurance companies, state Medicaid authorities, medical association leaders, hospitals, individual clinicians, including I would suspect some clinicians involved in gender medicine itself. Again, the broken chain of trust. But what about the other medical associations?

We often hear that gender-affirming care is supported by most major medical associations. First, it's important to note that US medical groups that endorse the gender-affirming approach are at odds with medical authorities in places like Sweden, Finland, the UK, and Norway, hardly bastions of right-wing conservatism.

In 2023, the director of Belgium's Center for Evidence-Based Medicine said, "If we had to review the WPATH guidelines, we would actually toss them in the bin." Adding what WPATH recommends is, "A pure experiment on children without any scientific evidence for it." Second, even in the United States, not all major, meaning large medical associations support WPATH's approach. Last year, for example, the American Society of Plastic Surgeons effectively sided with the CASS review, acknowledging the weakness of evidence for pediatric outcomes. Among those groups that do support WPATH's approach, the American Academy of Pediatrics or AAP has been one of the most vocal.

In 2018, the AAP allowed a young medical resident by the name of Jason Rafferty to write its policy statement in support of gender transition for minors. The statement asserts that children have indisputable knowledge of their transgender identity and that parents and clinicians should follow their lead. It cites WPATH's standard of care. At that point, it was the seventh edition as authoritative. But as two peer review articles and medical journals have shown the AAP statement contains critical errors including miscitations and misrepresentations of existing research.

A systematic review of guideline quality from the UK commissioned as part of the CASS review found that the AAP guideline is among the worst in the field. The problems with the statement were pointed out to Rafferty and the AAP soon after the statement was published, but the AAP has consistently refused to engage with or even acknowledge these criticisms casting them instead as transphobic.

Indeed, the AAP has gone to great lengths to silence its own members who have raised concerns about the organization's unwillingness to conduct or rely on systematic reviews of evidence. The AAP continues to insist to this day that gender transition for minors is evidence-based, safe and effective.

In a 2023 interview published in the Boston Globe, Jason Rafferty, the author of the AAP statement, said that gender-affirming care is about, "Affirming and validating the child's sense of identity from day one through the end." He explained that when a child declares a gender, "We operate under the assumption that what they're telling us is their truth, that the child's sense of reality and feeling of who they are is the navigational beacon to sort of orient treatment around.

In 2023, after a multi-year campaign from some of its pediatrician members who refused to be silenced, the AAP finally agreed to conduct a systematic review of evidence even though by this point several such reviews had been published and the AAP could easily have relied on them. It's been two years and there is no indication that I'm aware of that the AAP has begun that review or that it intends to adhere to accepted standards of systematic reviews.

So now let me turn to the Endocrine Society. In 2017, the Endocrine Society published a clinical practice guideline on gender medicine. Despite acknowledging the poor quality of evidence, the guideline makes

strong recommendations in favor of puberty blockers and cross-sex hormones, a move that has drawn criticism from some of the world's leading experts in evidence-based medicine. The Endocrine Society explained its decision by invoking the "values and preferences" of pediatric patients wanting endocrine treatments. It said that it places a higher value on "avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible" than on "avoiding potential harm from early pubertal suppression".

In other words, according to the Endocrine Society, helping a teenager achieve his or her cosmetic goals is more important than preventing harms from the use of off-label drugs. It's important to note that the clinicians who wrote the Endocrine Society's guidelines are themselves gender clinicians with conflicts of interest, and most were WPATH members.

Now, a key element of WPATH strategy has been what I've called credibility laundering. Medical associations with broader scope and larger memberships have specialized subcommittees dealing with LGBTQ issues, which today means primarily gender medicine. And these groups are WPATH-aligned or even affiliated. For example, Dr. Aron Janssen of Lurie Children's Hospital is co-chair of the American Academy of Child and Adolescent Psychiatry's Sexual Orientation and Gender Identity Issues Committee.

Incidentally, he's also a WPATH member and co-author of WPATH's eighth standard of care. It's not just medical associations that produce a broken chain of trust. Medical journals are also responsible. We now have a large body of evidence demonstrating that medical journals have lowered or abandoned their editorial standards when publishing research purporting to show benefits from pediatric transition, and they also suppress or decline to publish critical commentaries on these studies.

Leaders in the medical field may be forgiven for assuming that if a study reports improvement in mental health as a result of cross-sex hormone therapy, that that report is credible because it went through peer review. Again, the broken chain of trust. So to summarize, the medical transition of minors is a good example of medicine's failure to self-regulate. That failure is due not only to the broken chain of trust, which I've highlighted here, but also to the climate of intimidation activists have created within the medical field against any medical professional who would dare question gender medicine or its foundational concepts.

As Dr. Hilary Cass wrote in her important report from last year, "There are few other areas of health care where professionals are so afraid to openly discuss their views where people are vilified on social media and where name-calling echoes the worst bullying behavior." This must stop.

Annie Chang:

Thank you so much, Leor, for that very in depth review of how we got here today. And speaking about kind of the broken trust in the medical field. We're really lucky to have Dr. Haim join us. I want to turn to you next. Your perspective on this panel is especially interesting, both because you are a medical doctor, you're a surgeon, and then also you have personal experiences kind of going up toe to toe with these ideological and political behemoths in medicine. I just want to touch briefly. I know it's a long story about your personal experience here.

Eithan Haim:

Yeah, and thank you all so much for being here and especially to the FTC for hosting us. But yeah, my name is Dr. Haim. I'm a general surgeon in a small town outside of Dallas, and I was the whistleblower who exposed that TCH was lying about the existence of their transgender program. And I'm sure that many of you are wondering, there's so much deception in this field. Where are the doctors? Why are there not other doctors who are speaking up? And all of this happened with me blowing the whistle during my training, and I saw it firsthand myself.

There is a code of silence that exists among physicians in the profession today. If you break that code, then you'll be targeted in the most vicious way possible because when I found out that the hospital, I was working at Texas Children's, which is one of the most amazing hospitals in the country for taking care of kids, but they had this program that was harming these kids that had no basis in scientific or biological reality.

They were doing these children and they were lying about it. So I blew the whistle in May of 2023. There was a law passed the next day. More whistleblowers spoke out, Vanessa Sivich, who you'll hear about later today. And the hospital said that they were shutting down the program. But in response to that, I was targeted by the most powerful federal leviathan in human history. They tried to send me to prison for 10 years. I was charged with more felonies than some of our country's most prolific criminals. And this was for a crime that I had never committed that the DOJ could never even define where no patient had actually been harmed.

They were using HIPAA as a basis for their indictment, even though the victims they said were the hospital and the doctors, not the patients, the hospital.

Annie Chang:

Thank you, Dr. Haim. And moving on, I kind of want to get more into your medical expertise, and you touched on this briefly about this code of silence. Why, in your view has politics and ideology, how has that been allowed to stay in this type of medicine?

Eithan Haim:

It's a decades-long process where the institution of medicine had been taken over by radical left-wing ideologies. And as that creep has taken a hold in these institutions, people who spoke up were increasingly vilified. So people would suffer the traumatic experiences of speaking out and then having their profession, their professional lives damaged. Either they would be fired, they would be held back from promotions. They would be sometimes targeted by governing medical authorities in their state. And in cases like mine, they would be targeted by the federal government.

So you have real consequences to the doctors who speak out against this. And that is happening in conjunction with the professors at medical schools. The clinical doctors who are teaching medical students in residence. All of the people who are promoted, who are hired are not the ones who hold conservative values. Or not even conservative values, just not radical values. Being an average person essentially eliminates your ability from being hired in these prestigious academic centers.

Annie Chang:

I'd like to switch gears a little bit to the second question I pose at the top. We're talking about this cone of silence, how nobody's speaking up. So I want to really get into how we are here today. How are we here today asking these questions and having these discussions? I think we have a lot to thank to some of these panelists, including Dr. Haim. We also have a lot to thank to the work at the state level. We're the FTC, we're at the federal government level.

But state legislators and state enforcement officers we're willing to go to the mat on these disputes. We saw that in United States v. Skrmetti. So let's start with state enforcement. I'm sure it's at the top of all our minds on the Skrmetti Supreme Court decision that upheld Tennessee's Senate Bill 1, which bans healthcare providers from performing or offering to perform on a minor, a medical procedure if the performance or administration of the procedure is for the purpose of enabling a minor to identify with or live as a purported identity, inconsistent with the minor sex under rational basis review.

Many other states, including Alabama, however, also passed similar laws. Today we're joined by General LaCour who was at the forefront of that litigation in Alabama. General LaCour, can you briefly describe what you were seeing at the state level, particularly from Alabama before all the litigation eventually culminated in Skrmetti?

Edmund LaCour:

Absolutely. Thank you, Annie, for having me here today. I think Alabama was seeing, what a lot of states were seeing, which was a rapid rise in children identifying with gender dysphoria and a similarly rapid and unexplained rise in these clinics that were treating them with these untested treatments. So Arkansas was the first state to enact a law in 2021, setting age limits. Then Alabama in 2022, Tennessee other states the year after. And nearly every one of these laws was challenged almost immediately by the ACLU and other activist groups.

And they ran a similar playbook in every state. They would show up, demand immediate preliminary relief from the district court. They would've a carefully curated story sort of along the lines of the assessment model that Leor was talking about a moment ago. And then they would appeal to WPATH. It was their key weapon in their arsenal, which was these are evidence-based guidelines to provide medically necessary care to these children who are in deep distress. "And, judge, if you don't do something, they might kill themselves."

And so many of these district court judges who knew nothing really about this were forced to make judgments very quickly. And in Alabama as well as in other states, preliminary injunctions were entered that prevented us from enforcing our laws. In Alabama's case in particular, the district judge really relied on WPATH in his preliminary injunction order, but we saw that as a great opportunity because the WPATH guidelines had essentially been constitutionalized in the case. And we said, "Well, judge, that makes them the most relevant thing for this litigation. And so we should get discovery into how these things were made. Were these the product of dispassionate science or impassioned advocacy?"

And what we revealed was really a political, medical and legal scandal beyond what we had even imagined at the beginning of the litigation. As Leor referenced, the Biden administration was involved throughout the process in trying to craft these for the purposes of implementing federal policy. So there was this circularity there where the federal government was trying to alter the guidelines and then rely on the guidelines to alter federal policy.

Most shockingly was, again, the instance where in 2022 after years of development, SOC-8, the version eight was finally released on WPATH's website and there were age limits in the guidelines for the hormone treatments and surgeries. Now, many would argue that they were too low, but there were still at least age limits there. And then all of a sudden the guidelines disappeared from the website and a new version came up the next day that had no age limits whatsoever.

And WPATH didn't explain why this was. Well, discovery revealed at least part of the reason why is that Admiral Levine, again, a senior HHS official at the time, had been given an embargoed final copy and then immediately began pressuring WPATH for political reasons to remove all age limits from the guidelines. And then AAP, who Leor referenced as well, joined the party in saying, "We will come out against your guidelines if you don't abolish all the age limits on the surgeries and the hormones."

And we have emails of WPATH authors going back and forth saying, "Well, should we really let US politics govern these international clinical guidelines?" We feel bad about caving, but that caving is exactly what they did. And then we have emails saying, "Let's all get on message and fight misinformation, which they were putting out there into the public." As a result of that, there are some verifiable falsehoods in the guidelines that remain again on their website today.

So WPATH says in the guidelines that all statements went through what's called the Delphi process, which Leor could probably explain far better than I could. But it's essentially a process where you consult different experts, try to reach a sort of consensus, and that consensus is its own sort of evidence. Dr. Coleman, who was the chair of the guidelines said, "It's really the only evidence we have." But because Levine intervened at the end and said, "You need to change this statement and remove all the age limits," that process never went through.

Or that new statement that says, "No age limit is needed," did not go through the process. So that's a verified falsehood that's there in the guidelines. Leor referred to the conflicts of interest problem. WPATH claims that they followed the recommendations of the National Academies of Medicine for developing guidelines free from serious conflicts of interest.

Again, we show that that's not true. The National Academies says that only a minority of people involved in guideline development should be people who have some sort of interest in the procedures. But Dr. Coleman under oath in a deposition in Alabama's case said that most people, so not a minority, but most who were involved in SOC-8 did have a financial or non-financial interest. Indeed, all 119 authors were members of WPATH and Dr. Marcy Bowers, who also oversaw the guidelines' development said that in Bowers view, it was important that every author for the guidelines be an advocate for expansive transgender care in WPATH's view.

So again, we have guidelines now that are based on these undisclosed conflicts of interest, which raises serious problems. And I think that's how you get to a position where they can use the terms evidence-based and medically necessary in such a loose manner as to be almost meaningless. Speaking about the evidence-based, I mean, Leor already touched on a little bit how Dr. Robinson at Johns Hopkins had been contracted to do the systematic evidence review for WPATH to see, to look at all the evidence that might be out there and see if there's strong evidence, weak evidence, or no evidence backing up any of their recommendations.

In 2020, Robinson was already able to confirm to HHS that there is, "Little to no evidence when it comes to children and adolescents." HHS responded, "It's good to know there's little to no evidence." And then years later, "We're telling the Supreme Court that there was overwhelming evidence to support these treatments."

Leor already touched on how the evidence reviews were being suppressed by WPATH. In fact, they required final approval of any article that used any of the data. And anyone who's putting out an article based on the data had to, " Use the data for the benefit of advancing transgender health in a positive manner." But, again, the point of evidence-based medicine is to look at all the evidence that might be for or against your hypothesis, not to just pick the stuff that supports your view and leave the other stuff aside. So I mean, that bias undermines the entire process. But to make it appear neutral, WPATH imposed an additional requirement on their authors saying that in their manuscript, they needed to tell the world that they were, "Solely responsible for the content of the manuscript and the manuscript does not necessarily reflect the view of WPATH." I mean, that's very hard to square with WPATH having final approval of every manuscript.

The last thing I'll touch on medical necessity, as they are referred to, sort of the child-driven model. There are phrases like "embodiment goals" that show up in the emails that we receive from WPATH. I think those emails and even the guidelines themselves made clear that wants are being treated as needs in their view. And so as one author put it, it was in her view, "Clear is a bell that the SOC-A refers to the necessity of treatment in its broadest sense for gender dysphoria because it refers to the symptom of distress, which is a very, very, very," it's three verys, "broad category and one that any good-willing clinician can use for this purpose."

And so when you redefine medical necessity in that light, you can get strange sentences like this in the guidelines, "A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary, gender-affirming medical and surgical treatments." But of course, if there's no good evidence out there, calling it medically necessary clearly puts the cart before the horse. But that's what we have in the guidelines today.

Last thing here on medical necessity. SOC-A for the first time has an entire chapter devoted to men who identify with a eunuch gender identity. Associates chairman admitted under oath that even though no diagnostic manual recognizes eunuch as a medical or psychiatric diagnosis, WPATH's official position is that castration may be "medically necessary" for a healthy man with no mental health conditions who presents as eunuch and wants to be castrated.

So when the same guidelines say that it is medically necessary that middle schoolers like the ones we heard from earlier this morning with gender distress need to receive surgeries and hormones, one should to ask what does WPATH really mean by medically necessary?

Annie Chang:

Thank you so much, General LaCour. And you mentioned you got all this information during discovery, so I have two follow-ups on that. One, I've read speculations online that obviously your case didn't make it up to the Supreme Court, Skrmetti did. I've heard online that the Biden administration chose not to petition for cert in the Alabama case because you received all of that discovery. Is it your sense that you were able to uncover that and they wanted to keep that silent?

Edmund LaCour:

That was absolutely our view because after we got the documents, the same lawyers from the Department of Justice under President Biden were suing Alabama and were suing Tennessee. And Tennessee's case was going up on a very truncated six-week record at the preliminary injunction stage and they decided to seek cert even though one reason for the Supreme Court not to take a case is because the record is small and underdeveloped and the United States has argued against the court taking other cases on that very ground.

Meanwhile, we'd been litigating for a year and a half. We had all this record we had developed, we were getting ready to go to trial. And just a few days after, they asked the Supreme Court to take the Tennessee case. They actually filed a motion in the Alabama case to say, "Whoa, whoa, I know we sued Alabama and we need relief really quickly, but let's just hold up on this litigation. Let's press pause." Like they say with the puberty blockers, "and just wait and see if maybe the Supreme Court's interested in taking Tennessee's case because that could resolve a lot of things." And at that time, the discovery was still all under a protective order.

Now, once documents that have been produced under a protective order hit the docket as litigation documents like through trial or through a summary judgment motion, the burden shifts to the party who wants the protective order to be enforced to explain why the public shouldn't see these documents. And so that's what I think they were trying to prevent from happening. Fortunately, we were successful in opposing that stay motion and then another stay motion filed with SPLC. A few months after that, we got the file our summary judgment brief, and that included a lot of all this evidence that I've been talking about today, and that really helped to shift the narrative and sort of expose some of the scandal.

Annie Chang:

And so the Alabama case was stayed. And my second follow follow-up is so that effectively ended when Skrmetti was granted at the Supreme Court. What did you do?

Edmund LaCour:

Well, it actually ended a month before Skrmetti. They came to us and said, "We want to drop our case with prejudice."

Annie Chang:

Of course.

Edmund LaCour:

Which means we lose completely. Even before Skrmetti was decided though, which we took as a sign that if Skrmetti had gone their way, ours was the last case they would want to go forward as the next one up. Because even if heightened scrutiny is applied, when you see that the guidelines they've staked their entire case on are based on this sort of advocacy and not science, that would be sort of a terrible blow for them in terms of pushing this narrative. So they walked away a month before the Supreme Court even issued its decision.

Annie Chang:

And then you filed an amicus brief in this?

Edmund LaCour:

Yes. So in October of last year, we found an amicus brief in Skrmetti, laying all this out, really calling the United States to task for making their representations to the court when they knew what we knew and explaining what we had uncovered about WPATH, which again had been cited multiple times by the private plaintiffs and by the United States in getting the court to take the case and making their case at the court. That brief was cited extensively by Justice Thomas and his excellent concurrence. And so it was an honor to be able to do that work.

Annie Chang:

Thank you so much. I want to turn to private litigation and Jordan. Jordan is now serving in the federal government, but before that time, and I think some of here as former clients of his, you left your position as a partner at a boutique firm in Texas where I'm sure you're doing quite well for yourself, at a firm that was dedicated to representing members of the detrans community who have been harmed by what some have described as gender-affirming care. Before we go into your substantive work here, I just want you to share what motivated you to go into opening up this firm that specialized only in this work?

Jordan Campbell:

Yeah. Thank you first of all for having me. It's an honor to be on this panel. And when I say that, I mean truly it's an honor to be with these three guys because I have no right to be here. They're so much smarter than me. All I can really do is just relay what I have learned from hearing from my clients and literally hundreds of others that we were unable to represent for statute of limitations reasons, which is a whole separate topic. But my background was big law, commercial and antitrust litigation. And so it was a hard right career turn to go into gender litigation.

What got me there was essentially what we heard this morning, and it was just the stories and testimonies of folks I didn't know existed called detransitioners. And the more I read and the more I heard from them, hopefully like others in here, I couldn't turn away and I couldn't do nothing. I saw that there was really nobody that would stand up for them. There was nobody that would speak up for them and there was certainly no lawyers that would represent them. And so I said, "Okay, well I'll be one of those folks and I'll step up and I'll try to represent them the best I could.

So it's not a, I didn't know a ton about the medicine. I've certainly learned from folks like Leor who I've become good friends with. I've known Eddie for a long time and certainly learned a lot from their litigation. And by the way, for nerds who like to read amicus briefs, that is the best amicus brief I've ever read. You should absolutely read it. But it wasn't any of that, it was hearing from my clients, hearing from others and just saying, "Yeah, I feel like I need to do something."

Annie Chang:

Thank you for that. So we heard a little bit from General LaCour about litigation tactics that were used in state litigations to kind of keep this information out of the public view. I was wondering, in private litigation, you were litigating against, I'm sure healthcare institutions and these medical practitioners, sometimes maybe governments. I was just wondering if there's any discovery that you uncovered or facts that you uncovered that you're able to share today. Keeping in mind, I know some of it is subject to protective order.

Jordan Campbell:

Yeah. I would just say there are certainly tactics at the practitioner level that we would see that were very common. I literally cannot tell y'all how many times I've heard folks, clients or potential clients we've interviewed tell us about the suicide myth that they were told, which is the, would you rather have a living son or dead daughter or vice versa? Very, very common tactic. The surgical letters, by the way, that Dr. Grossman highlighted for us this morning as well, very common tactic. I would actually say those are some of the more detailed letters that you'll actually see. It's more common to see even more form letters that are even more fraudulent that just in two quick paragraphs say... We even had one client who had a doctor sign a letter that said they can certify that this patient meets all the WPATH guidelines, which include months of dysphoria, if not years. And the doctor said, "I've been treating this patient since the day that they signed the letter."

So I mean, the most blatant evidence of fraud of, I know this patient and I know they meet all the criteria and I just saw this patient today, but I'm going to sign off on it right here and check the boxes. So the letters are certainly very, very common tactic. The suicide myth is a common tactic.

I would just say that generally speaking, the overall thing that just really blew my mind, the more we would dive into records, the more we'd see from these institutions was just the absolute unquestioned rush to "affirmation" with zero guidelines. I cannot tell y'all how many patients we have spoken to were the absolute very first time they spoke to a clinician, they were prescribed cross-sex hormones or puberty blocker or both, which flies in the face of even the "WPATH Guidelines," which they all purport to follow, but in practice, none of them actually do, which that's the thing that really jumped out to me was they don't even play by the rules that they purport to follow.

Annie Chang:

So there's one last question I want to ask all of our panelists, and Leor touched on this briefly in the beginning. We're here today after Skrmetti, after the state enforcement action, after private individuals have put their livelihoods sometimes at stake to allow us to ask these questions and hear from people

today about what's been happening. So what's next? What's next in undoing the view and the politicization and ideology that's crept into medicine?

Eithan Haim:

If I can start off, I think one of the best strategies, especially for Jordan Campbell moving forward and anyone in the Department of Justice who has the capacity to enforce the law is what Dr. Grossman showed us earlier.

Me as a surgeon, if I use diagnosis codes that were that fraudulent, I would be in prison. That's a real crime, not like the fake crime that they charged me with. And all the Department of Justice has to do is enforce the law. These laws already exist, these people are committing crimes. If the investigations are done and the prosecutions are brought, then these people will be held accountable and there's a very good chance this will stop even in blue states.

Jordan Campbell:

Working on it. Dr. Haim. Obviously, there's certainly a legal angle that I'm sure the FTC may be interested in, obviously the Department of Justice is interested in. But I would also say more broadly, it's a cultural issue and it has been, I'd say the pendulum is swinging right now, and the reason for that is I just think that truth is actually now being brought to bear. That light is actually being shown on what is going on. And ultimately, I would think that truth wins out.

And so just as far as, how does this move forward? How do we progress in this area and recapture it? I think it's stuff panels like this where what is actually happening is being brought to light. I think ultimately that's what moves hearts and minds and that's when people wake up to see this can't be right. And ultimately, that's probably what changes things.

Leor Sapir:

I would say consistent with what I said earlier, I really do think both for intrinsic reasons and also for strategic reasons, we need to have understanding and grace for medical professionals, people in the mental health field who have trusted their colleagues for understandable reasons and have been misled. I think we need to continue forward pressing on with evidence-based medicine, continue insisting on the case for looking at evidence, thinking about the underlying clinical rationales, the concepts of transgender medicine, as Dr. Grossman very helpfully pointed out. But at the same time having some understanding and trying to help create an off-ramp for medical and mental health professionals who have got caught up on this issue.

I don't think it does us any favors to demonize those who don't deserve to be demonized, and I especially think that we need to have understanding and compassion for the kids and their families who have crossed the Rubicon and who have medicalized and who have committed their lives to these procedures. We can't demonize parents above all. I mean, to me, that's always been my red line, never demonize parents. Parents have been misled and lied to constantly. So we need to have understanding and we need to help create off-ramps. That's what I would say.

