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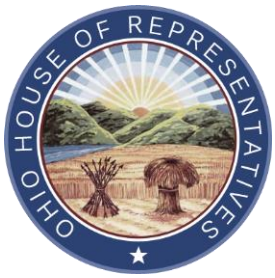

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Committees
Civil Justice
Infrastructure and Rural Development
Primary and Secondary Education

The Ohio SAFE Act

House Bill 68

135th General Assembly

Sponsor Testimony - April 19, 2023

Chairman Lipps, Vice Chair Stewart, Ranking Member Liston and members of the Ohio House Public Health Policy Committee, thank you for the opportunity to present sponsor testimony on House Bill 68, The Saving Adolescents from Experimentation (SAFE) Act.

My testimony today will be brief. However, I have attached an extensive list of frequently asked questions that will support my testimony and I look forward to your questions at the end.

The SAFE Act is necessary legislation because medical institutions have found it difficult if not impossible to self-regulate in areas that are so blatantly driven by politics. Three factors stand in their way: ideology, financial interest, and intimidation.

The SAFE Act is a necessary piece of legislation that has grown of the rapidly growing practice of medicalizing children for the purpose of changing their sex. Until recently, this phenomenon that began in Europe was little known in the United States. Boston Children's was the first to experiment with children beginning in 2007. Doernbecher Children's Hospital of Portland, OR began in 2013 with 16 patients growing exponentially to 724 in 2021. Ohio's Childrens Hospitals began in 2014. Although they refused to answer our questionnaire, The Cincinnati Children's Hospital gender clinic alone boasts of over 2,200 patient visits this year.[1]

While you will hear words like 'evidence-based', 'medically appropriate', 'life-saving' and so forth, these are all statements of opinion mixed with ideology rather than fact. Opponents will quote associations but not science. Despite their assuring words there is anything but consensus on either the effectiveness or the ethics associated with attempts to change a child's sex.

European nations were the first to experiment in this field and the United States has followed suit. Those nations have come to recognize that the experiment failed to produce the desired results but instead created much harm. As a result, they are closing clinics and revisiting their procedures. Great

[1] https://livingwithchange.org/

Brittan, Sweden, France, The Netherlands and Finland have all taken corrective action and pumped the brakes while a few in America want to stomp on the gas.[2]

Victims of gender medicine are on the rise, and they are self-publishing their own stories and occasionally they are afforded the opportunity to do so in the press. While some prefer to recover quietly, others are telling their stories out loud, providing testimony on important legislation and actively working to improve the healthcare system. Their personal stories are simultaneously incredible and heartbreaking. They represent the casualties and collateral damage of these unproven experiments on our youth.

The SAFE Act rights a wrong done to our children by prohibiting the dangerous and debilitating use of puberty blockers and opposite sex hormone on our children as well as surgeries for the purpose of gender conversion.

Additionally, The SAFE Act requires mental health providers to screen for comorbidities before diagnosing children with gender dysphoria. This act also requires providers to provide anonymized[3] data to the Ohio Department of Health in order to better understand and treat children experiencing gender dysphoria.

Several states have prioritized and passed similar legislation in their legislatures including, Kentucky, Indiana, West Virginia, Tennessee, Iowa, Missouri, Arkansas, Mississippi, Montana, Kansas, Alabama, Georgia, Florida, South Dakota, Arizona, Idaho, Texas, and Utah. This list changes almost weekly, as approximately a couple dozen other states are in the process. As more and more states pass protections, states like California and other states without protection for minors will become hot spots for juvenile sex change procedures. It's too late to be the first state to protect children; let's not be the last.

Missouri acted quickly once Jamie Reed, provided a sworn affidavit where she stated, "I thought I was saving transkids. Now I'm blowing the whistle."[4] [5]

Baldwin Wallace polling demonstrates that Ohioans want this bill from virtually every demographic measured.

Studies demonstrate that **85-95%** of children who experience gender dysphoria will naturally identify with their sex after experiencing puberty. However, **98%** will have their life choices altered through the use of puberty blockers and proceed with further gender conversion treatments. Just these chemical treatments result in overwhelming health risks as described in the FAQs.

Individuals who proceed with gender conversion are **19 times more likely to take their own lives**.[6] Contrast this statistic with the claims that gender affirmation saves lives. It does not. Reports only indicate a temporary reduction in suicidal ideation. This is to be expected during the "honeymoon

[2] https://www.city-journal.org/article/yes-europe-is-restricting-gender-affirming-care
[3] Fearmongers have falsely called this a transgender data base to increase opposition.
[4] https://ago.mo.gov/docs/default-source/press-releases/2-07-2023-reed-affidavit---signed.pdf
[5] https://www.thefp.com/p/i-thought-i-was-saving-trans-kids
[6] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885

phase." However, these are mostly ideations and claims of suicidal thoughts during adolescence but not actually suicides. Following individuals through the complete process tells another story.

Surgeries, demonstrated to be provided to minors in Ohio, will cease after implementation of the SAFE Act.

Minors do not have the ability to provide informed consent to any of these dangerous procedures. The prefrontal cortex of the brain, responsible for risk assessment, does not fully develop in and individual reaches their mid-twenties. They are incapable of reconciling the consequences of sterility, loss of the ability to experience physical intimacy, loss of bone density, osteoporosis, osteopenia, blood clots