Edmund LaCour:

Sort of piggyback on something Jordan said, I think getting the word out is so critical. One problem we faced early on was that some of the things that were being done were just so horrible that most people

wouldn't believe it. "No, that can't be true." It's like this move, surgeries aren't happening, and if they are, it's a good thing. But then you hear from the people who've been so damaged by it and that can, I think, hopefully open people's minds up. But then also I agree with Leor that there are some folks in the medical industry who have been tricked and there are some who are doing the tricking. And for those who are in that latter group, I think it's going to be important to continue to investigate.

Annie Chang:

Let's give a round of applause to our panelists. Thank you so much.

Jon Schweppe:

Sorry. I should have put that on. We now have another presentation for you about the medical harms of so-called gender-affirming care for minors. Michael Laidlaw, M.D., is an academically trained board-certified endocrinologist, who has been in private practice in Rocklin, California since 2006.

In 2018, he wrote an influential article for Public Discourse called Gender Dysphoria and Children: An Endocrinologist's Evaluation of I am Jazz, after recognizing a strong push to incorporate gender ideology into his local school system. From there, he went on to publish in medical journals and to speak and educate on the topic of harms from puberty blockers, opposite sex hormones, and surgeries in locations such as California, Washington, D.C., the UK Parliament, and in front of the Florida Medical Board. He has worked and testified on behalf of states, including as an expert witness for important legislation to stop the use of harmful hormones, puberty blockers, and surgeries provided to minors for the purpose of gender transition. Please welcome to the stage Dr. Michael Laidlaw.

Dr. Michael Laidlaw, M.D.:

Okay. Thank you. Thank you for having me here. Thank you Chairman Ferguson, Mr. Schweppe, Brandon Showalter, all the really excellent speakers here today, and thank you guests.

Let's see, next slide. We're waiting on the audiovisual I think so I'll just jump ahead. I'm here in D.C. It's very nice to be here. We're going to be next year our 250th Independence Day, and we just had a great 4th of July in our corner of California, but I couldn't help thinking, what would the founders think about what's happening today? What would they think if someone couldn't define what a woman is or what a man is or that you could give chemicals they didn't know about, hormones, to magically transform someone from a boy into an adult woman or a girl into an adult man. Thank you. All right.

So with that, again, I was first really... Took a deep dive into this when this book, if you've heard of it, I am Jazz, was read to kindergartners in our local school system and a parent urged me to read it as an endocrinologist. This is a propaganda book geared towards very young kids, kindergartners and elementary school. I found at least a couple of things that were untrue claims in there, that a boy could be born with a girl's brain, that a doctor could somehow diagnose a child as being transgender. There was a lot of information missing about types of medical harms that can happen with this treatment.

Today, I'm going to talk about what is gender dysphoria a little bit, how normal human sexual development works, what is gender affirmative therapy, hormones and such, who are the major promoters. You've heard a lot about that. I'll go through that a little bit. Nations and states that have turned away from this care and about suicide deaths and a conclusion.

What does all this hinge upon? I think Dr. Grossman covered this well. Objective biology versus subjective feelings. Gender identity is an internal feeling of being a boy, a girl, or some variation. Gender dysphoria is a legitimate psychological diagnosis found in the DSM-5 with an extreme discomfort with one's sex and perceived gender leading to significant distress and impairment of functioning lasting at

least six months. It's important to know that depending on which study you look at, so long as kids aren't interfered with with hormones, the majority 50 to 98% will desist or grow out of this by adulthood. Also, important to know is that many of these people, as you've heard today, have other coexisting psychological comorbidities such as anxiety, depression or autism, or self-harm.

Now, as an endocrinologist, I provide hormones to people. Hormones are very powerful medications that alter body and mind. So if I'm going to give insulin to a patient, I'm going to make sure I have some objective evidence of diabetes. I want glucose results. If I'm going to refer a patient for a thyroid cancer, I want a biopsy to show me for sure that this person needs this treatment. So we're going to radically alter, as I said, people's bodies, kids' bodies with hormones. How can I prove that this person is transgender? Where do I find the gender identity? Can you do a CAT scan or an MRI or a chromosome testing or other testing? And the answer is you cannot.

Again, there are only two sexes in case you miss that earlier. Sperm comes from your father, an egg from your mother, and there are no other gametes out there. There aren't 14,000 other gametes. There's only two to make you and all of us. You can look in chromosomal evidence that's found in all cells with nuclei in your body. An XX for a female, XY for a male. These cause different processes to occur and sometimes in a sex-specific way within cells.

During normal development, you actually develop your reproductive track and organs around weeks 8 through 12. And so there are primitive tubules. In the beginning, you have some that could become a male and some that could become a female, but what happens is you develop into one or the other and those other tubules are completely eliminated, which means that you can go down one track or the other, but you cannot cross tracks later. We don't have any medical way of doing that.

Again, sex is identified at birth. You can do it as an adult, as a four-year-old. They could look at their little brother or sister and know for sure. It's not assigned at birth. No one flips a coin or pulls out a lotto ball say, "This is a male or a female." It's very easy to identify. There are people with disorders of sexual development, which is outside of the scope of this and really not relevant here, but it doesn't make any difference sex, it's just a disorder of sex development.

I'm going to talk about what I call gender affirmative therapy, which really has four phases, one or more of the social transition, puberty blockers, cross-sex hormones or opposite sex hormones and surgical modifications, which you'll hear more from Dr. Lappert.

Now it's important to note... Is there any water, by the way? It's important to note as we're getting water. Oh, sorry, not observant. So doctors and pediatricians and doctors can examine patients and find out what stage of pubertal development they're in by looking at what we call Tanner Stages. And so Tanner I is the undeveloped prepubertal person, and Tanner V is an adult. Fully adult reproductive organs are present and fully developed. And stages II through IV are various in between stages of development. It's important to know here for our purposes that around Tanner Stage IV, sometimes III, that's when fertility is established.

Now, all of this amazing process is under the control of glands, one being the pituitary, which is a small, pea-sized shape organ in your brain, and that activates the testicles to make testosterone or the ovaries to make estrogen. And that rolls into place all the processes for developing puberty. Now, sometimes persons can develop conditions where they have problems with this communication and it stops puberty or they may not begin puberty. And this is treated by and diagnosed and treated by endocrinologists. But other types of medications such as Lupron, which you may have heard of, can also chemically interfere with this process and stop puberty.

Now, this has legitimate uses in central precocious puberty for very young kids, say they're age three or four who go through puberty early, but there's no FDA approval and there's no good evidence as you've

seen for using this for the purpose of gender transition. And as you might imagine, puberty blocks this normal advancement and normal advancement of fertility.

So different side effects of blockade of normal puberty. In the male, you'll stunt penile and testicular growth, which makes future surgeries problematic. Sexual dysfunction, as you might imagine, impairment of erection, orgasm, ejaculation, prevention of sperm production. In both sexes, you'll have disruption of normal brain development, which occurs under the influence of hormones and disruption of normal bone development.

In the female if you stop puberty at an early stage as recommended by WPATH and Endocrine Society Tanner stage II, you'll develop an early menopause-like state with blockade of normal breast development, decreased blood flow to vagina and vulva, sexual dysfunction with thinning of vaginal epithelium, vaginal atrophy, anorgasmia, problems with orgasm. Of course, interferes with menstruation and infertility. And you'll hear more about infertility from Ms. Lahl later.

You can also read labeling and note that there's many neuropsychiatric effects of puberty blockers right on the labeling. This is ultimately for many a pathway towards sterilization because first, you've impaired or perhaps destroyed sex organs with these medications. And then many, particularly from earlier studies, go on to have their testicles or ovaries removed, which is complete sterilization.

Now, I just want to talk a little bit about bone development. The pubertal phase and up through the 20s is an important time for developing bone and normal bone density. And so you can see at the bottom here, kids and adults ages and years and bone density. And you can see a rapid increase in both males and females from 10-year-old to late 20 years.

What happens with puberty blockers is that relative to their peers, they cannot put down as much bone and end up with a lower bone density than you would otherwise expect. And so there's this flatlining of bone density, which is important because this can lead to risk of osteoporosis and debilitating fractures when a person is older. Now, taking cross-sex hormones after may mitigate some of these effects, but again, as you'll see, that is not a healthy way to go either.

Here is a female who had undergone mastectomy surgery, and you can see evidence of what we call hyperandrogenism or high testosterone levels. You can see the abdominal hair, the facial hair. And I just want to show you, and I think this was covered earlier, but the normal female range of testosterone and females make testosterone as well as 10 to 45, 10 to 50 in blue there. But in the orange is what they're recommending for this gender transition, some 6 to 100 times higher than normal female levels.

This leads to multiple risk. Increased risk of heart attack and death due to cardiovascular disease, high red blood cell counts, potential liver dysfunction, as you heard earlier with Kayla, hypertension, various potential risks for the reproductive tract of ovarian breast, uterine cancer. Some of that's still being worked out. Of course, hirsutism or hair growth, deepening of the voice, sexual dysfunction in fertility.

This is a controlled substance and it's being used off-label. And this is important because this is data from a paper about the Food and Drug Administration Adverse Event Reporting. I want to note the similarities to anabolic steroid abuse in which we've written in a paper actually, a comment. So in the Adverse Event Reporting, they found evidence of aggression, anger reported, euphoria, depressed mood, dissociative identity disorder, affect lability, emotional disorder, antisocial/ self-destructive behavior, homicidal ideation, suicidal ideation.Many of these are similar as to what can be found in anabolic steroid abuse.

Now, let's talk about estrogen. Using estrogen in very high doses, maybe 2 to 40 times higher than the normal estrogen levels of males. This leads to, and Dr. Schwartz has a great paper and company about this, increased risk of, again, heart attack and death due to cardiovascular disease. Thromboembolism risk, two to five times increased risk of blood clots, deadly blood clots. Possible stroke risk, high

triglycerides. The breast cancer risk in males, and males can get breast cancer, has increased some 22 to 46 times, depending where you look. Benign tumors of the brain, prolactinomas. Germ cell neoplasms are other possibilities.

I'm going to skip through some of this because they've done a good job of discussing WPATH. WPATH is an advocacy organization, as you heard earlier. They removed age guidelines primarily as we found out from our great attorneys in Alabama due to Admiral Levine working behind the scenes in American Academy of Pediatrics, trusted since 1930. No longer.

Endocrine Society is an otherwise legitimate medical organization. I have been a member since 2006. They do great work except in gender stuff. They wrote guidelines in 2009 and 2017. And just to emphasize, I think Leor Sapir talked about this, but 9 out of the 10 authors of this 2017 Guideline were WPATH or WPATH affiliated. So I've often been asked, why are medical organizations following this sort of treatment? I think it's because WPATH early on in 2009, got involved and recognize why not use the hormone association to legitimize what we're doing.

I'm going to skip along. Again, systematic reviews of evidence have been done. And common themes in looking at this is that limited high quality evidence for most interventions, primarily low quality problems with methodology, small sample sizes, lack of control groups, lack of long-term follow-up, mental health benefits unproven. And so many nations have turned away from this, including the UK. There's Dr. Hillary Cass you heard about earlier. And we have our own HHS report, which is still under peer review, but in many ways expands on the Cass reports and is very extensive and worth a read. I don't have time to go into it. But I want to talk finally about death in this treatment paradigm, because that's the ultimate thing that physicians are trying to prevent.

And now, if you look at back in 2011, a study was published looking at the entire nation of Sweden general population compared to some 300 plus persons who had gotten hormones and surgeries. And so, you can see time and years across the bottom and survival with 100% at the top. And the top two continuous lines are males and females in the general population. And if you look at the dashed lines that shows what they call trans males and trans females, how their survival dropped off rapidly after 10 years. In fact, there was nearly three times the all-cause mortality rate and 19 times the rate of completed suicide.

Now, what about children and young people? This is Dr. Johanna Olson-Kennedy, who you heard about earlier, gender clinician and researcher at Children's Hospital Los Angeles. And here's a quote you've heard, what she tells parents, "We often ask parents, would you rather have a dead son than a live daughter?" Which is quite a claim in a way. It's a question, but it's also a claim that if your kid receives these hormones, they're going to live though they may be different gender than you had thought. And if not, they will die by suicide.

Which if true would be maybe an important way to discuss this. But if not true, it would be seen as, in my opinion, extreme form of coercion. And Jane Robbins is attorney and author. She alerted me early on to a study from the NIH-funded study and we looked for more information using FOIA requests to NIH. And there's a lot to talk about here, but in Miss Friday we'll cover some of this as well, but this is called, the title of this now ten-year NIH study is The Impact of Early Medical Treatment on Transgender Youth. There's four sites, academic institutions across the country.

And so, they were looking at two arms, a puberty blocker arm, starting puberty blockers at a very early age, say 8 for girls or 9 for boys, and monitoring the effects over two years and also cross-sex hormones starting at age 13 though that was lowered later. And they were studying mental health, psychological well-being, metabolic and physiologic parameters, bone health and so forth.

Now, we found information on that around 2018. And in 2019, one of my colleagues, Dr. Will Malone, who's also an endocrinologist, and my colleague Hacsi Horvath of epidemiology, wrote a letter to the Office of Human Resource Research Protections asking for a moratorium on this study because of all the things I mentioned earlier, which would clearly happen. We stated, "We contend that neither children, nor their parents, can meaningfully consent to permanent infertility or other potentially serious medical harms to treat a non-medical condition. We questioned whether these parents were fully informed of the health risks or the possibility of tragic regret."

We received a reply from NIH basically stating that they would not have a moratorium, that that would only stop the data collection. In any ways, these parents were informed of what would happen and they weren't going to do anything about it. Now, in 2023, a study was published in New English Journal of Medicine with the cross-sex hormone outcomes, or at least some of them, of 315 patients who were given this treatment of the cross-sex hormones.

And the most common adverse event was actually suicidal ideation on 11 participants. And two kids or young people actually died by suicide, which is I thought, "That's what we were trying to prevent with this, weren't we?" Apparently not. Now, in medicine, it's been common practice for centuries to do autopsies of patients, especially people with rare or unusual conditions, and compare that with their clinical course during life to advance what we know about different things. For example, adrenal insufficiency is one thing I know about where they had done that.

So, in The New England Journal, what did you find about these deaths? Well, nothing really. It's just a statistic. Were they males or females? We don't know. What were their ages? We don't know. What were their psychological care leading up to that? What were their diagnoses? Were autopsy performed on the study subjects? If not, why not? What were their testosterone levels or estrogen or progesterone or blood levels? What did the first responders reports say? None of this is known at this time. So, information is being concealed in my opinion.

And so, the first participant was enrolled in this study in 2016. We wrote our letter in 2019 and then The New England Journal published this data in 2023. And I was quite surprised because we had been following yearly progress reports and I never saw that death was mentioned. So, it was concealed. Until our wonderful attorneys in the state of Alabama subpoenaed HHS documents in late 2023 and found out the first death actually occurred way back in 2017, before we had written our letter. And I could not find any information about the second death.

Now, someone we do have information about, and you all here, many of you probably know about Yaeli Martinez, her mom, Abigail Martinez. The only reason we know about her case is because her mom has been very outspoken about it. Yaeli had depression. She was referred to for gender transition at Children's Hospital Los Angeles because of a school psychologist who said that she needed gender transition and she was administered testosterone.

Her mother relates that the daughter was taken away by the county and placed into foster care. She committed suicide by train in Los Angeles County at age 19. The mom says around 9:30 p.m. that night, she walked in front of the train tracks facing a train. She went on her knees, raised her arms up and just laid on the tracks. So, if you want to find out more information of a case report, you could look in your medical journals and find that. No. But you can do a public record request to Los Angeles County Coroner's Office, which is what I did, excuse me, and found the record.

And I don't want to be graphic here. But you can get a picture of it from here. She was identified as a 19-year-old female. Importantly, she had scars on both arms. This was not from a train collision. These were old healed scars from her history of self-harm, I would say. And her body was so badly destroyed that mom wasn't even allowed to see the child afterwards.

So, we'd like to prevent that from happening. We'd like to prevent other deaths from happening. We'd like to prevent all of the stories we've heard today of young people being severely injured or mutilated from this treatment. Just to know this is not standard of care. I skipped over that slide, but endocrine society even said it. We don't have the technology to turn girls into boys, boys into girls, so kids may believe it. Medications are being used off-label at high doses without proper FDA risk assessment. Multi-fold harms are evident or predicted. Proper long-term studies haven't been done. Multiple systematic reviews of evidence have found poor quality of evidence of benefit.

Young people have been permanently maimed and killed during the course of these treatments. And finally, the WPATH Standards of Care 8 is an extreme document, presents a grave danger to minors and should not be followed by any clinician or physician. Thank you.

Jon Schweppe:

Thank you, Dr. Laidlaw, for such an instructive presentation. We now have one more panel before lunch, and I do appreciate you guys being patient. We had a lot to fit in today. So, let's keep going with the focus on the science. What does the science actually say about gender-affirming care? Our moderator is Myles Lynch who serves the Federal Trade Commission as one of our attorney advisors in the Chairman's office.

Myles Lynch:

I guess it's not morning anymore, so good afternoon, everybody. I know we're running a little late right now and you'll probably are looking forward to lunch, so I won't give a long introductory spiel. But this panel is comprised of medical professionals who building off of we just heard from Dr. Laidlaw can help us understand what the science really says about the benefits and the risks of gender-affirming care.

First, I'd like to introduce, I'll let them get seated first, Jennifer Lahl is the founder of the Center of Bioethics and Culture Network. A nonprofit organization educates the public lawmakers and others on bioethics issues. In this role, Lahl couples years of experience as a pediatric critical care nurse and a senior-level nursing manager with passion to speak on behalf of vulnerable populations. Lahl's writings have appeared in various publications including the Cambridge University Press, the San Francisco Chronicle, and the American Journal of Bioethics.

Her newest book, The Detransition Diaries, was published in 2024 and co-authored by Kallie Fell. She's produced 11 documentary films, 3 of which examine gender-affirming care. Her film's Trans Mission: What's the Rush to Reassign Gender?, The Detransition Diaries: Saving Our Sisters, and The Lost Boys: Searching for Manhood were released in June 2021, September 2022 and January 2024, respectively. She's frequently interviewed by the media and has been called upon to speak alongside lawmakers and members of the scientific community addressing issues such as human egg and womb trafficking.

Next is Michelle Cretella. She's a pediatrician, writer, researcher, educator, and speaker. She's the past executive director of the American College of Pediatricians and the current chair of its Adolescent Sexuality Committee. She serves as a pediatric spokesperson educator for the Association of American Physicians and Surgeons and the Catholic Medical Association. Dr. Cretella serves as a peer reviewer for the Journal of American Physicians and Surgeons, Issues in Law and Medicine, and the International Journal of Behavioral and Healthcare Research.

She became a leading physician critic of pediatric transgender interventions following a 2017 interview with Tucker Carlson in which she detailed their harmful effects and called them medical child abuse. Dr. Cretella received her medical degree from the University of Connecticut School of Medicine in 1994. Completed her internship in residency in pediatrics at the Connecticut Children's Medical Center in Hartford, Connecticut in 1997. Completed a fellowship in college health through the University of

Virginia in 1999 and practiced pediatrics with a special interest in behavioral health in 1999 through 2012. At that point, she left clinical pediatric practice to devote more time to leading the American College of Pediatricians. Lauren Schwartz is a psychiatric and psychotherapist in private practice. She's board certified by the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association and a senior fellow at Do No Harm. Throughout her career, she's advocated for upholding the highest standards of care and medicine and mental health. Her recent advocacy centers on gender-affirming care, particularly on interventions she believes are unsubstantiated, such as puberty blockers, cross-sex hormones, and surgical procedures from minors and vulnerable adults.

Her efforts have highlighted the critical importance of high-quality medical guidelines, and she asserts that low-quality evidence should never be authoritative as to what constitutes life-saving evidence-based care. In 2024, Dr. Schwartz co-authored an open letter to the APA regarding his Gender-Affirming Psychiatric Care textbook garnering over 7,200 signatures including those of clinicians, educators, and researchers.

She's actively testified against legislation that she understands compromised ethical medical practice and jeopardized vulnerable patients' well-being. Most recently, Dr. Schwartz collaborated with other medical and research professionals to publish an open access review. This review compiles over 50 studies highlighting extensive health risk associated with feminizing hormones in natal males.

And finally, Patrick Lappert is a plastic and reconstructive surgeon who has been in practice for over 30 years. He's board-certified as a general surgeon and has served as the US Navy's chief of Plastic and Reconstructive Surgery at the Portsmouth Naval Hospital. He also served as the reconstructive surgery specialty leader for the Surgeon General of US Navy. He founded the Pediatric Craniofacial Reconstructive Surgery Unit as well as the Wound Care Center for the Portsmouth Naval Hospital, which was then the largest military hospital in the world.

Dr. Lappert retired from the Navy after 24 years of service with the rank of captain. He then worked as a plastic surgeon in private practice for 18 years. Recently retiring from the practice of medicine and surgery. Dr. Lappert has served as an expert witness in numerous legal cases concerning gender-affirmation care in state and federal courts. He was active in the legislative process that produced Alabama's law protecting minors from affirmation care, and he has authored chapters and books about scientific evidence behind gender-affirming care medicine and surgery and about the pastoral care of persons wounded by the gender-affirmation industry.

So, if I can open up by asking Ms. Lahl a question. Can you explain, I know we just heard a little bit from Dr. Laidlaw, what fertility preservation is?

Jennifer Lahl:

Actually, read my remarks just so I can stay on task. Oh, sorry. Thank you. Thank you. Very good. Yeah. Fertility preservation is an assisted reproductive technology that is offered in an attempt to hopefully maybe preserve somebody's fertility so that they can have a biologically-related child in the future. There's several different methods. One is you can freeze your eggs, ova, oocytes, you can freeze sperm, you can freeze embryos, so you actually make embryos with egg and sperm and freeze them. Or often as the case of prepubescent children, you can do ovarian or testicular tissue cryopreservation, and that's an option that's available just to the prepuberty kids because they don't have egg or sperm yet.

Fertility preservation was first tried and used and perfected in the field of species that are at risk of going extinct. So, it was a method that was used to try to preserve different kinds of species. Then it moved into the patient population of adult cancer patients where the therapy treatment they needed for their cancer treatment could negatively impact or harm or destroy their fertility. And then in the

early 2000s, it actually moved into the pediatric cancer patient population so that children who also are afflicted with cancer might have the ability to someday grow up and have a biologically-related child.

But now, we've seen it expand into the scope of gender-affirmation care as something that's offered. I'm probably the only person in the room that when the Cass review came out, the first thing I did was look to see what Dr. Cass said about fertility preservation. And I was saddened and a little bit shocked that she recommended in Section 10 that all children be offered fertility counseling and preservation prior to being put on a medical pathway.

And if I could just put a highlight under some things that Leor said, "If we move to this assessment model, if we move to this model where we can do it better, we can do a good way of treating these children. And also, if we trust the experts, who doesn't want to trust Dr. Hillary Cass?" We have to be mindful of, I think what I'm about to say, that maybe we don't want to offer this to children. As you said in my bio, I was a former pediatric critical care nurse. But for the last 20 years, I've been spending most of my energy in the whole area, fertility, infertility, and assisted reproductive technologies.

I was deeply concerned as a nurse, as a filmmaker when I learned that children who before their puberty was blocked or before they were put on cross-sex hormones or offered surgeries were offered fertility preservation as part of their care. And again, knowing that the younger the child is, they're going to be offered the actual freezing cryopreservation of ovarian or testicular tissue in stage 2 to 3 Tanner stages where they have not yet developed mature gametes.

It's one thing to provide the possibility of having a biological child for a cancer patient, adult or pediatric who needs a treatment to potentially save their life. But it's a whole other thing to offer a person who has healthy fertility who we knowingly are going to damage, but we're going to offer them fertility preservation as part of their care. The research that Dr. Laidlaw cited on one of his slides that we published in March of 2025 in Frontiers and Endocrinology titled Fertility preservation: is there a model for gender-dysphoric youth?

We found only two reported live births in the pediatric patient, female patient where ovarian tissue cryopreservation was done. Only two of those young women that were age 9 and 13 at the time of having their tissue frozen were able to successfully have a live birth. And one other case was reported in a 14-year-old female. It did not say whether or not she had been through puberty or not. But this young girl was able to, after four rounds of IVF, was able to finally give birth, have a live birth, but she did deliver prematurely, which is a risk of IVF pregnancies in general to have premature deliveries.

But in each of these three cases, all of these patients had to have a gonadotoxic therapy to treat their cancers for one of the reasons they were offered for fertility preservation. As far as what we found in the male population, we found zero reported success cases of young men that were offered the freezing of their testicular tissue. An important unknown for both of these categories is we do not know how many attempts were made.

So, of the three young girls that were successful in having live births, did only three young girls attempt this or did 3,000? We don't know. So, you have to take that stat with a grain of salt. For those who that have gone through puberty. So, they were offered to fertility preserve their egg and/or their sperm, this is no longer seen as experimental, but all of the data that we have is all lumped together. So, these young people that as part of their gender-affirmation care offered, accepted the banking of their egg and sperm. They're lumped in with people that are struggling with infertility. They're lumped in with the Silicon Valley women who are just freezing their eggs because they want to have their biological clock protected.

But we do know of all these data points that are lumped together that overwhelmingly per the CDC data that over 50% of all IVF cycles fail. And I don't know what's going to happen with the CDC data because

the group that tracks all this at the CDC was let go, as part of the DOGE, letting go of people. So, we're not sure if we're going to continue to track this or if this is the end of the data that we're going to have.

Embryo freezing actually in the CDC data shows the highest success in live birth. I mean, and the game is to get a live birth out of all this. It's the freezing of embryos. And we know in the gender youth population, they're not freezing embryos because they're not partnered with anybody yet. They just are freezing their own egg or their own sperm. But considering the gender-dysphoric population, if they want to have a child, they also just need to consider the financial costs. I mean, it costs about $1,000 a year to freeze and store and bank your eggs. So, if you're an 8-year-old and you're going to be freezing and banking and storing your eggs for two decades, you have to look at the financial costs.

And we don't know in the medical literature for egg and sperm that have been frozen for that many years, what is the success rate for any of those ending up in either a conception, a creation of an embryo, let alone a live birth. We also have to consider the fact if this is, say for example, a trans woman, a male who froze and banked their sperm, who then grows up and is partnered with a male, there's no egg in the couple, there's no uterus in the couple. So, they're going to double down on the risks and the complications of a third-party conception rate.

So, it's evident to me for all these reasons, that offering fertility preservation to the gender-dysphoric population is deceptive. As the chairman said in his opening remarks, this is a misleading claim. I mean, when you are being offered fertility preservation, you think that you are preserving your fertility, fertility as in having a child, when in fact you're freezing your gametes with no guarantee whatsoever that you'll get a live birth. Thank you.

Myles Lynch:

Thank you for that. Dr. Cretella, could I ask you, as a pediatrician, can you tell us your experience with gender dysphoria and gender-affirming care before it became such a big issue?

Dr. Michelle Cretella:

Right. I think it's important for the public to know how gender dysphoria was treated prior to the explosion in trans identities, the explosion in the diagnosis of gender dysphoria. I would say in America that the 2013 was probably that turning point. 2013 is when the Diagnostic and Statistical Manual 5th Edition came out and altered the diagnosis from gender identity disorder to gender dysphoria.

And one note I want to make is that no genetic or biological trait or condition explodes onto the scene. And across western cultures, western countries, industrialized countries, gender identities, dysphoria has grown at exponential rates. This is a sign. This rate of growth is a sign of a psychosocial condition. Psychosocially constructed predominantly. We have to understand that. That's a scientific principle. And that's been suppressed.

We've heard from Dr. Laidlaw earlier, and I think also Miriam Grossman, it's science fiction to tell parents and children and vulnerable young adults that, "Oh, you just have a brain that's not on the same page as your body. You have a girl brain in a boy's body or a boy brain in a girl's body," science fiction. No one is born with gender dysphoria. Everyone is born either male or female with a sex. So, that has to be ... That concept of, "Oh, you're just born with the wrong brain." That is the foundational fraud right there. I have to get that out.

But prior to 2013, and the best way for me to illustrate this, pediatricians almost never saw this issue. I literally had from my training, which started in 1994 through 2012, so nearly 20 years spanning, I had one case that was very classic of a little boy. I'll just call him Andy. And this one is online, although it was censored. This family brought in their son for his 5-year well-child check and they were concerned

because increasingly from age 3 to 5, he started playing more and more with girls' toys. In preschool, dressing like a princess. And by the time he was 5, he was now saying he was a girl.

At that time, again, pediatrics was not captured by gender ideology. So, I referred him and the family to a family therapist, and they engaged in very traditional child play therapy. And over the course of several visits, well, it came out that he believed mommy and daddy loved girls better than boys. Why? Because when he was 3, after being king of the hill, he had no siblings, but at age 3, a little sister was born and she had profound special needs. Mom and dad had to reallocate. They were all about sissy, all about sissy. Children are not little adults, from ages 3 to 5, especially, they have magical thinking. They can misperceive what's going on. And he honestly thought in one play session, Barbie's here, trucks there, "Mommy, daddy, you don't love me when I'm a boy." So, once that issue was unearthed, oh, my goodness, over time within a year, they were able to change the dynamic. And yeah, he grew to know that, "Yeah. I am a boy and mommy and daddy do love me."

Another time, and this might've been around 2007, 2008, somewhere in there, I received a call from a mother. She was going to be bringing in her twin girls, identical twin girls for their 12-year well-child check. And this mom called me up and said, "Dr. Cretella, I didn't want to say this in front of the girls, but Lee," I'm just going to call them Lee and Ann. "Lee refuses to wear female underwear. She will only wear boxer shorts, and she cuts her hair like a boy and only wears all boy clothing now. Do you think this is a problem?" And I said, "Well, come in. We'll talk and see what's going on." So, Lee and Ann, they were identical twin girls. And again, this was like their 12-year-old child check. From very early years, both girls were very active. Ann was always a girly girl, and she was hardcore ballerina. Lee, from the earliest years, she was always into rough tumble play. She was dad's pal. She loved her dad. And now age 12, she was totally into ice hockey and she was never into dresses.

So, I reassured mom, "Hey, from the beginning, these were personality differences, classic tomboy, what else is going on? How's dad doing?" "Oh, we got divorced. Within the year, we had a divorce." And now, dad he wasn't physically abusive or anything like that. He had the girls every other weekend. And while I was examining Lee by herself, I said, "Hey, saw you see these are your favorite clothes. Hey, tell me why do you wear these?" Just gesturing to the boxers. "They feel so good. They're just so comfy." All right. And she had told her mother the same thing, separately. So, what I ended up doing was making a referral to a family therapist to focus. I didn't focus on Lee or her tomboy qualities, but I explained to them, I said, "When families go through divorce, this is a huge adjustment and this affects us." And I said this to them all together, the two girls and the mom, "It affects everyone differently. And it can be really hard to talk about how we think and feel. We don't want to hurt mom or dad's feelings, but counselors who specialize in this can really help you share your feelings and it can be really healthy. It's really healthy to do this."

And then privately, I said to the mother, "This clothing," the boxers in particular, I said, "It's probably part fashion comfort that psychologically she's probably missing her dad and the whole boy thing and haircut coinciding with the divorce. That could be some of it." And I just encouraged her, "Celebrate the fact that you've got a ballerina and a hockey player at home. Let her make her clothing choices and just focus on the open communication." Also, with her divorced husband as well and the family therapy.

Both girls thrived through high school. Today, poor Lee would've been said, "Oh, you are gender non-confirming," which, sure, okay, she's gender, "And you're 12. Wow. We really should postpone your puberty. We want to pause your puberty," i.e. put you into a disease state. Puberty is not a disease. The absence of normal timed puberty is a disease. So, she would've been put on the medical pathway so that she could have time to really decide, are you male or female or non-binary.

So, in the past, children had a greater chance of having their personality traits, their unique personality traits being affirmed and being shepherded through a critical developmental stage in which they could really come to embrace their true physical and personality identities, if you want to say.

Myles Lynch:

So, Dr. Cretella, what would you say to a responsible pediatrician today should do in those kinds of cases?

Dr. Michelle Cretella:

Yeah. When I'm asked by fellow pediatricians, what can we do? Because if I say these things, I'm going to be fired or my career will end. I will refer them to therapyfirst.org, which has wonderful resources both for clinicians and families. I will tell them because as pediatricians, we can screen for mental health, for anxiety, depression, and underlying traumas. We call them ACEs, adverse childhood events. That is critical as every pediatrician can screen for ACEs for depression and anxiety. Every pediatrician can do that and then refer for treatment for those underlying disorders. You need to know who you can trust within your local mental health area, of course, but therapyfirst.org is phenomenal and I do send many physicians and parents there.

Myles Lynch:

Thank you. Dr. Schwartz, given that we're talking about mental health and all of this as a psychiatrist, can you explain to me where you fit into the gender-affirming care funnel? When are you looped into this process and what's your role?

Dr. Schwartz:

Sure. Absolutely. Well, first I'd like to start out with saying thank you to everyone here and for having us to be able to discuss this, and I know I only have a short period of time, so I don't want to miss being able to say first and foremost as a psychiatrist that is in clinical practice every single day working with patients that from a gender-affirming perspective, repeating a medical fallacy over and over, louder and louder doesn't all of a sudden make it true. What you've already heard today and we'll continue to hear is this is life-saving. It's medically necessary, it's evidence-based. It's widely accepted in medical and mental health arenas as safe and effective, and it absolutely is not. So as a psychiatrist, I work with patients every single day. I prioritize seeing them doing a primary assessment. I look at the biopsychosocial model.

I talk about family issues and developmental challenges. Are they going through things? Are there things in their past or their present or traumas that they've been through that have influenced things? I focus on health and wellness. We work together. I'm looking for a differential diagnosis. I look for medical reasons. Many times in psychiatry diagnostically, I'm ruling out things that may be contributing to symptoms, whether it's depression, it's anxiety, it's distress related to gender or otherwise. We talk about all of those things. Then I talk with a patient about risk versus benefit. I think that's where if you don't take home anything else, realize this is a very exceptionalized approach to treatment from this affirmation perspective. That all of a sudden we ignore everything else. There's diagnostic overshadowing. Don't look at anxiety, don't look at depression, focus only on distress related to gender and then immediately funnel these patients into an extremely harmful, medicalized pathway.

That's not medicine. In no other area of medicine do we permanently alter healthy bodies to better align with a person's current, often underdeveloped, especially when they're kids, sense of self. Our prefrontal cortices, that front part of your brain isn't even fully developed until your mid-twenties,

sometimes 25, 26, 27 years old. So to think that a child can make a decision whether or not they should go through unhindered puberty, that doesn't seem like a medical decision or conversation I should be having with anyone, let alone a child. So when I think about what I do as a psychiatrist and I support mental health and wellness and well-being of my patients throughout their entire lives, not just in that moment, my job is not to affirm quote unquote in that moment what the child thinks that they need or vulnerable young adult thinks they need. My job is to sometimes hold reality when reality is really difficult and really painful and we have to walk through that and walk through it slowly.

We don't rush to medicine. I think that's part of what has really driven this just affirming model is that we have let go of evidence. I rely as a clinical psychiatrist on evidence-based data and guidelines. My own professional association, the American Psychiatric Association, published a book Gender... I'm sorry, Gender Affirming Psychiatric Care in 2023. I with several of my colleagues who are here today, we wrote a letter and said, how can you do this? This book says that puberty blockers are fully reversible and cross-sex hormones, they're generally safe and effective and they're life-saving and they're necessary. And as a psychiatrist, the exceptionalized psychiatry practice is get out of our way, let us provide harmful hormones at doses we've never prescribed before in children and young adults.

It leads them down a path to surgeries and that's not medicine. It's not acceptable. No parent should have to bury their child ever, and we've heard from so many today that have gone through horrible traumas because of what medicine is doing, medicine and mental health. We are failing patients and families and we have to do better and I do hope that with the help of the FTC we can do that.

Myles Lynch:

Just one quick follow up, so you would say that you think it's aberrational how the best practices for healthcare are coming about in gender-affirming care relative to other types of healthcare? Do you think that it's an aberration how the best practices are being developed for gender-affirming care versus other?

Dr. Schwartz:

Absolutely. Yes. It's a remarkably, again, exceptional development of what we are calling best practices, and I think Skirmety was a wonderful example of it. If you want to read amicus briefs, read the one that the American Academy of Pediatrics that included the American Psychiatric Association, the American Medical Association, the American Association of Medical Colleges, 24 organizations, one included WPATH. They were together on an amicus brief calling this critical, medically necessary, and evidence-based care for gender dysphoria. That's false. It's a lie, but they submitted it to the Supreme Court. So yes, I consider it horrific.

Myles Lynch:

And Dr. Lappert, speaking of best practices, is there a diagnostic process that you can use as a surgeon that tells you whether a patient should get gender-affirming surgery with enough confidence to get informed consent?

Dr. Lappert:

Yeah. Thank you and thank you to the Federal Trade Commission. I didn't imagine 11 years ago when I started down this road that I'd ever be speaking to a federal agency about what's going on in the world of medical care in the United States. The transgender treatment industry actually operates in the American medical system through the use of deceptive labeling and deceptive practices. It presents gender-affirmation care as grounded in science. It claims that gender discourse is frequently lethal if not

treated with affirmation care. It claims that gender affirmation is life-saving. It claims that gender affirmation is medically necessary and that it improves the lives of self-identified children. It claims that affirmation care is founded in an accurate process of diagnosis. It claims that affirmation care is the standard of care and that all of this is based in an unassailable body of scientific evidence. All of these claims are deceptive and are made in support of medical and surgical treatments that produce severe and lifelong harms.

It mislabels gender affirmation surgery as reconstructive rather than cosmetic. Using that deceptive labeling to defraud public and private insurance programs as well as defrauding the finances of families while essentially medicalizing these young people for life. Virtually all of the publications of the transgender treatment industry from journal publications to gender clinic websites or legal declarations refer to the WPATH standard of care as the foundational document that serves as a scientific basis for gender affirmation, including surgery.

This document was produced allegedly using the Delphi consensus methodology that was spoken about earlier, but when you look into it, what you find, one of the criteria for a competently done Delphi assessment is that it's done by repeated voting processes that include members in that group outside of the organization that's doing the questioning. That the repeated questioning is happening and the voting is happening anonymously, and none of that is the case in the standards of care.

All of the participants in the Delphi methodology are members of the WPATH and we've also seen that how that Delphi process was further corrupted by the political influence exercised by the government. There is no body of evidence to demonstrate the accuracy of diagnosis. There's no long-term treatment efficacy that could support the labeling of the standard of care. The use the words standard of care is an intentional mislabeling standard of care suggests to us that there's a level of scientific evidence above what we call level three in plastic surgery that is sufficient to guide clinical decision-making and that it is called a standard of care because to do otherwise is to risk harm to the child or to the patient. There's no body of evidence to call it a standard of care. There is no body of evidence even to include gender affirmation care in a treatment guideline as an option.

There isn't sufficient evidence to include it even there. The WPATH document and all the derivative documents falsely label surgeries such as chest masculinization, which is the amputation of two healthy breasts from a young woman, they label that as reconstructive surgery. This is patently false. Speaking as a plastic surgeon, I can tell you that this is no small distinction. Reconstructive surgery is surgery that aims at the restoration of form and function that has been lost due to trauma, surgical care of cancer, infection, or congenital or in utero deforming events. The wounded or the lost part can be objectively defined and those findings guide the surgical planning. The restoration of form and function is the key. Gender affirmation surgery is not based in any loss of form or function. It's based in the emotional life of the patient. The motivation for surgery is emotional and subjective and the success or failure is measured using subjective test instruments like quality of life surveys.

This is the very definition of cosmetic surgery. Gender affirmation surgery is cosmetic surgery. Representing it as reconstructive surgery is an act of deceptive labeling because it suggests evidence of medical necessity where there is no evidence for such a claim. Such mislabeling is employed to mislead patients and parents and to defraud insurance. Proponents of gender affirmation care, including WPATH, make highly exaggerated claims concerning the lethality of gender dysphoria. If it is not treated with affirmation care, the number typically offered is something approaching 40% mortality by suicide. There is no sufficient scientific evidence in the world literature that can be cited to support that claim. The further claim without evidence to support it, that affirmation care including surgery is life-saving. That claim is used coercively, as we've heard earlier, to obtain surgical consent from parents. Gender

affirmation surgery begins with a false claim concerning risk and then mislabels the surgery as having proven efficacy in saving lives.

It obtains consent for surgery by the deliberate deceptive practice of the concealment of existing alternatives of care and their associated benefits. The claim of efficacy itself is based in the intentionally deceptive concealment of high-quality evidence to the contrary. For example, the most commonly performed affirmation surgery at present is chest masculinization in young women.

In a 2019 scoping review of the world literature published by Dr. Tolstrup, a scoping review is level three evidence. It's a systematic review of the literature in that he examined 849 papers in the world literature that examined gender affirmation chest surgery, and that's high-quality evidence. That review reported that the state of the scientific support for gender affirmation breast surgery is low to very low, meaning that there is no basis for offering such surgery as a treatment option for gender discordance. To offer such surgery without offering other therapeutic options to parents and patients is an act of deception by concealment of facts that patients and parents have a right to know if they're going to give consent for surgery.

The WPATH path document in its chapter on surgery further deceives by suggesting that affirmation surgery is effective because such surgeries begin with a proper patient selection. That's in the first paragraph of the chapter on surgery. This is an intentional deception. The transgender treatment industry has no process or test instrument that can be employed to confirm the diagnosis of gender dysphoria. There's no process by which the patients are selected for surgery versus not surgery. There is no testing process that stratifies either risk or benefit. There isn't even a common language of description for either the condition or its treatment. As Dr. Tolstrup demonstrated in his scoping review, there is no patient selection. The patient, typically a distressed child makes the diagnosis. The medical team does nothing to confirm or refute or otherwise characterize the condition. On the other hand, there's a very large and consistent body of scientific evidence showing us that gender affirmation surgery is very harmful to young people.

Chest masculinization surgery that we've been discussing results in the permanent loss of two human capacities, 100% of the time. Young women lose the ability to breastfeed 100% of the time. Young women completely lose erotic sensation from the area due to the severing of the fourth nerve nearly 100% of the time. Neither the capacity for breastfeeding nor erotic sensibility can be restored. In the case of genital surgery, there is the loss of reproductive capacity as well as the degradation if not complete loss of erotic sensibility. In addition to those losses, there's also the additional risk of urinary blockage, urinary leakage, incontinence, the risk of fistula formation resulting in fecal leakage through the counterfeit vagina, chronic wounds, the need for repeated surgery to correct these conditions and the markedly elevated lifetime risk of cancer caused by such chronic conditions in patients receiving high dose sex hormones. When surgical procedures such as gender affirmation surgery are only based in low to very low quality evidence, then by definition those surgeries must be labeled as experimental surgery.

The failure to label it as such is itself an act of deceptive labeling. Furthermore, experimental surgery that involves the high likelihood of loss of function that's described above can only be offered under stringent protocols that govern human experimentation. Such experimentation can never be done on children, given that it has never been proven to be lifesaving. In fact, it has not even proven simple efficacy. Gender advocates will often make the claim that breast and genital surgery on gender-confused minors is rare and should therefore not be a matter of national policy. The best estimate that I can make for you at present is that over the last 15 years, approximately 4,000 minors have undergone gender affirmation surgery in America, the most common procedure being chest masculinization of young women. That number does not account for what may be a considerable number of minors who have

undergone surgery in private fee-for-service clinics and whose records are privately held and therefore unreported.

There's also the added problem of underestimation due to the known practice, and this was discussed earlier, the known practice of mislabeling and miscoding these surgical procedures such as mislabeling bilateral mastectomy in a natal female and calling it gynecomastectomy, an operation commonly done in males to correct for the presence of breast glandular tissue.

They justify this deceptive practice by claiming that these women are actually men. There is deception in the consent process and this to your question, as I alluded to earlier, by misrepresenting both risk and benefit by failing to offer alternatives of care by using the false claim of extreme risk of suicide and obtaining consent under duress by failing to disclose the experimental nature of the surgery and failing to provide ethical oversight in such experimentation, all of that renders consent utterly meaningless. Furthermore, the consent process overlooks the startling fact that a person suffering from suicidal ideation is by definition considered legally incompetent to give consent or in the case of a minor to give assent.

To summarize, gender affirmation surgery is not supported by any high-quality scientific evidence. It is not based in any reliable diagnostic process. There is no test instrument that can be used to stratify risk, to select patients for surgery or to predict the likelihood of any outcome. The harms are very evident in lifelong whereas the benefit has not been demonstrated. It is a product that is deceptively labeled as reconstructive when in fact these are cosmetic operations that in the case of breast and genital surgery begin with the intentional mutilation of the patient. Cosmetic operations that consistently mutilate patients are perhaps the most striking example of malpractice that I can think of. All of these deceptive practices and mislabeling in addition to causing irreversible harm to vulnerable young people ultimately defraud families and insurance providers for financial gain. Thank you.

Myles Lynch:

Thank you, Dr. Lappert. Thank you for all those specific examples demonstrating about how these practices ignore patient harm. Does anybody else in the panel have specific examples of gender-affirming care practices actively ignoring patient harm?

Dr. Schwartz:

If I could jump in really quick, I think one thing that has been pointed out over and over also is that this is a model of care that's overselling benefits and remarkably under-reporting harms. My colleagues and I, we published a paper about a month ago. We looked at over 50 peer-reviewed studies already available to anyone providing gender-affirming care. These practitioners, these providers are fully aware. We looked at all of the harms. This is not something that's hidden. It's peer-reviewed, it's published, it's been available, it still is. We just compiled over 50 studies that looked at harms and this is just in one area of estrogen used in natal males. Please understand that they are asking us to ignore harms. They're asking patients and parents to ignore horrible outcomes at the expense of children's lives.

Jennifer Lahl:

I think just to tag on that, the same thing is in the paper that Dr. Laidlaw and Dr. Thompson and I published. The data's there. I mean, we just went looking for it. We found that there was zero young men that were offered testicular cryopreservation that went on and had a child, so it's not like we discovered something that was new or novel and I think I will just underscore the fact that I don't want

us to take the CAS review and just remember that one little point where she recommends this and I think it's because she's unaware of the data which is out there. Thank you.

Myles Lynch:

Thank you both. And obviously this event is focused on gender-affirming care for minors. I was wondering if anybody could weigh in on what exactly makes it different for minors than it would for agendas for adult. Is there anything particularly about children, the vulnerabilities that they have that make this especially problematic?

Dr. Michelle Cretella:

I think it's their vulnerability, their vulnerabilities. That's why our laws normally protect minors because children are not little adults. Adults have better, higher cognitive development and function, have lived a longer lives, have had greater experiences, can better assess risk and benefit. Even adults, of course, cannot offer informed consent if they're being fed lies, right? So whereas we're focused here on protecting minors and being more maybe paternalistic because we recognize that children and adolescents have underdeveloped judgment centers of their brain and have lived shorter lives. Every adult requires and has a right to the true facts in order to give informed consent. And I think those of us who have spoken and will speak, we are often defamed and, oh, why should we believe you versus the AMA, the AAP. I think it comes down to three things. Follow the science, follow the money, and follow your heart.

Science proved long ago that sex is determined by genes alone and there are only two. No one is born in the wrong body. What we are dealing with in this population of minors who are seeking so-called gender-affirming care. Science has also revealed they are the most vulnerable of the vulnerable. We're dealing with children who have an average one study found an average of five traumas in their childhood. They have untreated psychiatric disease. They may be on the autism spectrum, they may have ADHD. Many are experiencing LGB attractions, so that's follow the science. It's a vulnerable population. Follow the money. AMA, AAP, ACOG, APAs, they are heavily funded by big pharma. This is a cash cow for big pharma and for all those big pharma funds.

Those of us who speak today, we are not getting paid to be here and it's quite the opposite. We put our reputations and our livelihoods on the line. Follow your hearts. You got to ask yourselves, is it loving for big medicine to offer your daughter, your sister, your LGB child, your ADHD child, mutilation, castration, diseaseing, and sterilization? Is that loving? I call it criminal. My profession used to call it eugenics. That's where we are and that's what we have to get out.

Myles Lynch:

Jennifer, do you want to give one last mark to it or did you cover it? All right, well thank you all. I think now it is time for lunch, so thank you. We will return at 1:30.

Jon Schweppe:

Welcome back everyone. If everyone could have a seat as we're coming back from lunch. Just wanted to, from the last panel, thank our medical experts for such an informative panel. Really appreciate all these folks making the trip out to Washington to share with the Federal Trade Commission today. So now we will have remarks by Commissioner Holyoak. Unfortunately, she could not be here today. She's at a family reunion combined with her mother's 80th birthday, so I think that's a pretty good reason, but this is an issue she cares deeply about, and so please watch this video from Commissioner Holyoak.

Commissioner Melissa Holyoak:

The FTC staff who are contributing to today's workshop. [inaudible 04:31:23] for us today are my own. They do not necessarily reflect the views of the commission or any other Commissioner. Right after I gave birth to my second daughter, it became immediately apparent that she was very ill. There had been no indication during my pregnancy that she had any medical problems, so we, like other unfortunate parents, experienced the trauma of having our newborn whisked away unexpectedly to the NICU. My husband and I learned that part of her heart was swollen and she was suffering from persistent pulmonary hypertension. It was one of the most frightening and trying periods we ever experienced. This was not the way it was supposed to be, and this is not what I had envisioned and dreamed of for nine months. I had never felt so helpless in my life as I watched her fight for her life over the coming days. During that time, we relied on the doctors to provide us complete and truthful information as we made medical decisions to treat my daughter. Thankfully, my daughter recovered. She's now a healthy 16-year-old who has blessed our lives in countless ways, and we can't imagine our family without her.

My heart is with those parents who have had similar experiences faced with watching their children suffer from injury, illness, or disease. I empathize in particular with parents whose children experience mental health challenges. Treatments are often complex and may involve a combination of psychotherapy, medication, and other therapies, but whatever health problem a child may be experiencing, it is critical that medical professionals provide parents with complete and truthful information in order for parents to make those difficult medical decisions.

Today, the commission is exploring whether to address unfair and deceptive practices in what is sometimes called gender-affirming care for minors. Recent reports estimate 1. 6 million Americans over the age of 13 identify as transgender. Some transgender individuals suffer from gender dysphoria, a medical condition characterized by persistent clinically significant distress resulting from an incongruence between gender identity and biological sex. Left untreated, gender dysphoria may result in severe physical and psychological harms.

While some have questioned the FTC's role here, there are three principal reasons why the FTC should use its authority to combat unfair or deceptive practices related to gender-affirming care. First, the FTC has a strong history of enforcement actions against unfair and deceptive healthcare related claims. In December 2022, the FTC published a health products compliance guidance, which notes that since 1998, the commission has settled or adjudicated more than 200 cases involving false or misleading advertising claims about the benefits or safety of dietary supplements or other health related products. For enforcement purposes, the advertisement of reported health benefits may be accomplished through a variety of marketing techniques, including by medical practitioners. The guidance further explains that claims about the health benefits or safety of foods, dietary supplements, drugs, and other health related products require substantiation in the form of competent and reliable scientific evidence. Importantly, such substantiation cannot be based solely on a medical practitioner's experience.

A healthcare practitioner's observation about the effect of a health product on patients is anecdotal and doesn't provide evidence of a causal relationship, nor can substantiation be based on advisories from a medical organization because those are based on best currently available evidence rather than a causal link between the recommended course of action and the health benefit. Further, the guidance instructs that a claim may be misleading if it fails to inform about significant safety concerns. Simply put, it is black letter law that misleading and unfair health related claims can violate Section 5. And it is increasingly clear that there are serious questions about the risks and purported benefits of medical transition treatments for children with gender dysphoria. Justice Thomas describes the risks in the US Supreme Court's recent decision, United States v. Skrmetti, which involved a challenge to Tennessee's law restricting sex transition treatments for minors.

For example, there are significant safety risks relating to the use of puberty blockers. Using puberty blockers to suppress normal puberty has multiple organ system effects whose long-term consequences have not been investigated. Such use may lead to decreased bone density and impacts on brain development. It also remains unclear whether patients ever develop normal levels of fertility if puberty blockers are terminated after a prolonged delay of puberty. There are also significant safety risks relating to cross-sex hormone treatments, which involve very high doses of hormones of the opposite sex. For girls, the treatments can cause increased cardiovascular risk, irreversible changes to vocal cords, atrophy of the lining of the uterus and vagina, and ovarian and breast cancer. For boys, cross-sex hormones can cause increased cardiovascular risk, breast cancer, as well as sexual dysfunction. And for girls and boys alike, it is generally accepted even by advocates of transgender hormone therapy that hormonal treatment impairs fertility, which may be irreversible.

The asserted health benefits of treatments for transgender adolescents include the reduction of anxiety, depression, and risk of suicide. Yet just last week, an article in the Atlantic discussed how these benefits have been presented to parents reporting that a physician with Children's Hospital Los Angeles explained, "We often ask parents, 'Would you rather have a dead son than a live daughter?'" Similar reports in The New York Times indicate that parents were presented with this Hobson's choice, which felt like emotional blackmail. But as the Atlantic article reveals, the question medical providers have posed to parents did not present a truthful representation of the consequences of gender-affirming treatment. When Justice Alito asked an oral argument in the Skrmetti case about suicide rates, the ACLU lawyer confirmed that there was no evidence to support the idea that medical transition reduces adolescent suicide rates.

Indeed, in 2024, the United Kingdom's National Health Service commissioned an independent review of the use of puberty blockers and sex hormones to treat children with gender dysphoria. This review found a lack of evidence to support the conclusion that hormone treatment reduces elevated risk of death by suicide. Parents deserve, and the law demands complete and truthful information regarding the grave health risks of transition treatments for minors, as well as complete and truthful information regarding health benefits that are actually substantiated. After weighing the risks and benefits, more than 20 states have enacted laws banning six transition treatments to minors. In affirming the Tennessee law, the US Supreme Court acknowledged the fierce scientific and policy debates about the safety, efficacy, and propriety of medical treatments in this evolving field, but that the court's role was not to judge the wisdom, fairness, or logic of the law before it, but only to ensure that it did not violate the equal protection guarantee of the 14th Amendment. Similarly, the FTC plays an important but limited role in this area.

The FTC does not regulate the practice of medicine. The FTC cannot make policy decisions limiting sex transition treatments for minors, but what the FTC can and should do is protect children from deceptive statements regarding such treatments. The FTC has previously enforced and will continue to enforce against deceptive representations made by medical practitioners, including claims in connection with treatments for transgender children. Second, reviewing claims of health benefits for transgender minors is particularly important given the significant and evolving changes in protocols for treating gender dysphoria. In the Skrmetti case, the Supreme Court detailed these evolving changes in clinical guidelines. WPATH, the World Professional Association for Transgender Health published one of the first set of guidelines in 1979 where it advised that hormone and surgical treatments should only be provided to adults. It later changed that recommendation in 1998 to prevent hormone treatments for minors in rare circumstances. WPATH further relaxed its guidelines for minors in 2022 to allow puberty blockers, hormone treatments, and surgical procedures at the onset of puberty, while still recognizing that our understanding of gender identity development in adolescents is continuing to evolve.

Importantly, WPATH's changes do not necessarily reflect widely accepted practices. In fact, recent changes across the world show that there really are no widely accepted practices, but instead drastically evolving standards in this area. After the UK's National Health Service published its 2024 report on the topic, NHS England enacted prohibitions on the administration of puberty blockers to new patients under the age of 18 outside of research settings and instituted a process for reviewing referrals for hormones for adolescents under the age of 16, but England is not alone. Finland, Norway, and Sweden have also raised concerns about using puberty blockers or hormone treatments on juveniles with gender dysphoria and have limited such treatments in some cases by allowing them to go forward only in a research setting. And in Australia, after the state of Queensland placed age restrictions on puberty blockers and hormones, the Australian government began developing new clinical practice guidelines.

Review of these clinical guidelines conclude and as the Atlantic article describes, the fairest thing to say about the evidence surrounding medical transition for adolescents is that it is weak and inconclusive. While relevant legal precedent already recognizes that advisory guidelines cannot serve as the basis for substantiation, what these evolving guidelines emphasize is that the risks and benefits of transition treatments for minors are nowhere settled and any definitive claims or statements should be carefully examined.

Finally, the FTC should prioritize enforcement against unfair and deceptive practices, especially when there's potential for serious harm to children. As previously mentioned, these treatments result in increased risk of cancer, infertility and sexual dysfunction, decreased cognitive development, as well as irreversible physical changes. Given the very serious safety risks, potential for permanent harm and the inconclusive evidence of health benefits, it is appropriate for the commission to ensure that parents are receiving accurate information.

We will continue to prioritize enforcement that protects the most vulnerable among us, especially our children. A recent op-ed in The Washington Post said the quiet part out loud. There, MIT professor Alex Byrne discussed his participation in a review of gender dysphoria treatments published by the United States Department of Health and Human Services. He explained, "I'm hardly a fan of the current administration. I have never voted Republican and as an academic from Cambridge, Massachusetts, I hold many of the liberal beliefs of my tribe. That includes support for the right of transgender people to live free from discrimination and prejudice, but," as he explained, "medicalized treatment for pediatric gender dysphoria needs to be passionately scrutinized like any other area of medicine, no matter which side of the aisle is cheering it on." From the opposite side of the aisle, I agree that we should work together to scrutinize and ensure complete and truthful about the risks and purported benefits of medical transition treatments. We owe this to our children. Thank you.

Jon Schweppe:

Thank you, Commissioner Holyoak. Let's take a moment here to thank the wonderful FTC event staff for putting on an absolutely incredible workshop. We had about 200 people here today and then hundreds more listening online, so really, really a wonderful thing. Also, I want to thank the security staff as well for keeping us safe here today. All right. So now we have Chad Mizelle with the Department of Justice Chief of Staff, and I'd like to now welcome Chad to the stage.

Chad Mizelle:

Thank you all very much. Thanks for being here. Thanks for giving attention to this very, very important issue. I'd like to start by thanking, first of all, President Trump, who has given me the honor of being able to serve you all, being able to serve the American people and especially want to give a shout-out and thanks to my boss, the very tough Pam Bondi, who I think is doing incredible job at DOJ. Thank you. Well

deserved. Well deserved. She's doing such a great job and she's particularly tough on these issues. She was a career prosecutor for 16 years. She was a state attorney general for eight years. This is her passion. This is something she feels very, very strongly about, and I'm very happy to be here to announce some of the things that DOJ is doing on that front.

There's a basic principle of law. You cannot deceive consumers. You cannot lie to them to get them to buy your products, use your services. You cannot commit fraud. This is true in providing medical services, but also more generally. There's no doubt in my mind based not only on what we've heard here today, but just looking around with our own eyes that the industry that is formed around providing gender-affirming care and transitioning services for children has perpetuated one of the greatest frauds on the American public. And that is especially true with respect to our vulnerable children and their parents. One of the most important tasks of government is to prevent this fraud from continuing. And to remedy the consequences of this fraud in recent years, the FTC has a very broad mandate and a consumer protection mandate specifically with powerful investigative tools attached to that. It's very well positioned to tackle this issue, and I would like to thank all the commissioners and particularly my dear friend Chairman Ferguson for the great work that he's doing on this front.

The DOJ also has numerous civil and criminal tools to root out fraud. We are focusing these tools on everyone who's involved in the multi-billion dollar industry of harming our kids, and I want to point out a couple things that we're doing. First, with respect to civil and criminal fraud. Although the details, the exact details of the public of the targets of our investigation are not yet public, we have issued nearly 20 subpoenas against clinics who are engaged in transition related investigations. Thank you.

We're investigating violations such as healthcare fraud, false statements, all of this which could result in either civil or criminal liability for these clinics. We have also investigations into hospitals and other providers related to fraudulent billing, false claims under Medicaid fraud and the False Claims Act. We're going after false and deceptive claims by non-profits and medical associations that have provided false, deceptive or scientifically dubious assertions about transition related medical interventions, allegedly is cover for the clinics and the hospitals to be able to do what they're doing. And finally, we've issued subpoenas to major manufacturers of the drugs used in trans-related medical interventions for possible violations of drug marketing laws and the Food and Drug Cosmetic Act. We've also prepared draft legislation. We're working with Congress on existing criminal laws related to female genital mutilation to more robustly protect children from chemical and surgical mutilation. Thank you.

And we're continuing to work with Congress about enhancing the ability of injured parties to seek remedies, to get recourse because as you all know, that is so important. The way you're going to take down this multi-billion dollar industry is for people to speak out, which is exactly what we're about to hear. We are using all of the tools at the Department of Justice to address this issue. Now, before I introduce, I do want to give a shout-out, if you are somebody who has been harmed in this industry, let us know. If you're a parent, if you're a child, if you were somebody who was lied to, deceived, told that a particular pill might be reversible when we all know it's not actually reversible, we want to know about that. That will help us in all of our investigations, not just on the civil side, but on the criminal side. So please come forward. Come talk to us.

We have DOJ representatives, I think here at the conference. Some of them spoke. Obviously, I'm going to be here. If you guys have any questions about how to get ahold of us, you can reach out to any of the FTC staff who we work very, very closely with, but please continue to reach out to us. Now, we're going to move to a very important conversations with parents and survivors. Earlier, Chairman Ferguson had the opportunity to hear about the harrowing personal experiences from Claire Abernathy, Kayla Lovdahl, Simon Amaya Price, and Gareth Amaya Price, and the truly heartbreaking story of Elvira Syed about the tragic loss of her daughter. There are too many of these stories.

Please join me right now as we welcome to the stage, Prisha Mosley, Soren Aldaco, Beth Bourne, Forrest Smith, Helen Spiegel Lee, and Gwen Turecki. We're going to invite these individuals to the stage. I'm not going to introduce them all beforehand because as part of this, you guys will see they're actually going to be introducing themselves and giving some of their stories as well. Yes, a round of applause. Thank you. Great. To get started, I would just like to jump into it. There's not much I can say that wouldn't detract from the personal experiences that you guys have had, and so to just start off, Prisha, I would love to give you the floor.

Prisha Mosley:

Hello. Okay. Thank you very much for having us here and for listening to our stories. My name is Prisha Mosley. I'm a 27-year-old detransitioner and mother. I am also a victim of medical fraud and abuse. When I was a teenager, my doctors lied to me and as a result, I was medically harmed and defrauded. I was a struggling girl suffering with mental illnesses and with multiple comorbidities including panic attacks, depression, and borderline personality disorder. I experienced a sexual assault as a minor, which made me fear being a woman. I learned about trans online on Tumblr. I felt that I identified with what I read online. I hated myself. I couldn't eat. I struggled to look at my body and I self-harmed. This must mean that I was trans. When I brought this to my nutritionist who was treating me for anorexia, I was immediately introduced to a pediatric endocrinologist who agreed that I had been born in the body and needed medicalization.

I was 16 years old and my body was perfectly healthy. No one cared that I had trauma associated with being female or that I hated my body and had delusions about how it looked. As soon as I said the word trans, all medical ethics went out of the window. I was convinced by the endocrinologist that I had a medical condition. I was led to believe that I had a male brain trapped inside of a female body and that this incongruence would ultimately lead to my death by suicide. I was told that it was a form of intersex. It was under the guise of these lies that I was referred to a woman for a letter of recommendation to begin testosterone injections. After suing her for fraud, I discovered that she was not even licensed as a doctor or a therapist. She was simply a woman who decided that my healthy female body was wrong.

In the letter she wrote for me, she did not mention that I was unable to eat often for days in a row or that I was on a number of psychiatric medications. Instead, she affirmed that I was born in the wrong body and needed to be administered wrong sex hormones in order to stop my mental suffering and continue living. She asked my parents if they would rather have a dead daughter or a living son. I believed that I would die without transition. Medicaid was billed to cover my testosterone injections under endocrine disorder unspecified even though nothing was wrong with my endocrine system. Now, my healthy functioning has been taken away and I cannot regulate my own hormones. Testosterone did not improve my mental state, but worsened it. I was put on more psychiatric medication and given muscle relaxers to deal with the side effects. Cutting episodes worsened.

No one told me that testosterone was the cause of the cysts on my ovaries. I was told when I complained about pain that I was going through male puberty, which is something a teenage girl cannot do. My body was falling apart and my doctors gaslit me and told me that it was good. Testosterone mutilated my genitals before I could legally consent to sex as an adult. I was lied to about the effects it would have, and I suffer with atrophy and disfigurement and pain. I have never had sex as an adult with normal, healthy vagina. I didn't understand what was being taken away from me. When I gave consent, I was too young and I was not being given accurate medical information. My consent was stolen. A year after starting the testosterone injections, I was led to believe by activists and my doctors that I needed to remove my healthy breasts.

I was told that they were causing my continuing mental distress and that I would feel relief when my body was modified. No mental illness can actually be cured by cosmetic surgery. I suffered severe surgical complications as a result of giving birth. The papers I signed said that I may have trouble breastfeeding, concealing the reality that my chest is surgically sealed shut. My nipples were grafted and reattached in the wrong spot, and now they are just decorative. I was unable to breastfeed my baby, the milk that came in. I had no idea that I had breast tissue left inside of me or that this was possible. It was the worst pain and heartbreak I have ever felt. I wanted to die. It is impossible to change sex, but I was led to believe by my doctors not only that I could, but that I needed to do so to live. No mental illness or mental suffering can be relieved by making cosmetic changes to the secondary sex characteristics. But this is the treatment that my doctors offered me and no alternative. I was never given any other option. My doctors never used real medical terminology. They tricked me, using euphemisms like top surgery and with pseudoscience, like the genderbread man. I genuinely believed that I needed drugs and surgery despite the fact that my body was healthy and I just hated myself. My doctors defrauded me. I am not alone. No human changes sex or is benefited by the purposeful disruption of their endocrine system or the removal of their healthy body parts.

Chad Mizelle:

Prisha, thank you so much for that. I don't want to pry too much, but can I ask your child's name?

Prisha Mosley:

Unfortunately, I can't share his name because I actually got threats on my children for the fact that I showed up here today to do this.

Chad Mizelle:

Wow. I'm so sorry, Prisha. Well, thank you for sharing that. Soren.

Dr. Michelle Cretella:

First, I want to say I love Prisha. Thank you for sharing all of that. My name is Soren Aldaco. I am a 23-year- old woman from Texas, born and raised in the suburbs, the urban sprawl between Dallas and Fort Worth. But now I live in Austin where I just graduated with my bachelor's degree and I now study how the internet is influencing identity formation. Thank you. With that, I speak on behalf of myself today as someone who began transitioning socially at age 11, was on the internet, chronically online, like a lot of people my age were and are. And that's where I was first, like I said, exposed to the idea that I could be born in the wrong body and that surgically and medically altering my body might be a good fix for my mental health conditions or my discomfort generally with that body, which was changing, which is pretty normal for puberty.

But that was mostly a role-play identity, something that I used as a framework for developing a sense of self. Until age 15, when I met my biological father for the first time. I went inpatient, I had a little bit of a mental break as I'm sure many people would have meeting their biological father through Facebook for the first time. And while inpatient, the doctor picked up on the fact that I bound my chest and I went by a different name and what was on my record, and he pushed me until I told him, finally, after he had kind of fished for the idea that some people don't identify with their body parts down there and eventually pushed me until I came out as trans to him and then called home and told my family that that was the root cause of all my problem. No credence to the fact that I had just met my biological father, no credence to the fact that I had a strained relationship with my stepfather who helped raise me, but who is pretty profoundly disabled.

And so from there I started to internalize that idea that medical transition might be a path forward for resolving this distress that seemed never ending. And so I began attending a support group in the DFW area. There were several support groups actually in that area run by the same organization, Trans-Cendence International. And it was at that support group that I met a nurse practitioner who had a transgender adult child and was furnishing hormones to pretty much anyone who came and saw him. And after one appointment, at age 17, without ever meeting my real parents or even that the adults who took me were my parents, which they weren't. He prescribed me testosterone, an estrogen blocker, Anastrozole. He facilitated me to lie about my sex on my government documents such as my license, and I could have gotten my birth certificate changed as well if I had wanted to and referred me to a specialist anytime I would have a complication pop up.

If I had vaginal atrophy, it was the gynecologist who was really quick to offer me a hysterectomy, if it was dizziness and headaches and joint pain, it was the rheumatologist or the neurologist or the cardiologist or the orthopedist. I saw all of those at age 16, 17, 18, 19. And so he too also used endocrine disorder not otherwise specified, I believe it was called, to get these covered by my private insurer. But worse than that, that medicalization, which happened right before the onset of COVID in January of 2020, led me to begin to explore in that pandemic lockdown, the idea of amputating my breasts as a form of treatment for the stress and the distress that the hormones didn't actually absolve because they weren't actually treating so much as they were adding onto the list of problems I was already experiencing.

And at that point, I had seen a therapist who had a trans ex spouse and she helped write a totally fraudulent letter. And by fraudulent I mean full of things that were not true, such as my client has lived as a man for the last 12 years, which as someone who was born female and will die female, I had not. But that was especially untrue during COVID, right, when there was no opportunity for me to even go into the public to live life as a normal person or adult, let alone the opposite sex. So she ignored a history of sexual assault that I disclosed to her and after I stopped seeing her, I ghosted her. She did not revoke that letter, but she did terminate my status as her client. From there, I saw the Crane clinic in Austin, which I strongly advise being researched.

They moved from California to Texas because of Texas, at least in my opinion, Texas's tort reform laws, which make it extremely difficult to sue them for medical malpractice. They told me that they could get my surgery covered in-network despite being out of network. So they had a 90% success rate. Told me, alongside listing all the complications I could experience from the surgery, that they had never really had any complications like that. And I would later find out, after experiencing complications, that was because they ghosted clients who had complications. They told me nothing was wrong with me on three separate occasions until I ended up in the hospital. And when I asked just what are you guys going to do to prevent this from happening in the future? They stopped responding to me after trying to get me to sign a non-disparagement agreement and giving me $400, which I did not take because I wasn't going to sign that NDA.

And I'll wrap it up here. I think the main through lines in my story were ideological ties that center, catered specifically to transgender patients, had a lot of really affirming imagery and people laughing and feeling good, kind of like those drug commercials, you guys, I'm sure you've seen. There was no differential diagnosis, no exploration of the root cause or interest into why I was feeling the way I was feeling. And there seemed to be this kind of common thread with supporting the whole person rather than what their expertise was and what their specialty was as doctors, not activists, it was like putting diesel in a gas engine for me. I was never given the insight that I was altering a fundamental process in my body, which is my endocrine system. And although I was on 14 different medications when I de-transitioned in 2022, I'm now on two for Hashimoto's autoimmune thyroid disorder that I think I may have obtained from the testosterone.

Chad Mizelle:

Soren, thank you. If I can ask, you mentioned what you're currently studying, and it does seem as you continue to research on this, the link between access to social media and in a lot of the stories we're hearing and transitioning, are you seeing that as part of your research as well as you're going through that?

Dr. Michelle Cretella:

Yeah, I'm really interested in that. In particular, I think kids use frameworks to understand how to move through the world. That's why it's important they have parents who love them, to show them what kind of adult they could become. And when the internet is doing the parenting, which I don't think often is totally the fault of the parents, you guys didn't grow up with that. You guys didn't see the consequences until our generation had already suffered them. I think it can be really easy to slip into online groups that tell you who you are instead of letting you explore it in an embodied way in the real world through all five of your senses and not just this audio-visual matrix that is social media and the internet.

Chad Mizelle:

Great. Thank you. Thank you so much. Beth.

Beth Bourne:

Hi, my name is Beth. My ex-husband and I, we got a divorce when our children were young. My daughter was an excellent student. She loved gymnastics and math and reading. She was also creative, sensitive and sympathetic. At the end of sixth grade, my daughter suffered trauma and she became withdrawn. In seventh grade, she was placed in an honors class with other gifted students. Some of these students were trans-identified girls. This was 2018, when the teachers and counselors were being trained by the California Teachers Union on ways to support the LGB and transgender students. In eighth grade, my daughter started seeing a private psychiatrist to help with anxiety and some pretty serious self-harming. At 13, my daughter came out in a letter to her father and me as transgender. Within a few days, we received an email from her school counselor saying our daughter had asked the school to change her name and pronouns.

That counselor also put in place a gender support plan that was not disclosed to her father or to me. When my daughter was 14, she began experiencing some dizziness spells. And so we took her to Kaiser Permanente Davis to meet with the pediatrician on duty. This is a pediatrician who had never seen our daughter before. My ex-husband, in the exam room, referred to my daughter with her new male name and male pronouns. And in an excited tone, the doctor asked my daughter if she would like to have her medical records changed to reflect her new name and her male pronouns. This is the first visit. The doctor then recommended that we take our daughter to the Kaiser Proud Clinic, a pediatric gender clinic in Oakland, it was a one-stop shop where she could meet with endocrinologists, an OB-GYN, a gender specialist.

So the next day I called this pediatrician and I said, you had no right to suggest to my daughter that she seek medical interventions at a gender clinic when we were just there for a wellness visit. So I asked the doctor, what would you do with someone my daughter's age if she said she wanted to change into this opposite sex? And she said, well, we refer them to the Kaiser Roseville endocrinologist. So then I spoke to the endocrinologist and I asked him, what would you recommend for someone my daughter's age who wanted to become a trans man? And he said they would go to the Kaiser's gender specialist and talk with them about puberty blockers and hormones. And when I said, would you talk with our private psychiatrist? He said, no, we prefer to keep all treatment within the Kaiser system.

So when I voiced my concerns to the pediatrician and the endocrinologist about what was happening, the endocrinologist said, this is an emerging field. Quote, this is an emerging field, quote, we don't know the long-term medical effects, but with any medical treatments, there are benefits and there are risks. So I asked him what would the benefits be? And he said, quote, it's been shown that youths have a lower risk of suicide and less suicide ideation if they are offered medical treatment. He also said that, quote, youths will feel better when they're on hormones and that they can stop their periods and give them the physical traits of the opposite sex.

And the endocrinologist, of course, referred me to WPATH as the leaders in this field and to the endocrine society. And he also recommended I talk to Gender Spectrum, which is one of these groups that encourages parents and families to transition their kids. Fortunately, my daughter's psychiatrist was willing to have a counseling session with my ex, my daughter and me in the same room. And she explained because I asked her to, the risks of medicalizing with blockers and hormones, this includes brain development, delayed brain development, and loss of bone density. So we agreed, this is when my daughter was 14, that she would not do anything medical until she was 18.

So I realized later how fortunate we were that we were able to send my daughter to a private psychiatrist to seek DBT, Dialectical behavior therapy outside of Kaiser and keep her away from the Kaiser Gender Clinic. My daughter desisted from her trans identity about four years later in her senior year of high school. She's now on her third year of college and she's doing great. I just can't imagine what would've happened when my daughter was 14, if we had taken her to that Kaiser Proud Clinic in Oakland. The doctors in Davis, the endocrinologist, they were all captured by this idea, and they were disingenuous when they were telling us that it would decrease her risk of suicide or suicide ideation.

Chad Mizelle:

Thank you. Thank you, Beth. Forrest.

Forrest Smith:

Yeah, I just want to take a second and thank everybody. So I'm from a little bit of an older generation of transitioner, I think, kind of sit right on the cusp by my transition was from 2015 to 2020. I'm also a male. And so one of the things that I think has been happening in our conversations about Transgenderism in general is we kind of clump the men and the women together. But there's some interesting patterns, I think, between the two different groups. I don't know if anybody's familiar with Ray Blanchard. He's one of the original sexologists who used to talk about this, and I saw him responding to an interview about ROGD, rapid onset gender dysphoria. In girls, we've seen a lot of the ROGD, and when he talked about the boys, he said, with the boys, he tends to see that it doesn't just come about overnight, that it tends to be something that they've been brewing about for a longer amount of time.

And I would certainly say that that's true in my story, which is I'm up here. This is for minors, protecting minors. I transitioned, I began my transition at the age of 20. So I didn't fall into that bracket of minors, but I still believe that young men and young people are vulnerable. A lot of times they're carrying something that they may have been carrying since they were a child. I know in my case, when I've sat down recently and gone to the depths of my soul and my heart about this, writing my memoir, where does the story begin? I go all the way back to the first time. I remember my parents leaving me alone with my sister at my grandma's house, and I just had this kind of thought, this isn't my family. Because I was a child and they left me at my grandparents' child.

But that feeling, I remembered that feeling for the rest of my young adult life. Whenever I would feel like I didn't belong somewhere, those were the words that I would remember. I was still brewing on something that happened when I was a small child, and you mix into that, dysfunction in the home,

sexual abuse, grooming online, pornography, you mix into that and then you've got a pretty tenacious identity by the time somebody is 16 years old or 18 years old. And I think it's good as a culture that we're talking about this the way that we are now. Because when I think about the young man that I was, I seem to have been really set on a track, and if transgenderism wasn't what it is today, I still probably would've had issues. But as the situation is today, I ended up in the same pipeline that everybody... All the other speakers here ended up in. And so we've heard a lot about that. I don't necessarily want to... I can share more about those details, but I'll just stop there if you have any questions.

Chad Mizelle:

If you're comfortable sharing, I'd love to just hear maybe a little bit more about the detransition process. What was kind of going through your mind then and what maybe prodded you to say, I need to make a change?

Forrest Smith:

And this goes back also to the transition. So I was briefly homeless for two months at the beginning of my transition, and during that time, I became enrolled in the Homeless Youth Continuum in Portland. And so my entire lifestyle was supported through this vast network of non-profit organizations. Some of them are private, some of them are very good, admirable, noble organizations. I was able to live a really nice lifestyle, living high on the hog, on the Homeless Youth Continuum as a transgender woman, I kind of became an icon, but that, I aged out at 24. You age out and suddenly all of those opportunities are gone.

And so my transition, I was also putting off the decisions about surgery for those two years that I was totally housed. And then the medical surgeries happened right at the end when I lost my housing, which is kind of the irony and part of the oversight from the medical system, is that the surgeries were solicited by social workers in the HIC. There were around me in some of those housings, I wasn't paying attention, but there were detransitioners kind of dropping like flies, and then it was actually, I went into a crisis as I lost my housing, that I went through those surgeries.

That crisis is part of what ended up bringing me back around at the detransition. I caught COVID and I totally lost my housing in Portland. I went back to live with my parents and that forced me to look at my family dysfunction, to look at my family and realize there's problems, but it's not as bad as I thought it was. My parents aren't evil people. I can live with them. It forced me to confront things from my past, and then there was also a lot of isolation during that period, so I kind of cut off the trans people around me. There was still a lot of difficulty in receiving any kind of care. I had some counselors suggest that I was still feeling dysphoric because I hadn't had a full vaginoplasty.

I had an orchiectomy and I had the breast implants, so I was operated on, and that regret is part of what shocked me out of it because it wasn't what I had intended going into the transition. I hadn't thought that far ahead. It was gradual. I have daily journals from that period, and it took months to unwork. First I acknowledged that I regretted it, and then I acknowledged that I regretted it before I believed that I was a man, I still thought that I was a trans-feminine person and I regretted it.

So I had to unwork layers and layers. I took years of therapy. I found a forensic psychologist that was a specialist in men's sexual issues. That was a smart move. It took years and it took years to get back into the workforce to bond with my family. I mentioned writing the journals, but I had a beautiful moment with my grandparents. I thankfully was able to reconnect with my grandparents in the last year of their life. Both of them passed away within a year, and I had a beautiful moment out on the farm with them where I actually had this very clear thought where, actually, this is my family.

That's my grandpa, that's my grandma. So the detransition, it's been five years now, and it takes a lot to rebuild your whole life when it's not just the medical damage, it's a much deeper social damage. It's a damage to your whole sense of being, right? You build wardrobes, you build a whole life, you build all your papers, everything. You have to change all of that. It's a real deep hole.

Chad Mizelle:

Wow. Thank you. Thank you for sharing. Helen.

Helen Spiegel Lee:

Hello everybody. Thank you very much. So I'm going to read my statement because I am not that great at this. So when my son was three years old, my ex-wife, with the help of medical and school professionals put him firmly on the transgender path. In the fall of 2014, my son's preschool teacher informed me that my son wanted she pronouns. This happened only one month after the traumatic dissolution of my marriage. At that time, I had joint custody and it became a constant battle. I shared with everyone that my son did not express any of these preferences to me. I wondered if he was trying to gain more attention from my ex and if she was using gender to split his loyalties. None of this seemed authentic, but every time I posed reasonable questions and expressed curiosity or doubt, I was looked upon with suspicion. Overnight, I became the dreaded non-supportive parent. At the same time, my ex engaged constantly with school providers and medical professionals, and she demanded that her family and friend support my son's rebirth, as she called it, as a transgender girl.

The gender-affirming model does not welcome questions and inquiry. Repeatedly, I was told by almost everyone that I must accept my daughter, that not accepting the utterances of a three-year-old was tantamount to abuse and would lead to self-harm. It made no sense. I was now in a world where up was down and down was up. It was a time of unrelenting despair. I could not eat, I could not sleep. I barely functioned at work. My unwavering love for my son was all that really kept me from giving up. I was angry back then regarding gender ideology and the medicalization of minors. I was frightened and vulnerable. I needed help. I made an appointment to see gender management services GeMS at Boston Children's Hospital in 2016.

I brought my son to GeMS three times. Initially I went with my ex, but as we became less and less aligned, we attended separately. We saw Dr. Amy Tishelman, a clinical psychologist and the director of research at GeMS once yearly in 2016, 2017. And lastly, in 2019. For four long years, my son lived as a boy with me and as a girl everywhere else. The situation was traumatic for both of us. I was constantly worried about the effects on my son of being torn in two. At one point, I even tried to use the girl's name, but I couldn't do it. I just could not participate in the charade. Over the years, Dr. Tishelman noted time and time again that there was difficulty in parsing out the impact of the parent's conflict on the child's gender presentation in each home. Even with the documented uncertainty of my son's presentation, Dr. Tishelman at one meeting coerced my son to convince me to go along.

Her notes are quoted as thus. Following my meeting with Rosa, I met with Ms. Spiegel and her partner, and again, with Rosa's permission shared that Rosa told me she'd like them to refer to her as Rosa and use female pronouns. Rosa agreed to come to the room, and all four of us met together. At this time, Rosa reiterated to her mother and partner that I want to be called Rosa, and I want to be a girl. My wife and I were stunned, but smiled and the meeting concluded. My son was six years old, and within the gender affirmation model, he and the therapist were in complete control. At the final visit in 2019, Dr. Tishelman had my son fill out a gender worksheet, assigning numbers to how he felt. Tishelman's conclusion was that today she reported that she's not a boy or a girl, but something different. Again,

there was ambiguity, but she dug in deeper. Dr. Tishelman advised us that we should start thinking about puberty blockers for Rosa.

Finally, I sued for full custody. Things were moving at breakneck speed towards medicalization, and I had no other recourse. At the trial, Dr. Tishelman was called to testify. My ex had Dr. Michelle Forcier as her expert witness, and she also testified. Dr. Michelle Forcier is a pediatrician affiliated with Hasbro Children's in Rhode Island. She is possibly better known now as the chicken lady in the film, What is A Woman? It is documented in the court findings that Dr. Tishelman cautioned that failing to strongly support gender diverse children can lead to suicidal ideation and attempts. This, of course, has never been proven. At the same time, Tishelman also testified there is insufficient research around socially transitioning children, and that there are differing opinions. Dr. Forcier also agreed with Tishelman that there was insufficient evidence.

The court findings state in Dr. Forcier's own words, research on gender dysphoria is in its infancy. At my trial in 2019, both these experts in their fields admitted to poor evidence. It is chilling to recount that during our visits to GeMS, Dr. Tishelman repeatedly advised the importance of accepting Rosa and ultimately suggesting the use of puberty blockers while failing completely to admit that evidence around social and medical transition of children was sparse. My son was never gender dysphoric. My son was never transgender. It was all a lie.

Chad Mizelle:

Helen, thank you so much. Thank you for sharing that. Gwen?

Gwen Turecki:

Sure. Hi, my name is Gwen Turecki, and I'm a mom from Michigan. My son was around 14 when he sent me a text that he was a girl, and at first I thought, hey, he's at theater, and they're just dressing up like girls. The next text was HRT, and I meant that as cross-sex hormones. At that time, I dove into research. He was away, so I was able to jump on the computer. I have a background in Library and Information Science. So I found Dr. Grossman. I found Jennifer Bilek, pro-trans sites, anti-trans sites, and crucially, parents with the inconvenient truth about trans. I connected to other parents and quickly realized this is a cult, and guided my son out using proven cult techniques. Basically what I did is I leveraged stuff that was out there for other cults and tailored it to the needs of my son.

We navigated the depths of the transgender ideology, starting with his pediatrician's office. And the reason why I did this is my son and I have a very close loving relationship, and he would expect me to follow a protocol. So we went to his pediatrician's office, who referred us to the University of Michigan's Mott Children's Hospital gender clinic, notably the pediatrician that we were referred to was not his normal doctor, and this is at a different children's hospital. She was in the process of transing her teenage daughter, and it's like, okay, jump down the rabbit hole. Here we go.

At Mott's Gender Hospital, because I did make an appointment, because according to the protocol, to get someone out of a cult, you slow walk them and bring your kid closer. My kid and I were always very close, but we have a common bond around music. We did more crate diving for albums together, because we're into that stuff. So at the Mott Children's Hospital Center, there's a three-hour session with everybody all together. So his father [inaudible 05:27:31] my son and myself. The therapist explained that the purpose of the session was to help our child connect to what was happening with his mind and align his self-image with his body, citing WPATH as a standard of care. When I asked why there's a 4000% increase in the number of trans-identifying girls in the UK, I was told society's just become more accepting. Amazing. She explained that Western societies have become more accepting

into the ways of thinking. Please note that my son's father immediately affirmed and aligned with the therapist.

I sat in the office and I listened to her weave a narrative, not based on biological reality, opening on the door of possibilities of changing physical appearance without even considering underlying conditions like going through puberty during COVID lockdown. Basically, these kids' social fabric was ripped upside down. The second hour was with my son alone, and I was unable to question the session due to patient confidentiality. The third hour was all four of us together again, the therapist, and she kept on saying to my son, I feel like there's something you need to tell us. She was coercing my son into self-doubt. So I recognized this as, like I said, coercion, and began to steer the conversation away, asking for next steps.

What do we do next? And after a single three-hour session, she said, hey, the next step is let's contact the endocrinologist. That's when I shut it down and I turned to his father and my son and it said, we're going to talk about this at home. I needed to control the situation. Seriously, it was like Alice in Wonderland. It was crazy. The rest is history now. And now I have a thriving, healthy 17-year-old man with an exceptionally bright [inaudible 05:29:44] future. My son was tested for talented and gifted, and had that trajectory. Had we followed the past set by the University of Michigan's Mott Children Hospital, the story could have ended tragically. My son is exceptionally talented, gifted, just like Elvira's daughter. Thank you very much.

Chad Mizelle:

Gwen, thank you for that. If I may ask that subsequent step, that conversation at home with your son, was that a sort of one-time thing that you were able to, was that a months-long process? Is there anything you could share about

Gwen Turecki:

That? Sure. Okay, so that really didn't happen. I wanted everybody to go into neutral corners and because his dad was affirming, I had to walk that fine line. So anyway, the slow walking, the slow walking, also bringing closer, bringing closer.

About three months after that visit, I walked into my... And I was feeling him feel a stress because I think part of it is that he felt heard. So about three months after I walked into his room, was like, "Hey hun, what are your feelings about cross-sex hormones now?" And he said, "Mom, that's like putting lipstick on a pig." My heart leapt. Okay, but we turned quite out of the woods yet, right? So fast forward, perhaps another four months, he walks into the kitchen, granted, at this point my kid's like six foot, I grow them big, and he says, "I'm thinking about growing a mustache. What do you think, mom?" I'm like, "That's a great idea." Inside my head I'm doing back flips, going, we made it. And so after that I help coach other parents, [inaudible 05:31:42] parents. I have parents in South Africa, Australia, thanks to X. It's easier to do that. There is a way to get your kid out of this.

Chad Mizelle:

Thank you. If we could just do one more round of applause for everybody out there, thank you. As you all have heard, it is certainly not easy emotionally to get up and tell your stories, but as Prisha told us, it's a danger to themselves and to their families to even speak out whenever you're speaking out against a multi-billion dollar industry that is built on lies and deception, whenever you start exposing those lies and deception, they want to come after you. And so thank you guys again for everything that you've done, for what you're doing for sharing your stories. Thank you, thank you, thank you. All right, with that, I think we're going to continue on the program, so I'm going to hand the mic back over to John. Thank you all.

Jon Schweppe:

Thank you, Chad. And what an exciting announcement from the Department of Justice. Now let's shift gears a bit. We've talked with medical professionals, we've talked with parents and survivors and heard their stories. But as the truth emerges, it's important to note that a number of truly courageous people took great personal, professional, and financial risks to themselves to blow the whistle on the gender industry. And I'm pleased to announce that we have six of these whistleblowers at this workshop today. Earlier you heard from Dr. Aton Heim, and now we have a panel with five more. These are individuals who truly paved the way for this moment. So I'd like to introduce our moderator for this panel. He serves the Federal Trade Commission as a special advisor in Chairman Ferguson's office, Ian Mason.

Ian Mason:

Well, as John mentioned, we've heard today the personal stories of young people subject to so-called gender-affirming care and their parents. We've heard doctors and researchers reason conclusions about these practices, but the understanding, especially the popular understanding of what's happening depends on an additional pillar. The accounts of whistleblowers, actual participants in this industry who had the courage to come forward despite potentially devastating consequences for their careers, for their reputations, and for their families. We're grateful to have five of them with us today. Jamie Reid is the executive director and co-founder of the LGBT Courage Coalition, which advocates for cultural and medical approaches that accept and support gender nonconformity without medical intervention. In February, 2023, the Free Press published her explosive first-hand account of her time in a pediatric gender clinic. Jamie holds a master of science in clinical research management from Washington University and a BA in cultural anthropology. She co-hosts the Informed Dissent podcast, has been profiled in the New York Times, advocates for legislation across the country, and addressed a rally on the steps of the US Supreme Court during the US v. Skrmetti oral arguments.

Tamara Pietzke is an independent clinical social worker in Washington state. She earned her master's of social work from University of Washington and after more than a decade as a mental health therapist in community and healthcare settings, she founded her private practice in 2024. In 2023, she gained national attention for speaking out about the mental health field's approach to youth gender transition, raising concerns about blind information without adequate assessment leading to a backlash, including the loss of her job and an ongoing state investigation.

Leta Boylan is a former psychiatric nurse at a taxpayer-funded facility for teenagers and adolescents. During her time there, she became aware of a series of institutional policies that promote and reinforce social transition of minors while hiding such treatments from their parents. Due to Leda's, unwillingness to lie to parents and engage in dishonest, incomplete documentation, she was targeted by the facility's administrator and fired in December 2024.

Vanessa Sivadge is a pediatric RN who exposed the illegal use of Medicaid to cover sex hormones and transgender treatments for minors at Texas Children's Hospital. After blowing the whistle, Vanessa received a visit from two FBI agents in July of 2023. Despite this and other threats, Vanessa came forward in June of 2024 with journalist Chris Ruffo to expose the Medicare fraud, medical malpractice, and illegal billing in the gender clinic. Two months later, Texas Children Hospitals hospitals fired Vanessa. Vanessa has since launched an advocacy organization committed to fighting for the protection of children in the state of Texas called Protecting Texas Children.

Sara Stockton is a licensed marriage and family therapist, lecturer, researcher, and clinical supervisor with other 15 years of experience specializing in gender dysphoria among youth and families. In 2023, she co-offered one of the US mental health assessments for evaluating youth readiness for medical gender transition. Published in the Journal of Marital and Family Therapy. Growing concern that

prevailing clinical approaches were harming young people, Stockton publicly addressed these issues in the 2022 documentary "What is a Woman?" She testified in state legislatures on bans regarding transgender care for minors and served as an expert witness in family court cases involving child protective services.

So we're here today largely because of your stories raising awareness of these issues. So why don't we start with those stories themselves. We'll just go down the line. Vanessa, if you'd like to start.

Vanessa Sivadge:

Thank you so much. My name is Vanessa Sivadge. I'm honored to be speaking on today's panel on Blowing the Whistle on Gender Medicine to join my voice with the growing number of medical professionals who recognize gender medicine for the farce and the fraud that it is. For 10 years, I've had the privilege of working as a pediatric nurse in Houston, Texas. In 2018, I accepted a job at Texas Children's Hospital, the most prestigious and largest children's hospital in the United States and Houston. And I thought at the time that I had peaked in my career convinced that I would be working here until I retired. A couple of years later, in 2021, I transferred to a multi-specialty outpatient clinic, not knowing that a fully functional and robust gender clinic was active in my workplace. The things I saw over the next few years I will never unsee. Eventually I was asked to do things that went against my nursing ethics, my personal beliefs, and most importantly, my faith in Christ. I had a crisis of conscience one day when a physician, the transgender physician, asked me to do patient teaching, which is not uncommon. Nurses do a lot of patient teaching in the hospital. But on this particular day, I walked into a patient's room and I was asked by the doctor to instruct them on how to administer an intramuscular injection. What I didn't know was that this child, this boy, was going to administer estrogen to himself to affirm the false identity that he had adopted. And realizing that I enabled him to do that was devastating to me.

I considered quitting my job. I could no longer play an indirect role in perpetuating these harms against children. Until one day in May of 2023 when I read an article by an anonymous whistleblower within Texas Children's Hospital who had come forward courageously to expose at the hospital, had been secretly providing transgender treatments to children, had hidden this from parents and from lawmakers in the state of Texas. And I knew this to be true because I was the nurse, one of the nurses working at this clinic that was supposedly non-existent. This person is Dr. Aton Heim without whom I would not be here today.

We did not know each other at the time. We had no knowledge of who the other one was. But what I did know was that someone within the hospital had shared my concerns and was deeply concerned about these children being harmed. And so a couple of days later, I came forward anonymously to corroborate his testimony as a nurse working in the clinic where this was taking place.

And that was supposed to be the end of the story. I was going to go back to work and things were supposed to go back to normal. But two months later, in July of 2023, my husband and I were having dinner on a Monday night and there was a knock on the front door. And lo and behold, we go to open the door and there are two federal agents who are flashing their badges. They say they're from the FBI and they're asking specifically to speak with me by name regarding issues at my work and in a video that has now been viewed over 6 million times, because our ring camera captured this exchange at the front door, these agents informed me that I was a person of interest in an investigation targeting a leaker, not a whistleblower, but a leaker who had allegedly violated patient confidentiality laws by breaking HIPAA, which was of course an utter fabrication and a complete lie. And I knew at that moment that they were lying to me. They were trying to turn me and to use me to eventually testify or speak against Dr. if it ever came to that. Thankfully it did not.

But they informed me that they couldn't protect me if I didn't help them, that I was unsafe, that my career and my safety were at risk, and it was the most terrifying encounter we've ever had at our front door on a Monday night. And so that really set the stage for what happened next. I went back to work, of course, no one knew that this had happened, but I think we saw this a lot during the Biden-Harris Department of Justice era where whistleblowers, people with a medical conscience and a moral spine, pro-life people were targeted because of what they believe or just because they believed they were doing the right thing. And so we were no exception to that.

But I went back to work and I discovered that not only had the hospital lied to the public about the existence of this secret program, but they were also billing Medicaid fraudulently for these cross-sex hormones and puberty blockers, which in Texas is a violation of state law. I saw children that were misdiagnosed intentionally. I saw false diagnoses. I saw all these things that were deeply concerning and deeply and 100% illegal. And I knew that I had to come forward at that point to expose that the hospital was committing fraud against the federal government. And so in June of last year, I came forward publicly with my identity, was promptly placed on leave by the hospital and in August of last year, the hospital fired me. And this was illegal for a number of reasons. I had also submitted a religious accommodation request.

So we retained the Burke Law Group, Marcella Burke, who is an incredible attorney. And I'm so grateful for attorneys all around the country who are really defenders of truth and who are on the right side of this issue. And then Donald Trump was elected president and three months later, the Trump administration under the leadership of Secretary Kennedy at HHS announced a formal investigation into Texas Children's Hospital for illegally terminating my employment. And I'm very, very grateful for that.

And to wrap up, I now have the privilege of serving as the founder of Protecting Texas Children. Our mission is to safeguard the innocence of every child by affirming biological truth. We work towards building a future where children can grow a happy, healthy and whole by not erasing who they are, but by learning to embrace how they've been beautifully created by God. And so I'll end here. What is happening in clinics across the country is not rooted in rigorous science, nor is it grounded in ethical medical practice. It is a marketing campaign masquerading as healthcare. It is a billion-dollar industry that thrives on misleading claims, emotional manipulation, and the systematic erasure of informed consent. The issue of gender medicine has shattered political boundaries and united voices from the right, the left, and the center. Not because of ideology but because of conscience. This is not a partisan battle. This is a battle of good versus evil. And at the end of the day, there are no Democrat children, there are no Republican children, just American children. Thank you.

Ian Mason:

Thank you so much Vanessa. Jamie, if you'd like to go.

Jamie Reed:

Good afternoon. My name is Jamie Reed and I hold a master's of science in Clinical Research Management from Washington University in St. Louis, Missouri. I am also a lifelong Democrat, a mom of five boys, three of whom were adopted out of the foster care system and I'm a lesbian. I am also the public whistleblower from inside a pediatric gender center. I participated in transitioning nearly 1,500 unique patients who ranged in age from 3 to 26 over almost five years, I was once a true believer in pediatric gender medicine. Now I understand. I participated in an industry that was based on fraud, deception, and in layman's terms "we were running a racket". Patients with significant comorbidities were treated using unethical and deceptive informed consent practices. They were never properly assessed, informed of their condition or given a diagnosis. A diagnosis itself is the first required step for

any consent to be valid and not fraudulent. These were also vulnerable patients who required specific special safeguards.

First, they were minor patients and should have been provided all of the safeguarding protections we would want for all children. Second, they had significantly presenting comorbidities, often falling within the definition of a stigmatizing complex medical disease, some even meeting the criteria for a legal medical disability. We were harming disabled children. These comorbidities include but are not limited to autism spectrum disorders, anxiety, depression, borderline personality disorders, eating disorders, self-harming behaviors, somatization disorders, learning disabilities, ADHD, and significant trauma histories. Third, many of the presenting patients before the social contagion cohort, would eventually, if not medically treated, become homosexuals like me. That is they will identify as adults as gay, lesbian or bisexual. The entire diagnosis is based on regressive stereotypes and self-described feelings from minor children and their parents. My clinical experience shows that these quote "biopsychosocial assessments are not consistent, comprehensive, or truly diagnosis diagnostic".

For an assessment to be diagnostic, there is a very simple way to prove if it actually is so. It so simple that so many of us actually forget it. There must be a statistically significant number of patients who will not ever meet the diagnostic criteria. So in lay terms, there has to be a statistically significant number of patients and parents who would've been consistently told no by these centers. That never happens. I might hold a master's of science and clinical research that is not a requirement to understand the basic concept of medical diagnostics. Parents and the public have been deceived into believing that these assessments are diagnostic, that they're consistent, that they're comprehensive, and that no child is ever receiving treatment without one. If the assessment met the criteria of consistent, comprehensive and diagnostic, the diagnostic provider should be able to easily produce their assessment tools, give them to the FTC to be analyzed, and they should also be universally consistent across all of our states. This has never happened and they have not shared any data to show a percentage of those presented are being told no because this is not happening.

But, and this is a huge "but", even if this field was actually doing what it claimed to do, even if it was completing a true biopsychosocial assessment and saying no to a significant percentage of the patient population, please know that those who would be told yes would be homosexuals, like me, and especially the gender-nonconforming homosexuals. Under the Dutch model, we would still be okay to be rendered sterile without sexual function, with destroyed endocrine systems and be allowed to die early simply because we are gender non-conforming homosexuals. And so to some of those not here today to Laura Edwards-Leeper, to Annelou De Vries, we homosexuals are no longer okay to be harmed for straight people's comfort and we are fighting back.

I personally witnessed the consequences of prescribing these treatments without proper informed consent, one of my patients after her radical bilateral mastectomy at 19 called begging for her breasts to be put back on. This harm has not been contained to children or minors. Another patient's intellectual function was so impaired that they could not identify to me where they lived or explained what type of identification they possessed. Multiple staff members expressed concern about their ability to consent to any medical procedure. Despite these and similar red flags with many patients, this patient even stated that they desired to have biological children, yet they were prescribed a treatment that would ultimately render them sterile for life. We as clinicians in the gender industry openly stated, "It does not matter if patients even met the diagnostic criteria". We did not care. If patients even had "gender dysphoria." We did not care if a patient said they were trans, then they were trans. Parents were unaware that patients were self-diagnosing, that clinicians had completely abandoned the diagnostic process entirely. Parents who didn't agree with our lives were isolated, abandoned by our centers. We tore married parents apart and we tore children apart from caring parents who told us no.

Imagine in a different field if children went in self-declaring that they had a malignant cancer, if they went to an oncologist and that oncologist without labs or biopsies, if that child demanded to go through chemotherapy and surgery, that the clinicians would comply and then the clinicians would then bill our insurance for those procedures, medical visits, making money for the hospitals and themselves based on this deception. This is precisely what we were doing in the gender center. And then we expanded this deception into a racket. We created specific lists of affirming therapists who would do exactly what we wanted. A therapist could only get on that list if they would comply. We needed a letter for insurance. So guess what we did? We wrote it. We made it fill in the blank. We pre-drafted it. And I know this because I am the one who not only created this letter, but I emailed it out to all of those same therapists for hundreds of our patients.

I wish I could say to you that I became a whistleblower the first time I heard the nurse say, "But Dr. Lewis, we are committing insurance fraud." Because that was said, and I wish I spoke up sooner. The final death blow to my ethical medical soul, and what finally led me to speak up, is that we significantly harmed our patients. We didn't just deceive them or their parents. I hurt children. And I said to that same Dr. Chris Lewis, "Chris, we are harming patients." And he said, "I know, but what do you want me to do about it?" I hurt the very children I was employed to protect. St. Louis Children's Hospital. Mission statement is simple. St. Louis Children's Hospital will do what is right for children. We did not. And all of us must now reckon with what we have collectively done.

Ian Mason:

Thank you so much. Tamara, if you'd like to.

Beth Bourne:

So apparently I was supposed to prepare something written and I did not. So here goes nothing. I am Tamara and at the time that my story began, I had been a therapist at MultiCare Hospital in Washington State for about five years. In March of 2023, I had a client come in and say that they identified as a wounded male dog. A female client came in and said that they identified as a wounded male dog. And I did not know what to do with that information. I had heard people come in before and say, "I feel like I'm actually transgender." And I just had kind of treated them the way I treated any other client. We just did therapy on all the different things in their life that were causing them distress. I never felt like I had to have an opinion because I just trusted that people who were working in these gender clinics knew what they were doing. So I felt like, "Okay, whatever, we'll just continue. I'll do what I know how to do. We'll treat anxiety, depression, other issues that are happening in your life."

But at this point, when this client came in and said that, I was like, "Okay, so at what point is someone's identity actually a mental health illness? At what point do we need to press pause and deal with this as if something's going on that needs some mental health attention?" And so I emailed my boss, I emailed my colleagues and I said, "Hey, I had a client come in and say that they identified as a wounded male dog and I don't really know what to do with this. At what point is someone's identity something that we treat as a mental health diagnosis?" And they said, "There's no time that that would happen. If this client is not saying that this identity is causing them any distress, then it's fine. You just basically say, 'Awesome, I'm glad you know who you are,' and you continue to be a therapist."

And my boss was on this email too, and I was like, I don't know how to process this. So I kind of just set it off to the side and kept kind of thinking this stuff through what is going on here with gender identity and the way that we are treating these people and these young children who are just trying to figure out who they are, what is happening here? And then September of 2023, we had a mandatory gender-affirming care training. None of our trainings until this point had been mandatory. And I know I'm going

to sound so naive, I had never heard gender-affirming care, those three words together before. And so I was like, "What is this?" And I just had a bad feeling that because since it was this mandatory training that we were going to go in and be Indoctrinated and threatened, basically have our jobs threatened.

And so it was like the training was supposed to happen after Labor Day weekend. And so I spent every night that weekend, after I put my kids to bed, I sat in bed and I just researched everything I could about gender-affirming care. And I realized it wasn't that easy to do. I would Google "what are the dangers of gender-affirming care" and the result would be "How to be a good friend to your LGBTQ..." And I was like, what is happening? I came into this situation so naive. I truly had no idea, I was processing it all. And any article that I found or any organization that I found that was like, "We're hurting people."

I had written a letter saying that I would not go to this training. And so I wrote this letter and I said to all the people that I found who were giving a voice to the fact that we're hurting children, I said, "Please read this for me. Tell me that I'm not wrong because I might lose my job over this." And so I sent it to literally strangers on the internet and I was like, "Please tell me that this is the information that I'm putting together here is not wrong." And I got emails back and said, "You're not wrong. You're absolutely right. But you have to go to this training because if you don't, you're going to render yourself irrelevant. They're just going to fire you. And then you lose your influence. So you have to go."

And so then we talked through some questions that I could potentially ask. I don't know if you can tell I'm not controversial. I do not want to make anybody feel like I'm attacking them. So I went into this meeting and I can tell you with certainty that I was so gentle and so cautious with the way I was presenting these questions. But there were 122 of my colleagues there. And when the opportunity presented itself, I said things like, "Hey, if countries in Europe are pressing pause on this, why are we mandating this of our clinicians now?" It was a virtual training and the chat box blew up and they were like, "You are doing harm to our patients. Keep politics out of this." And again, I'm so stupid. I was like, "Politics? I didn't say anything about the president. I don't understand what you're talking about." And so I just could not believe the hostility. The person that was doing the training was like, "I want you to understand we are not going to... No more of these questions from you. This is not up for debate."

And so I left that training and my boss called me and she was like, "That was not the correct time or place to ask those questions." Like, "Oh, okay. I thought that they had said that we could ask questions. So I just assumed." And so after that, I just kept emailing my boss, emailing the person who I did the training, and I asked them these questions in email so I could keep a record of things that they were saying. And I just wanted to make sure that, am I crazy here? What is happening? And they just kept saying the same response over and over again. No matter what I asked, at no point did anyone say, "Okay, hey, let's look at this. What are you seeing online? Let's look at this research together and figure out whether or not there's anything here that we should reevaluate."

And I just thought that they would, we're here to help people. Why would that not be a conversation that they would want to engage in? Instead, they just decide that I'm a monster. And so they basically just said over and over again, "I want you to understand we are not going to agree on this issue. This is best practice. MultiCare will not tolerate anything less. And there is no reason why a person's mental health would impact their identity. It doesn't matter if they've had a history of trauma. It doesn't matter if there's co-occurring disorders. It doesn't matter because they know who they are and you're not allowed to question that at all." And so again, I didn't really know what to do with that.

And then I had a client come in, a 13-year-old who was a female who was mostly non-verbal. When we would talk, she would just continue to scroll on her phone and rock back and forth. And I kept trying to engage her and it was very challenging. She had a history of trauma, really intense trauma. And shortly after I started seeing her, I saw that she had a gender clinic appointment coming up, her first one. And I asked her how she felt about that. And she said she didn't know she had one. And then she kept

scrolling on her phone and we talked about something else. And then after that initial appointment, I read the note and it said, "Ask your therapist for a letter to start testosterone." And I could tell it was a form letter because I later went back and was like, "Okay, yeah, they're all the same." But it said that she so eloquently said how distressed she was in her body as a female, which I'm like, "There's no way she doesn't talk. That's not a thing that happens."

And so then her dad asked me to write a letter to start testosterone. And so I was like, "Finally, now people will actually listen to me. This is obviously not a good candidate. This is a child who's got so much else going on." And so I emailed my boss and I emailed the person who did the training and I said, "Hey, can we look at this client's chart together? They want me to write this letter for this young child to begin testosterone. And I just feel like there's so many reasons why that's not a good idea." And then I don't think I even got a response back. But my boss came into my office a few days later and was like, "I want you to know this has gone above me. The person who did the training has reported you to risk management." And again, I am so dumb.

I was like, "Finally, risk management and I can have this conversation together. We can look at how we're hurting this client and realize that we are hurting people." And so I met with risk management numerous times. They ultimately determined that I was the risk. They took the child from me, said I was incompetent to work with gender distressed young people, and just gave the client to somebody who would just automatically write that letter, no questions asked. And shortly thereafter, I left MultiCare. I was like, "I can't work for an organization that I don't respect. And I went someplace else. And three weeks after starting that new job, my article in the Free Press came out, that new job, they called me up at 7:00 that night and were like, "You're just not the right fit for this position." Lost my job. Single mom of three little kids. I was like, "This is a nightmare situation". I'm so grateful for the Courage Coalition because I don't know what I would've done had there not been support in place. But I ended up opening my own practice. At the time that I was opening my own practice I got letters from the state saying I was being investigated for not being gender-affirming and first suggesting that gender dysphoria is a mental illness, and so that's where we are today.

Ian Masson:

Thank you so much. Lita, if you'd like to go.

Lita Boylan:

Hi. I am very grateful to the FTC for this forum. My name is Lita Boylan. I'm an LPN and a CHES. I worked as an agency nurse in the psych hospital at North Central Healthcare in Wausau, Wisconsin from 2017 until December of last year. North Central is a taxpayer-funded facility. On the adult unit. In 2017, I had a 19-year- old trans-identified female patient who had already had a double mastectomy and who nearly bled out because testosterone caused her ovaries to become polycystic and then they virtually exploded.

On the adult unit in 2018 I had a trans-identified male patient in his 20s who was abused so brutally as a child that he was legally blind and had an IQ of about 70 related to a permanent traumatic brain injury. He was prescribed four times the amount of estradiol that oral contraceptive contains in spite of the fact that he was unable to live independently or maintain employment. During the pandemic, North Central Healthcare opened a brand new youth psych unit, and by 2023 it had become not just a unit that I worked on, but the primary unit that I worked on.

Many days, every single minor female patient was trans-identified. It was unusual for us to have no trans patients on a given day. Most teenagers experienced suicidal ideation at some point. This is not a great part of the human experience, but it is also not an uncommon one. If a child who is struggling

discloses suicidal ideation at school, it starts an unceasing cascade of interventions which occur without parental input or consent. School staff are legally obligated to report to law enforcement who will remove the child to the emergency room where the child is subjected to medical tests and placed on a 72-hour hold and then delivered to a facility like the one that I worked at.

All of this is done without parental consent. Sometimes it is done without any parental contact. The North Central administration is headed by an individual who is well-known for a previous scandal in the state of Wisconsin at a facility that is state-run that involves children. She had an unwritten but brutally enforced policy that clinical staff were to call the kids whatever they wanted to be called and that we were not to inform the children's parents of their desire to socially transition. The implied threat of suicide is wielded with regard to gender dysphoria in a way that is utterly contrary to the standard, which acknowledges both the suggestibility of people who are actively experiencing suicidal ideation as well as the long-observed phenomenon of suicide clusters, which occur especially often in young people.

In other words, they come in, say that they're suicidal, and we say, "Gosh, we shouldn't discuss that unless you're trans, in which case we have to do whatever you say." Payer sources are billed fraudulently utilizing misused codes. Medicaid fraud was commonplace. It was openly discussed during rounding. Most of the children who came in had insurance via their parent's employer. If they did and the child said, "I don't want my parents to know," they had cottoned on to the fact that if they dropped certain codes for insurance, it was going to trigger a letter that would then get back to the parents. We were on the same campus as county social services, which meant then the social work from the inpatient unit would go talk to social services triggering a CPS investigation. Especially if the parents were not married to each other, what would end up happening is the kid would get on Medicaid, then they could bill Medicaid repeatedly for a 72- hour stay, which was also fraudulent because they were misusing codes.

So I know HHS and DOJ are here. I don't know if this is an FTC thing. Guys, I used to work for an ACO. Codes are my second language, so right now we have CMS who will not let you bill for, I believe it's I-110 for essential hypertension. It won't wait that for an RAF score, but we can bill for, what is it, the E-290 code that is the unspecified endocrine disorder. So we can do that for kids, but we can't do essential hypertension for adults with government payer source healthcare. Make it make sense. My minor patients who are as young as 11-years-old would want to both impress and fit in with their somewhat older peers. They would frequently change their names and pronouns. This was always kept a secret from parents. Clinical, educational, medical, and mental health professionals of perceived authority who had already proven that they could override the wishes of the child's parents were now also in the business of hiding things from parents.

There is no acknowledgement on the part of the administrators who act as accountants, who have no clinical background, who have no scientific degrees, who never interact with patients, who do not do assessments, who have no understanding that science is not an outcome but is in fact a process, that affirming a cross-sex gender identity in children is not a psychologically neutral act. It starts another unstoppable cascade of intervention, but this one ends in permanent sterility, disrupted endocrine systems, sexual dysfunction, mutilated genitalia, and an increased risk of completed suicide by every high-quality study that has been conducted on this issue.

To a person, every single trans-identified minor female patient that I took care of described herself as either neurodivergent, same-sex-attracted, or a survivor of sexual assault. Some girls were all three. Most were on self-harm precautions and presented with significant scarring. The best part of my job was meeting with parents alone and telling them emphatically, "You have to let yourself off the hook. This is bigger than any one family." The trust that parents and families put in us to care for their beloved children is an awesome responsibility. The parents of my community pay a millage to fund a facility that

usurps their rights and engages in iatrogenic harm perpetrated against their children. There is no way for parents to consent to treatments that are neither acknowledged nor explained. How will they ever trust us again?

Ian Masson:

Thank you so much. Sarah, if you'd like to take us home.

Sarah Stockton:

Good afternoon. Thank you to the members of the FTC again for hosting this event. My name is Sarah Stockton and I'm a licensed marriage and family therapist. Since beginning my training at Syracuse University in 2008 with an emphasis on sex and gender issues, I've spent over a decade developing standards for assessing youth with gender dysphoria, signing hundreds letters of affirmation, letters for medical interventions, and training other counselors to do so, but today I'm here as a whistleblower. I have seen children and teens rush into irreversible medical decisions, sometimes after a single session, promised reversible solutions with no chance to learn other ways to manage distress. I've watched families left heartbroken.

At Syracuse I helped develop a comprehensive assessment for gender-questioning youth based on the Dutch protocol, emphasizing thorough evaluations to give time to explore identity before medicalization. We were told to market this option so that a child wouldn't have to experience the wrong puberty. Our 2013 assessment tool was designed to give teens and families space to consider past, present, and future expectations while ensuring interventions like puberty blockers were carefully weighed. But what I witnessed was very different. By 2015, gender clinics started popping up and organizations like Planned Parenthood began prescribing hormones without these thorough evaluations. Families were told puberty blockers were fully reversible, despite emerging evidence of risks like bone density loss and infertility.

Vulnerable teens, including those on the autism spectrum or in foster care were funneled into medicalization for what were often social difficulties or trauma, not necessarily gender dysphoria. In one case, I met a father very similar to Simon's who came into my office because the parents were going through a divorce and the child was requesting puberty blockers. I was very concerned about the implications in basically the story that the father was sharing with me. One of the things that we have not talked about enough and I think we need to talk about is Munchausen by proxy. I asked the courts to give me some time to talk to the father about his reasonable concerns with puberty blockers. The court overruled me and within one month, the father took his own life.

Soon thereafter, a former patient of mine who's seeing me for anxiety issues who was gay, came into my office distraught after he reported that he was harmed by another therapist who rushed him into medical transition. He was so upset with nowhere to turn to for help. I had never heard of the term detransitioner and I had never encountered someone who has been this distraught and harmed by what has happened. I tried to help him with emails and calling his providers. They would not provide any guidance or resources of what we could do, no recommendations but to continue his transgender identity. He did not report gender dysphoria. He wanted help for how difficult dating was due to being a gay man.

We had been assured that regret was rare if it existed at all, and that affirmation was the only path. Almost every professional I encountered validated that I wasn't just treating children but saving them. Yes, saving children. In reality, the system was failing them by prioritizing affirmation over developmentally-informed therapy. Ignoring that in mental health, what we focus on often grows, not diminishes. The pressure to affirm intensified after the pandemic, as I saw spikes in trans-identification,

particularly among youth on the autism spectrum are those isolated and online during lockdowns. It appeared to me that many were adopting a trans identity to cope with other issues, not necessarily from deep persistent dysphoria.

Schools normalized rapid affirmation, leaving no room for gender-nonconforming kids to explore non-medical paths through the natural distress of adolescence. When I raised concerns about a friend group of four teens transitioning altogether in one month, I was silenced and I was told I had no basis to question that. My staff, colleagues, and even courts warned me of professional consequences for questioning the one-size-fits-all approach. Even when I was trained under this protocol and I did deny adults who were suicidal, but when it was children, it didn't matter. Suicidality only meant to affirm quicker. I eventually decided there was nothing I could do, so I just quietly opened my own private practice and stopped helping youth completely.

Many years would pass, and in 2022 I could no longer stay silent. My clients, a lot of them teachers, were bringing in stories of desperation, needing guidance, unable to discuss developmental concerns without risking their careers. Inspired by public discussions, I spoke out in the documentary What is a Woman and at Syracuse University in 2023. The result, the backlash was swift. Petitions with thousands of signatures were made against me, public disavowal by my former mentor and co-author of the publication. I was terminated from the University of 15 years and blacklisted from organizations after I was there with 15 years without any formal complaints against me, and every single evaluation was about being my exemplary service. And then my group practice collapsed.

But I am here because the truth matters. Our children deserve comprehensive, developmentally-informed assessments, not rushed affirmation that they may not fully understand. They need safe open-ended spaces to explore distress without being pushed toward irreversible medicalization. The FTC must continue investigating misleading claims like life-saving, reversible that undermine informed consent. I urge you to reinforce rigorous standards for youth gender care, protect professionals who raise concerns, and ensure gender non-conforming children have the time and support they need to find their path without corrosion.

In retrospect, the promise of saving children often meant recommending interventions that would make sure that they and their legacy would no longer exist. It would mean that I would risk their fertility and their sexual function, bypassing all the safeguards we apply in every other area of therapy. You would find it very strange if I told you that I was playing with dildos with 10-year-old typical children. But in this gender-affirming care, that's not only what was taught to me, it was promoted. We were a part of a drug of an assembly line, taught that gender-affirming care was the only solution.

Today, schools and medical organizations are endorsing the gender affirmation model, medicalizing distress while social media tells children that finding an identity is the most important part of development, even if it means disconnecting from their embodied selves. I continue to work with individuals with gender dysphoria and those who are gender non-conforming, helping families in custody cases and working with legislators to build safeguards for children. We need to rebuild trust in the medical community while caring for a generation of children who now face disorders of sexual development that we, in part, have caused.

When we talk about worrying about suicidality, my biggest fear is that the largest cohort that will end up taking their life are the detransitioners because they do not know and they do not have a way out. If you cannot transition your sex, there is no way to detransition your sex. And these children are also being told that that is a possibility. I already have children coming in and saying, "It doesn't matter if I transition my sex, I can detransition it." You cannot. Our children and their families deserve care, time, and honesty, not promises the medical system cannot keep. Thank you.

Ian Masson:

I want to thank all our panelists today, not just for being here, but also for their courage coming forward in the first place and letting us know all what's happening in their worlds. Thank you so much.

Jon Schweppe:

Thank you, guys. Thank you. Thank you, Ian, and again, thank you to the brave whistleblowers for all they've done to protect kids. Folks, for time purposes, we're going to run past that break and we're going to go straight into our next presentation and we will have one more panel after that, which will be hosted by Commissioner Mark Metter, so stick around for that. Erin Friday is a licensed California attorney and has been a registered Democrat for more than 30 years. She's the President of Our Duty USA, a national nonpartisan organization dedicated to shielding children and vulnerable adults from the influence of gender ideology and a director for Genspect USA. She's heavily involved in legislative advocacy, frequently proposing and opposing bills related to gender interventions.

She has written multiple amicus briefs in cases before the Supreme Court and federal courts of appeal, bringing attention to the perspectives of detransitioners and parents of gender-confused children. Her work and viewpoints have been featured in respected outlets such as The Wall Street Journal, The Economist, The Daily Signal, The Federalist, Daily Wire, The Epoch Times, PragerU, The Sacramento Bee, and Post-Millennial. Erin has been on CBS, Fox News, and NewsNation and has been featured in films both in and beyond the U.S., establishing herself as a significant voice in national discussions on parental rights and child protection. Ladies and gentlemen, please welcome to the stage, Erin Friday.

Erin Friday:

Good afternoon. I am honored to speak today as an awakened Democrat from California. I know, oxymoron. I am offering a roadmap for investigations into the nefarious gender industry. Dismantling the worst medical scandal in human history requires an understanding into the collusion among nonprofits, the medical community, and our government, that has created a new category of humans who were inconceivably born in the wrong body. This has led to an ever-growing billion-dollar industry to fix them. My goal is this, to see the decimation of the deceitful gender industry for both minors and adults. And to see that the individuals who set society on this course are held accountable civilly and criminally, including every medical society that has abandoned ethics and science in fealty to the transgender mafia. In 2007, endocrinologist Norman Spack and his protégé psychologist Laura Edwards-Leeper opened GeMS at Boston Children's, the first pediatric mutilation clinic. Dr. Spack and Leeper abandoned the established treatment of watchful waiting for children who were distressed about their sex. A cohort of children that had a desistance rate of 98%, if not affirmed. They not only adopted the flawed Dutch treatment protocol, but they streamlined it, moving children even faster towards medicalization because according to Leeper, there were staff shortages.

There are now over 400 gender clinics in the United States. There is money to be made and some doctors enjoy playing God. In 2023, I attended a conference in which Dr. Edwards-Leeper proudly recounted that Dr. Spack would tell people, "Everyone needs a Lara," because she claimed that her mental health assessments could distinguish between which child would benefit from sex trait modifications and which would not. When I asked if she followed up with any of her patients to confirm her superpowers, her answer was no.

Notably, she rarely disapproved gender interventions for any of her minor patients. We already heard about Amy Tishelman, we'll hear a little bit more about her. Psychologist Amy Tishelman joined GeMS in 2013. She recently testified that she had only just asked to create a database to track the outcomes of the more than 1,000 children whose bodies the clinic had altered. Boston Children's has been

experimenting on children for 18 years without follow-up, while simultaneously reducing the mental health assessments from 20 to 10 to two hours before prescribing puberty blockers, cross-sex hormones, and surgeries.

Dr. Spack and Edwards-Leeper methodology exemplifies the incestuous nature of gender medicine and the falsification of medical papers that reach predetermined conclusions through data manipulation and circular referencing. They leveraged their prestige to convince other medical providers to adopt their unsubstantiated treatment protocol. In 2009, Dr. Spack contributed to the Endocrine Society's guidelines which declared puberty blockers to be fully reversible. That is untrue. Despite acknowledging that the evidence supporting the safety and efficacy of blockers was low or very low, the guidelines recited in the 2012 WPATH SOC 7 as a basis for recommending blocking children's puberty.

Well, that is likely because Dr. Spack also happened to be on the executive committee for the WPATH SOC 7, so he was citing to himself. In 2012, Edwards-Leeper and Spack published a paper in the American Academy of Pediatrics and again stated that puberty blockers are reversible, citing back to the Endocrine guidelines and WPATH. This circular citation strategy has created a false impression that independent groups supported their conclusions. Another example of manipulation can be found in the $10 million NIH study led by Dr. Olson Kennedy, the head of Children's Hospital LA. That study failed to show that children's mental health improved on blockers. Back in 2021 Olson Kennedy presented the one-year result from her study at a USPATH conference, the U.S. arm of WPATH. But at the two-year Mark Olson Kennedy withheld the disappointing results.

She finally published them in 2025. Well, why the delay? As Lior pointed out, it was because she was afraid that her findings would be weaponized and used in court and used to stop prescribing puberty blockers for children. So this pediatrician placed a political agenda above children's welfare. Since the NIH puberty's blocker study results were not what Olson Kennedy had hoped for, she attempted to temper the failure in the study's abstract. She concluded that children's mental health would have likely worsened if their puberty hadn't been blocked, but her study had no control group, meaning that there's no possible way to support this claim. Her obviously false conclusion is emblematic of the glaring activism at all costs in gender medicine.

As Dr. Laidlaw stated, Olson Kennedy employed the same gamesmanship with the hormone study results, dropping the tracking of suicides, the most stated basis used to justify gender interventions because two out of the 315 children had committed suicide. Under any normal circumstances, this level of harm would have ended that study, but Olson Kennedy buried the lead. This type of manipulation is rampant throughout gender medicine. When the so-called experts are ideologues who stand to benefit from the results, scientific rigor disappears.

Let's spend a little more time on Joanna Olson Kennedy. She's captured on video stating that if girls miss their breasts after top surgery, they can simply get new ones. She is proud that she has performed sex trait modifications on children who are in foster care, homeless, prostituting, and drug-addled. She has said it is no big deal if she transitions kids who ultimately turn out not to be really trans because those kids have no fragility. She has stated it's not the worst thing to be trans, and after all, whose fault is it if she transitions a cis kid? Her answer? The child patient. She was merely providing what the child wanted.

Olson Kennedy opened the soon to be closed, largest pediatric clinic, Children's Hospital LA. It is well-known for the pressure created on families by Olson Kennedy and her wife, a female who identifies as a male. Inside that clinic, they would separate the parents and children into different rooms. They would bring in celebrities and other trans-identified people to talk to the kids and speak persuasively to them, telling them about all the different interventions they could get while others worked on the parents in a separate room, guilting them into accepting their newly-minted son or daughter. Olson Kennedy

partnered with public and private schools through Gender Spectrum, a now largely defunct advocacy group whose mission was to, and I quote, "Get gender ideology into every classroom." She, along with other clinicians, use schools as pathways to create and find her victims. Here is an example. This is a California middle school advertising a Gender Spectrum conference featuring gender surgeons and clinics in its weekly newsletter. Middle school. This slide is from a second gender spectrum conference in which kids in pre-K and older were invited. Those who have read the WPATH files, which I recommend that you all do, may recognize Dr. Satterwhite. He's noted preschool kids. This surgeon performs nullification surgeries. Think Ken doll crotch.

He also performs surgeries that leaves a person's natural genitalia intact while adding fake opposite sex genitalia. Keep this in mind as you hear the phrases life-saving and medically necessary. Then there's Scott Mosser who was caught on video stating that he has no age limit for removing girls' breasts. He also contributed to the adolescent section in WPATH's SOC version eight. What we really need is a crime board showing the connections and reach of each provider because it's quite stunning how a few people can create a whole industry that preys on the vulnerable.

For almost two decades now, gender providers have been placing children on puberty blockers, hormones, and surgeries without knowing the full effects while influential medical societies, major hospitals and providers are assuring parents that these interventions are life-saving and improved mental health. These are not mistakes. These are intentional deception. For example, Jason Rafferty's 2018 AAP Transgender policy is riddled with errors and dramatic statements without any citation. Despite a very public analysis by James Cantor, the AAP did not waiver from its position but doubled and tripled down. It should be of no surprise that Dr. Rafferty makes his living from a gender clinic. The AAP, as Lior stated, promised a systematic review. That was in 2023. Two years later, it appears to not having even started it. I believe that's because the AAP knows and always knew that there is no scientific basis for changing children's sex traits. Investigations must occur into influential medical and mental health societies who publicize false statements knowing that their membership will blindly rely on their protocols. I recommend starting with these societies. Sticking with puberty blockers. The number of kids being placed on puberty blockers is increasing at an unprecedented rate. These figures here don't include Kaiser Permanente. We heard earlier about Kaiser. They are a giant in the trans industry and they seem to make money both as insurer and provider, and that needs to be investigated.

I think a reasonable estimate is that in 2024, the number of kids placed on puberty blockers is close to 4,000 new patients, especially in light of the admission by director of Boston Children's Dr. Jeremi Carswell, that puberty blockers are being handed out like candy, which in her mind is great in some ways. Great. This despite her own acknowledgement that puberty blockers are not reversible.

Puberty blockers are profitable. The drug Lupron by AbbVie costs around $27,000 for six-month supply. A six-month Supprelin implant by Endo Pharmaceuticals can cost $210,000.

UCSF is a leader in altering children's sex traits. Its pediatric clinic was founded and is led by Madeline Deutsch, who also serves as president of USPATH. We really need that crime board showing all of these connections.

The infamous Dr. Diane Ehrensaft, who also works at UCSF, she teaches that 2-year-old boys who unbutton their onesies are communicating that they're really girls, and girls who dislike barrettes in their hair are communicating that they are really boys. She also believes that there are an infinite number of genders, including a Prius gender. I can't make this up.

So this screenshot is from UCSF's website as of June 25th this year. It clearly states that puberty blockers are safe and fully reversible. I wonder why then its consent form states otherwise. This is a consent form from 2021. Let me point out a couple interesting statements. First of all, it says that children with trans identities need to have their puberty postponed, that the medication is not permanent, and that

blockers treat the trauma of unwanted puberty. Puberty is not a choice. It's something humans all go through.

Next, it says that the long-term effects and safety of puberty blockers is not completely understood. Well, I thought it was reversible. Isn't that what it said? Bone density will diminish, but is expected to return to normal. Now, lawyers, we will hone in on that word "expected". Expected? In other words, you think so? Maybe? Then again, we don't know. Oh, and puberty blockers might affect fertility. This consent form directly contradicts UCSF's website. This is purely and simply deceptive practices. In this example, the child's doctor was Stephen Rosenthal who partnered with Johanna Olson-Kennedy in the NIH study that still has not released the results of puberty blockers' effect on a child's physical health. Rosenthal also contributed to the Endocrine Society's and Pediatric Society's guidelines for transgender health, both of which state blockers are safe. Rosenthal and Olson-Kennedy need to be at the center of the crime board.

Dr. Marci Bowers. He is the current president of WPATH. He justifies the eunuch identity for children because the word eunuch appears in the Bible. Again, I can't make this stuff up. As this country's most prolific castrator, having performed over 2000 penile inversion procedures, including on children, he admitted during a Duke symposium that puberty blockers started at Tanner stage 2 plus estrogen result in a life without any sexual pleasure for males. How does one explain to a nine or 10-year-old that he will never experience sexual pleasure in a manner that he can understand and consent to? We all know the answer. It can't be done.

Incidentally, billionaire JB Pritzker, the governor of Illinois, and his trans-identified brother are major contributors to Duke.

A 2024 Mayo Clinic study reports mild to severe gland atrophy and changes in testicular cells in males treated with blockers. It reports that this finding calls into question the reversibility of blockers. Irrespective of this admission, the Mayo Clinic's website as of this June continues to state that puberty blockers are reversible. Almost every major medical clinic or gender clinic advertised on its website that puberty blockers are reversible or merely a pause button with knowing those statements are untrue or at best unknown. Some have been scrubbing their website since the executive order and FBI probes were announced. I watched it in real time.

I want to spotlight one particularly dangerous gender clinic and that is Seattle Children's Hospital. Not only does it state that gender interventions are life-saving and puberty blockers are reversible, but it partners with its autism center. Youth with autistic traits are overly represented in the exploding cohort of children and young adults adopting trans identities. They tend not to conform to rigid sex stereotypes, leaving them vulnerable to believing that there's something wrong with them. Combining the autism and pediatric gender centers provides a steady stream of patients for expensive and lifelong gender treatments. Seattle Children's is not alone in this marketing scheme.

Seattle's gender clinic authored and the AAP published a perspective advancing the notion that refusing to modify a child's sex traits constitutes medical and emotional abuse. Parents who refuse to consent to have their daughter's breasts removed or sexual function destroyed are seen as abusers by the largest pediatric medical society in the United States. And if I recall correctly, Seattle Children's had one of the most prominent booths at the AAP convention this year, where some detransitioners and I were escorted out from our paid-for booth because we dared to try to educate pediatricians. So yes, the AAP knows of the harms, but continues to support gender procedures.

This is a screenshot from Whitman Walker Medical Clinic, a clinic right here in DC, that provides services to patients 10 and older. Excuse the vulgar language. It's not mine, it's theirs. Whitman Walker claims that females can grow a male phallus from testosterone. Of course, that claim is an outright lie, though

prescribing testosterone for females is genital mutilation. That part is true. I want to spotlight one surgeon who deserves immediate investigation.

And this is Dr. Sidhibh Gallagher, a plastic surgeon in Florida. An FTC complaint was filed and ignored under Biden, but I hope this administration will investigate this predator who targets the youth, the overweight, and the vulnerable. She advertises on TikTok, Instagram and YouTube using childlike antics to sell her services while posting pictures of her lavish lifestyle her young victims' bodies provide to her. Here are a few examples. Here she's celebrating her success in a possible fraudulent insurance claim. Here are a couple pictures of her victims. Note that this young girl has scars all over her body from cutting herself. Dr. Gallagher was more than happy to let her pay for her to use her scalpel to make even deeper cuts. The woman on the side, she has no nipples. Humans have nipples.

Turning to cross-sex hormones. There are two major online distributors of cross-sex hormones, Plume and FOLX. Both are supposedly only accessible to adults, but their marketing suggests otherwise. Plume started with seed money from Craft Ventures, one of California's most prestigious VC companies, raising over $38 million. Both of these online cross-sex hormone distributors are capitalizing on the market predictions of substantial growth in the gender industry. In 2022, cross-sex hormone sales were a $1.6 billion business. Planned Parenthood is also reaping the benefits of this market. This is why they want to shut us up.

Let's examine one of Plume's ads. That young woman looks like a minor to me or at suggests that Plume is marketing to minors. It also looks like Plume is getting into the surgery business or perhaps partnering with surgeons who will remove the healthy breasts of young girls. Plume, by the way, is affiliated with Stork, so Plume sterilizes the person and Stork finds them a baby. This slide also shows a snapshot from a newsletter from Plume that a child can sign up to receive. I received it and I faked that I was 16 years old.

Now why would Plume be publishing that runaway minors in New York are able to get hormones in its Stuff We Think You'll Like section? Looking for more clients, enticing children to run away from their parents who won't affirm them. FOLX also markets to children. FOLX had its senior director of audience development, Kai Proschan, speak to kids from Friends for youth at the Chan Zuckerberg Center. The kids there looked to be about 10 to 14. I was actually there. Kai, a male who was wearing an outfit worthy of a red light district, talked about medical transition to a group of at-risk children. These online services are tailor-made to circumvent parents' consent and detection. A website called Gender Mapper directs children to both FOLX and Plume if their parents won't consent. Since both of these online services use telehealth, adults can easily order for minors, the drugs come in unmarked packages, and it's easy to change the delivery addresses. Mental health providers across the country have colluded with the medical-gender complex in their abject failure to safeguard against transgender interventions. Websites like Gender Affirming letter Access Project and Do Something: Identity(ies) facilitate approval letters for gender interventions for free or in an hour with no follow-up, with real assessments for minors and adults. Every medical provider who is just checking a box is not providing mental health care. They are order-takers. The FTC can pursue every last one of them for deceptive advertising.

While this may be out of the FTC's purview. I do want to raise the college transgender connection. Many colleges have transgender clinics right on campus or are affiliated with them, providing an endless stream of paying customers. Parents send their kids to college for an education and their daughters come home with missing breasts and facial hair and their sons on estrogen. I don't know if I can play this. It should work? Okay. I will end with a video that sums up everything that is wrong with gender medicine. This is from a WPATH seminar in which Dr. Dan Metzger admits that talking to a 14-year-old about gender interventions causing infertility is like talking to a blank wall and the regret that comes later is real.

Glenna Goldis:

I think when we're doing informed consent, I know that that's still a big lacuna of that we're just, we do it, we try to talk about it, but most of the kids are nowhere in any kind of a brain space to really, really, really talk about it in a serious way. That's always bothered me. But we still want the kids to be happy, happier in the moment, right?

Erin Friday:

Yeah. Medicine should never be about giving a child what he wants in a moment in time. The whole of gender medicine, even for adults, because we can't forget about the adults. Talk to a parent with a 17-year-old child who thinks that they're the opposite sex, their biggest fear is time because they can hold the line until that child turns 18 and then it's no holds bar. So the whole of gender medicine, it's a complete sham based on false science. Thank you.

Jon Schweppe:

Thank you, Erin. That was a very informative presentation. Before we begin our next panel, I'd like to remind everyone, as the chairman mentioned during his speech this morning, that the FTC will be opening a public request for information related to this workshop in the coming days. Be sure to stay tuned to our website and our social media channels for more on that and how you can submit comments, but go ahead and start preparing them now.

We'd love for the folks here today, especially those who didn't get the opportunity to speak, and especially for those who are watching online, to have the opportunity to share their stories with the FTC.

Now, first of all, I just want to thank you guys. I know this was a really long day. It was a bit of a marathon. We are on our final panel and I'd like to welcome to the stage my friend, newly minted but already off to the races, FTC Commissioner Mark Meador.

Mark Meador:

Thank you everyone. Why don't we have the next set of panelists come on up at this point? While they're coming up, I just want to say thank you to all of you for being here today and to all those in the chairman's office who've invested their time in setting up this workshop. I know it was a big undertaking. These are incredibly important conversations to be having, both here at the commission and as a nation. We also know it can be a difficult conversation sometimes. And let me be clear, every person deserves dignity and respect, and the commission certainly recognizes that.

In my view, treating people with respect and dignity means being honest with them, including about the effects of medical interventions, about the evidentiary basis, about the anticipated outcomes, and this is especially important when we're talking about decisions involving children. That's what today's workshop is about. It's about honesty, the basis for all the work we do here at the Commission to protect consumers.

And that brings me to the topic of our panel, what the FTC can do as an agency about the unfair and deceptive practices that exist in the field of youth gender medicine. Because as this workshop draws to a close, it's become clear that a great deal of work is needed. And so I'd especially like to thank the distinguished members of our panel today, and I'll now go one by one with their introductions. First we have Josh Payne. Josh is a founding partner at Campbell Miller Payne PLLC, a national law firm based in Dallas, Texas, representing detransitioners and others harmed through gender transition procedures. Josh has served as lead counsel on behalf of Detransitioners in medical malpractice litigation in Arizona, Massachusetts, New Hampshire and North Carolina. He also serves as lead counsel in a wrongful death

case in Tennessee on behalf of the parents of a young adult son with autism who committed suicide after being placed on cross-sex hormones.

Next we have Glenn Goldis. Glenn. Glenna Goldis, sorry. Glenna is a consumer protection lawyer in New York City with experience in government and civil legal aid. She's speaking today in her personal capacity, not on behalf of her employer. Glenna has successfully prosecuted deceptive practices in sectors like for-profit education, debt collection, telecom, and bail bonds. A gay rights advocate, she publishes a newsletter about the transgender movement called Bad Facts. Glenna holds a JD from New York University School of Law and a BA in philosophy from the University of North Carolina at Chapel Hill.

Next we have Brandon Showalter. In addition to being a long-time friend of mine and an avid vocalist, Brandon is a journalist with the Christian Post who has reported extensively on the developments of gender ideology around the world and other bioethics issues. He's the creator and host of Christian Post's Generation Indoctrination documentary podcast series, and has been featured in several documentary films on the issue. He holds degrees from Bridgewater College of Virginia and the Catholic University of America.

Next we have Paul Dupont with the American Principles Project. Paul is the policy director for American Principles Project, where he is responsible for helping to build and execute the organization's public policy agenda. He's a 12-year veteran of APP, having served in various roles from communications to operations and research. Paul has been particularly involved in helping support APP's advocacy on transgender issues, from defending North Carolina's HB2 in 2016 to promoting efforts to end taxpayer funding of gender transitions today. He's a graduate of Villanova University where he received a bachelor's degree in political science and humanities.

And last but not least, we have Jay Richards from the Heritage Foundation. Jay is the director of the DeVos Center and the William E. Simon Senior Research Fellow at the Heritage Foundation. He's also a senior fellow at the Discovery Institute. Jay is the author of 14 books, including two New York Times bestsellers. His most recent book is Fight the Good Fight: How an Alliance of Faith and Reason Can Win the Culture War.

Thank you all for being here today and why don't we just jump right into it. So under the FTC Act, an act or practice is deceptive when it, one, misleads or is likely to mislead a consumer, two, a consumer's interpretation of a representation is reasonable under the circumstances, and three, the misleading representation is material. So Josh and Glenna, can you tell us about some of the representations that providers have made in regard to so-called gender-affirming care, both the need for it and its effects?

Glenna Goldis:

Yes. Thank you, Commissioner. Thank you. First, I just want to express gratitude to the FTC for holding this event today and for inviting me to be on this panel. We've heard a lot of deceptive representations all day today. The other speakers have been identifying them accurately, in my opinion, all day. I'd like to drill down on some of the foundational false claims in gender medicine that really show us that the problem goes all the way to the root of this practice.

And this can actually be awkward to focus on because the false claims are not just made by gender doctors. In much of the country that jargon is part of our normal lexicon now. For example, sex assigned at birth, lots of everyday people are using it because they think it's the nice thing to do. But once you realize how harmful gender ideology is, I think that people can maybe start trading in those phrases.

So I'll start with sex assigned at birth. The doctors ably handled this one earlier. Sex is not assigned at birth, so that is a false statement. The words "assigned at birth" imply that sex can change. So for young

patients, especially in a gender clinic, they show up because they want to change sex. And when doctors tell them sex is just an assignment, they get the idea that they'll be getting a sex change. And it's important to note under the FTC Act that it does matter who the target audience is. So even if you are an adult and you think, "Well, that phrase is innocuous. I know what sex assigned to birth means. I know it's just meant to be nice." Well, we must look at it in terms of the patient population that's hearing it, and these are distressed children, so it is deceptive toward them.

Second, this is a big one, gender identity. Doctors claim that consumers, patients have a gender identity that is incongruent with their body, but it's impossible for gender identity to be different from a body or the same as a body because gender identity, the way it is defined by gender doctors, has no definition, it has no properties. So this is an important point. I think a lot of people assume that gender identity means wanting to be one sex or the other, and gender doctors almost make it look like that's what they mean because they say that gender identity can be male, female, or something else. But it's a trick, because, remember, gender doctors think that a male is anybody who says they're a male. So it's a circular definition like gender identity is somebody who has a male gender identity kind of thing.

And then the doctors just double-down on their deception when they try to add more verbiage to make it seem like gender identity does have properties and it's not just a circle. So just to give you some examples, Jack Turban wrote in the New York Times that the most basic part of gender identity is a person's transcendent sense of gender. And this was the New York Times. And he did not define the term "gender" after referring to the transcendent sense of it. Instead, writing that gender, quote, "Goes beyond language."

Another gender doctor, a pediatrician, wrote that gender is a, quote, "Multi-dimensional concept with complex expressions and that it is related and distinct from sex in ways that modern science is still exploring." So she's going to know the definition of gender in the future once science is done. And just a side note on that, I'll try not to go on too many tangents about this, but a lot of times gender doctors will kind of use language to imply that they're going to get the answer to gender questions soon. Science is almost there. And they say, "Look, this is a really new area of study." It is not. All this stuff goes back to the early 1960s. Institutions have been investing in it since then. Major universities. It's had very little change in the theories underlying it since the early 1970s when they coined the term "gender dysphoria". So whenever they try to use that excuse of like, "Oh, we're new," that's not true. They're not new. This stuff is all very old. It is not cutting edge.

And finally, I'll just give you one more example. Daniel Shumer, a pediatric endocrinologist in Michigan, he doesn't have a coherent definition of gender either. And when he was deposed recently, he admitted that when he explains gender to patients, quote, "I have oversimplified." So he's not as complicated as the woman with her complex multi- dimensional concepts. He boils it down to some other not true thing.

So with all that being said, it seems safe to say that patients don't know what their doctors mean by the term "gender". And doctors don't really have any meaning. They seem to be using it as a placeholder to lead the patient to believe that since they have this gender-related problem, they need a gender-related solution, which is gender-affirming care. So that's kind of the function it's serving. I think that whenever you see the term "gender", pretty much in the gender world, the gender medicine world, it's deceptive.

So then I'll just give you one more kind of foundational false statement that they make. And this is from, for example, the American Psychological Association and the American Academy of Pediatrics. They claim that sexual orientation means attraction to a gender. Sexual orientation ... There's no scientific basis for saying that. The studies are about sex, sexual attraction to people based on their sex. And recall, gender doesn't have a definition, so it's not even possible for that claim to be true. And this is really important because it leads consumers to believe that gender-affirming care will allow them to

date and form relationships as though they were members of the opposite sex or non-binary sex, I'll try not to go off on that. So this is playing out in the real world.

In the gay community, we see these young women pursuing gay men, trying to form relationships with them. They think it's viable because they have a male gender identity. Their doctor told them so. And these institutions are telling them that sexual orientation is based on gender. So this just leads to a lot of discomfort and sadness and awkwardness for parties on all sides of this equation. And that's putting it mildly. So again, this is a really material deception that is being imposed on these young people.

Mark Meador:

Thank you. Josh?

Josh Payne:

Thank you, Commissioner. I would like to look at both the problem that's presented by the people making these statements and the solution. And the deception is when viewed in the round, but you can look at it from both angles. They state the problem as your child is going to commit suicide if this intervention is not carried through and if you don't agree to this, and then they come along with a solution that they say is rock solid. So you have a drowning victim and here's the life raft.

And because a deceptive communication is viewed holistically, it is a clearly deceptive message. The message is, "You are dying and here's your life raft." That is the core deceptive message. Another angle of this from an aspect that the FTC is well-versed in is implying that something is FDA-approved. And again, when viewed in the round, you're in a doctor's office, somebody there wearing a white coat, exercising authority over you, presenting a life raft to you, you are assuming this has every conceivable seal of approval out there, and there is no inkling in the parent's mind or the patient's mind that the FDA hasn't vetted this and has not approved this. And so to not have a disclaimer that this is absolutely not FDA approved, not even really reviewed, it's entirely an off-label use and is one of the bits of evidence from earlier today. The whole thing is off-label. That's a disclaimer that's vital and it's not being made aid.

Mark Meador:

Thank you. Switching over to unfairness, under the FTC Act, an act or practice is unfair when it, one, causes or is likely to cause substantial injury to consumers, two, can't be reasonably avoided by consumers, and three, isn't outweighed by countervailing benefits. So I was hoping Brandon, Paul, and Jay could tell us a little bit about some of the injuries that are alleged to have followed from the push to get young people into aggressive gender-related medical interventions.

Brandon Showalter:

I'll go first and I would like to thank you, Commissioner Meador, and the FTC for this event today. The injuries are incredibly brutal. I've seen things that have put gray hair in my black hair, and you'll age pretty fast. You don't want to see the kinds of things that I see in my inbox and I hear from parents about what has happened to their children.

And I'll say when we talk about unfairness and deceptive trade practices, because it is based on an irretrievably flawed premise that it's actually possible to be born in the wrong body, any medical treatment toward that end is going to do damage, guaranteed full stop, because it starts with a lie. That's just it. And it leads to horrors that I'm about to describe. I'll just talk about three injuries that I've seen. I haven't seen fully, but I've seen part of it and heard about it.

One detransitioner man who walked into his appointment, the first he was reportedly told by an intern working in the intake office, "If you think you're trans, you are trans." He went fully down the trans path. His story was featured in Abigail Shrier's book, Irreversible Damage. I also reported on his story. Hormones, wound up getting an orchiectomy, the removal of his testicles. And he was never told even during his appointments, they never used anatomically correct language during his appointments, they castrated him for $1,000. That poor man had severe suicidal ideation in his post-operative regret, severe endocrine complications, and he even, when he tried to have sex, wound up ejaculating blood. And to this day, the weirdest email I've ever had to send was to Dr. Laidlaw asking is it really possible to ejaculate blood? And yes, it is, after you had been castrated.

Another woman on Instagram who was led down this path had a phalloplasty surgery and ended up having to have over two dozen "corrective revision surgeries" because they so badly mangled her down there that she had to urinate out of her anus into an ileostomy bag. And she was posting about this carnage that was done to her body on Instagram. It's gruesome.

Another woman who has got the worst story I have ever heard about, and she's featured in the documentary podcast that I produce and host, I can say her name, her name's Amy Atterbury. I just have to honor her because it's the worst story I've ever heard. She had to be in the next room over where doctors disfigured her daughter's forearm to make a fake penis. Medicaid paid for her to have a double mastectomy and all of her reproductive organs cut out, but her daughter's forearm was cut up to make a fake penis and she had to be in the next room over for 13 hours as the doctors did what they did to her. And reportedly, I've heard that there's some other corrective surgeries going on that are either planned or may have happened. They're currently not speaking as far as I know, where they will have to do some sort of revision where they cut the sex organ in half and reroute her urethra.

You want to talk about... I mean, I totally try to avoid making any comparisons to the Holocaust because I just don't like to. That's a uniquely horrible episode in history. But I will sometimes be emailed by Jewish readers who say we're living in a culture of Mengele's. This industry needs to be dismantled from the top to the bottom because it all begins with deception and a lie that it's actually possible to be born in the wrong body, and there are products and services that are marketed to that end.

Mark Meador:

Thank you.

Jay Richards:

Well, I knew we were coming at the end and probably the harms would be discussed in exquisite detail by other speakers and panels. In fact Erin, Friday,` said almost everything I was planning to say just prior to this, but so let's just briefly summarize the manifest and obvious and documented harms of so-called gender affirming care. We won't even talk about the social transition, just puberty blockers, cross-sex hormones and surgery that have been discussed in this room today. Reduced bone density and bone strength from puberty blockers. The state of Georgia didn't include puberty blockers in its bill restricting these procedures because the sponsor had been told that it was entirely reversible. Puberty blockers are just reversible. We know that's not true. You know it's not logically because you can't reverse time.

And so, if a child has his puberty blocked at 13 and his peers go through puberty and he gets off of them four years later, that part at least is obviously not reversible, and we know there's serious physiological effects of this. It likely harms brain health. This is a topic of continuing research. I happen to have seen a report that will be coming due here very briefly that focuses on the adverse events reporting system. So not the Bayers, not the vaccines, but the other FDA's reporting systems on puberty blockers. Just look at all of the reports. There are very profound and underappreciated effects on mental health and cognitive

development from puberty blockers alone. Remember, we haven't gotten to cross-sex hormones yet. There's psychological distress. There's obviously infertility, at least if these are continued and insofar as they're the beginning of a treatment pathway that leads to infertility, stunted growth, which is at this point quite well known.

Now let's turn to cross-sex hormones. Again, fairly well known already, heart health risk. We don't have long-term data on this, by definition because we're in the beginning of the experiment with doing this with kids, giving girls massive amounts of testosterone. But we can be quite certain that it's going to have a signal in heart health. Infertility, for obvious reasons. Seems to be a serious increase in cancer risk, which is also discussed today. Mental harm. Many detransitioners, especially females, will talk about an initial euphoria from testosterone. Same thing that men that get testosterone supplementation will experience. But this is sort of a honeymoon and a year or two in, many detransitioners report actually quite harmful and distressing mental effects.

Again, the sort of regret and detransition was not supposed to happen, but cross-sex hormones has very specific physiological effects. Some of the detransitioners that spoke today, for instance, commented on the depth of their voice, which in the scheme of things may seem superficial, but it's a reminder of the kind of permanent effects that these drugs have.

And then, almost inevitably when we get to the surgeries, this is sort of obvious, and Brandon's given us a few examples, but these are not one-and-done surgeries. Most of us who've had surgery, I had to have a quadriceps tendon reattached to my knee in 2019. I had one surgery and a few months of recovery. The so-called gender-affirming care in which you create facsimiles of the other sex or of no sex, depending on what the doctor's sort of metaphysical theories on these things are, right? That's not a one-and-done. These usually require maintenance. They very often require follow-up. They may, in some cases, and I know there are detransitioners in this room, involve years just trying to heal the wounds from the initial surgery. That's the reality of this thing.

And then, the one thing that was not discussed quite as explicitly as I think it should be is that there is a iatrogenic harm to the beginning of this procedure. Just puberty blockers alone, even if they were by themselves reversible, we know that if a child is put on the transition pathway and starts taking puberty blockers, he or she is much more likely to continue down the pathway to full transition. In other words, it fast tracks children based upon a really bizarre and almost certainly false diagnosis all the way to the end. The question of whether puberty blockers alone are sterilizing doesn't quite answer the question. Even if they weren't, if it fast tracks kids onto a protocol that leads to sterilization, then yes, they are. These are manifest harms.

Now, any surgical or medical intervention has risks so why would anyone be willing to bear this? It's almost certainly because of the false calculus that parents are presented with. If you're a parent, and I will say I'm someone that works on this issue. I have no personal connection. I don't have a child or family member that has struggled with this. I do know this as a parent, the worst scenario you can possibly imagine for your child to suicide. And so, if you think, "Okay, suicide's the worst," and then you're told by a trusted physician, "I have a way out for you though." It sounds terrible in the abstract, but it will prevent the worst outcome. It's only with that emotional blackmail, I think, that most parents would ever have entertained starting this process in the first place, and it's precisely why the FTC has relevant jurisdiction on this issue.

Mark Meador:

Thank you.

Paul Dupont:

I don't know what else to add about the harms, the obvious harms that this causes. I mean, I think the panels we heard before this, what Brandon and Jay just talked about, I mean, the harms are numerous and obvious. I don't know if I'd be preempting you, Mark, by jumping to the second part of the definition of what makes a practice unfair, that it can't be reasonably avoided by consumers. When Erin was up here earlier, she mentioned Dr. Johanna Olson-Kennedy, how she said that she wouldn't have any issue with transitioning patients who would later regret it because, well, that was what they were asking for at the time. And I feel like that's often used as a cudgel against detransitioners who later regret it of, "Oh, well, you should take responsibility for reactions." And that kind of goes to this question, can this be reasonably avoided?

And I think we have to look at the fact that the system that's been set up, it's really been set up to create a pipeline that's easy to get into and almost impossible to get out of once you're in it. And so, a few things to that point. I mean, obviously, we've heard, again, all the testimony earlier today about the emotional blackmail that's used at the very outset, telling parents, "Would you rather have a dead son or living daughter?", or vice versa. The ways in which at the outset, the... Sorry, the ways in which the patients are really just pushed into this and pressured into it with the fear-mongering and whatnot, and then the fact that they're not fully informed.

This came from a free Press article about Planned Parenthood, which is I think a particularly bad actor in this. Free Press about Planned Parenthood. Planned Parenthood's materials for clinician state atrophy can begin with within just three to six months of exposure. But on the brief patient consent form, it's about three pages long, that both Hineman and Anna signed, this was referred to as only genital dryness. There's a lack of informed consent at the outset.

And then, when patients are in this pipeline, they're encouraged to continue no matter what's happening. And that's again, by design. This is from the WPATH Standards of Care 8. We recommend healthcare professionals maintain existing hormone treatment if a transgender and gender diverse individual required admission to a psychiatric or medical inpatient unit unless contraindicated. That means if they're going through some sort of psychiatric episode, the WPATH standards of care is saying continue to administer hormones anyway.

And again, I think we've heard throughout today examples of that. And again, that's not a mistake, that's by design. That's what their standards of care states. They're in the pipeline. They're continuing to be pushed down this pipeline. And oh, by the way, if they do have regrets, if they do want to detransition, well, insurance will cover the initial cost of transitioning, but a lot of times various detransition care is not covered by insurance. So there's a financial obstacle to getting off the pipeline as well. I think when you throw all that together, you really can't help but conclude this can't be reasonably avoided by consumers.

Mark Meador:

Thank you. Looking ahead, if there are in fact violations of law associated with the youth gender medicine, a critical question is going to be what are the appropriate sets of remedies or solutions that we should be seeking? Josh, Glenna and Paul, what in your views, what does relief realistically look like for American consumers and patients?

Josh Payne:

An important point to make is that, Commissioner of course, as you know, the FTC is able to collect civil penalties in certain circumstances, not necessarily turning that money over directly to individual consumers, but through its consumer protection power, it is controlling conduct, incentivizing conduct,

disincentivizing bad conduct. And once it determines through its investigations who it believes it should enforce the law against, the major players and targets, it can bring administrative cases against those individuals. That can take time. But it's useful because at the end of the process, an order is created that can be enforced through civil penalties, not just against the respondent, the target, but also against what they call non-respondents, non-parties to the proceeding who know about the order, must still follow the order. And if they do not, they subject themselves to those civil penalties.

The FTC, I almost said the FDA, the FTC can engage in rulemaking. Again, that's a process that involves time where it perceives the practices at issue to be what it calls prevalent. I think a lot of what we've been discussing today, I know representing detransitioner clients and medical malpractice cases, as my firm does, these practices are indeed prevalent, which would give rise to the FTC's ability to make rules that limit this conduct.

And then, finally, what I think has historically been an underutilized tool in the FTC's toolkit is it can actually go to the courts and seek injunctive relief. And that's probably the quickest way to stop the bad conduct. If an investigation is ongoing, if an administrative cases in the pipeline or pending, the FTC does all of that part in house, but it can separately go to a federal judge and obtain pretty much immediate injunctive relief off the back of some kind of mini-trial or evidentiary hearing where it's able to lay its case out and say, "This is urgent".

And interestingly, it's not just an ongoing violation, it's also to prohibit anticipated violations. It's not a defense against the FTC's request for injunctive relief for the hospital system or drug company to say, "Well, we're not violating it yet." If there is an imminent threat and they're about to violate it, the FTC is still entitled to seek that injunction from the court to stop the anticipated violations. Those are the key remedies that are out there. And I would draw particular attention to the injunctive relief remedy, which may not be the FTC's immediate thought naturally of that's where we want to go because they can do so much in house, but I think it's a very useful tool that should certainly be considered by the commission.

Mark Meador:

Thank you.

Glenna Goldis:

One of the big social injuries that has come out of this scandal is the decline in medical institutions, especially medical societies and medical journals. You heard about that earlier today. We have these institutions that they're basically healthcare lobbying groups like the American Medical Association, the American Academy of Pediatrics. But the fact is Americans want to have these institutions that give them good information that seems to be objective. Everybody wants that in America. But unfortunately, we've seen that, really, these organizations have become political in the gender scene. They have batted away dissenting views. They've only printed things that supported theirs and even printed errors at some point. And of course, the associations have published endorsements or kind of de facto endorsements of practices that are not evidence-based and that are harmful.

And so, I don't think that the government should go in and force them to be objective. That's not possible. But I think by acting against them, by seeking injunctions, as Josh says, against their deceptive activity, that will pressure them to change. And also just the act of conducting thorough investigations in the course of pursuing a prosecution and making that public will be really helpful in exposing the medical associations to the public and to themselves so that they see the road back because they're at the point where they're going to start losing members. Pediatricians are going to think, "You know what? This is not representing me well, this group. They're actually making me look bad. I don't like what they're doing. I'm not going to pay dues anymore."

They could lose other revenue streams as well. There have already been reports that the American Medical Association has lost traction on Capitol Hill because they're just perceived as being so aligned with the left. And like I said, they are fundamentally a lobbying organization, so this is a big problem for them. They have their own reasons for responding to the action that the FTC takes and reforming themselves.

Mark Meador:

Thank you.

Paul Dupont:

And I'll just add to that, I think obviously both Josh and Glenna here have covered a lot of the different avenues that the FTC can pursue. I think there's also a whole government approach here as well though, right? We had the DOJ represented here earlier, and they certainly have a role to play in this. The memo that was released by Attorney General Bondi earlier this year, laid out a number of different pathways there, which it sounds like they are pursuing enforcing statutes against female genital mutilation, going after violations of the Food and Drug Cosmetic Act, False Claims Act. I mean, we've heard already a bunch of times false billing issues. There's all sorts of avenues to accountability there, I think.

And then, also with the FDA, all of these drugs are being used off label. The FDA is certainly within their authority to commission a review of the off-label drug use of puberty blockers and also warning manufacturers of consequences of promoting that off-label drug use if they are doing that. Which again, I think there's definitely an avenue to investigation of that. Definitely there's a lot that the FTC can do, and I think there's also a lot that other governor agencies can do as well.

Mark Meador:

Thank you all for those comments. Investigating these effects that you all have laid out of youth gender medicine and the representations made about them, it's certainly going to be a priority for the agency going forward, but in doing so, we're going to need the best available information that we can get. As we explore this topic in accordance with the law, Jay and Brandon, who should we at the FTC be talking to as we investigate, and what are some of the key questions that we don't yet have the answers to? And just overall, what does a comprehensive investigation look like?

Brandon Showalter:

Well, one of the things that I've appreciated about today is that names have been named. Erin said a moment ago that some doctors from California should be at the center of the crime board. Start with the people that have been named today and just start digging around, and you'll find a hornet's nest and their associates and their affiliates.

I think the other people that it's just so important to talk to are the parents, because I've been getting messages all day from the hundreds of parents who are watching this, overjoyed, gushing and joyous that a federal agency has put on this day-long seminar because they have felt so unseen and hidden. They've lived in a straight-jacket of silence. And so, the fact that you have federal lawyers that are willing, I mean, they're literally probably dancing in their closets, watching this, in their wardrobes. Some of them, they live inside a cone of silence, even within their own homes and neighborhoods. They have not had a voice. They can tell you firsthand how they were deceived, misled. They haven't been heard. Dr. Grossman has been an excellent advocate for them. But the voices of the families that have been shattered into a thousand little bits, you want to talk about how they were misled and deceived and

ripped apart. Talk to the parents and zero in on the predatory doctors that have been named today. That will get you started.

Mark Meador:

Thank you.

Jay Richards:

Yeah, what Brandon said, essentially ditto. I mean, obviously, everyone that has attended this, everyone that's been on this stage today, start with them, everyone that has attended. But I could tell you, as someone who spent several years working on this in the policy space and others, in some ways I feel like some of us here probably are reaping what others sowed years ago.

This was a very tough issue initially, in which it felt like there was absolutely no way to win. Now, I just happened to be convinced, no, there's no way this can ultimately be maintained because it's contrary to the evidence of the senses and things that everyone knows. This is not really abstract stuff to say, " There's males and females, and we could tell the difference." That's what we were dealing with. Nevertheless, it was first really hard to get people to believe that this was happening.

It was hard to get Republican members of Congress and staffers to think, 'Okay, yeah, this is something maybe, okay, maybe it happens in California or something, but it's not widespread." I mean, this was the idea. I recall a state hearing in Nebraska with Luke Hein, a detransitioner, who had had a double mastectomy, and someone else was testifying and insisting that it never happened in her state. That that didn't happen there, and there was a victim right there in the room. So that level of denial of the reality of it.

And so, as awful as it was sort of initially when detransitioners started deciding, "Okay, we're going to talk about this," that changed the game entirely because you can have 12 people making interesting scientific and philosophical arguments, and one detransitioner just sort of lays them to waste. And so, to have parents and children who are the primary victims of this ideology as it manifests itself in medicine, they got to be in the front in terms of just showing how fundamental and real this is and why it matters.

But then also, the experts themselves, the particular specialists, including many of the medical scientists here mixed with competent generalists and translators. It's sort of hard to describe this, but sometimes a medical specialist for all their specialization can also be subject to confirmation bias and sort of a narrowing of vision. But the generalist is often not likely to have the grasp of the details. And so, a combination of people who've studied this as generalists, who've translated it in what it matters, and the specialists are absolutely crucial.

And then, just to reiterate what Brandon said, you should talk to the members of the committees, of the medical associations that came up with their respective guidelines that the American Academy of Pediatrics, at the Endocrine Society, at the American Psychiatric Association. Ask them not just sort of in general, but specifically how they came up with those guidelines and what the scientific procedures were that they followed in order to do that and find out what they have to say. And then-

Brandon Showalter:

Just tag on one quick thing. Just add to that, I think the biggest stronghold, just to phrase it that way, the medical societies and the courts are the biggest thing that keeps things anchored in insanity here in America. Because if you have ideologically captured court systems, as the FTC takes action and tries to adjudicate these things, if they are deferring to these medical organizations, and it was what was so genius about what the state of Alabama did, was that they went after WPATH's vaunted guidelines, and

they discerned rightly that that was the source of the problem. Because once they blew that apart, they were able to show the judges that all of this was just hogwash. Yeah, put the screws to those who are writing these junk guidelines because they're just based in lies, and that I think will open the floodgates.

Mark Meador:

Thank you. Thank you both. And Jay, one of the things you said reminds me, someone Brandon and I both know is fond of saying that bad ideas can only bear the weight of reality for so long. And it seems like that's what we're coming up to here. And so, I appreciate all of your comments today for the whole panel. It's been incredibly insightful, and I think it gives us a lot to take into consideration as we move forward as a commission.

I'm sure we could discuss it all day long, but unfortunately that does just about conclude the time we have for the panel today. I'd like to take this opportunity to, again, thank our distinguished guests for their time and their thoughtful reflections.

To tie things up for the day, we've had a remarkable and groundbreaking workshop. We repeatedly heard from parents and individuals gravely impacted by youth gender medicine gone wrong, who suffered the harms of misrepresentations about the effects of these medical interventions. We heard from critics of the politicization of scientific debate in this area who explained the various pressures that keep researchers from speaking openly about their findings and how all of this ultimately results in medical decisions that are made without the best available data. Parents and young people deserve better.

We heard from scientific experts and ethicists who spoke to the state of research in this area, experts willing to look at the data rather than merely repeat the slogans of activist organizations and what they had to say was deeply concerning, or it should to anyone concerned with the well-being of American children. We heard from whistleblowers who risked everything to reveal the truth about what's been done in the name of so-called gender-affirming care. All too often we learned medical decisions haven't followed the science. Corners have been cut, ethical lines have been crossed, and young people have suffered the most.

On this most recent panel, we heard from experts who help us to chart a course forward as we continue to engage on this issue as a commission. These conversations have been so important because for too long those in power have only given a voice to one side in this debate. Sadly, it was the side that is perpetrating the very fraud that needs to be uncovered and stopped. That changed today as those of us with the power to change things finally gave a voice to the powerless. I'm very grateful for our panel's thoughts and the contributions of everyone who joined us today. We'll need them in the months and years ahead. No child should suffer from dangerous, unproven, and unwarranted medical interventions, especially if those interventions are unfair and deceptive.

This workshop may be drawing to a close, but the commission's work has only begun. To that end, I'd like to thank the chairman and my colleague, Commissioner Holyoak, for their leadership and engagement on the issue of youth, gender medicine, and the consumer protection issues related to it. Together, we look forward to fighting even harder for the best available science and for the rights of children and families. And I'd like to thank all the distinguished and courageous guests we've heard from throughout the day. Let's please give them another round of applause.

And then, last but not least, I do want to give a special thanks to Johan Schweppe in the chairman's office for all the great work he put into making sure this workshop was a success. Thank you all and Godspeed.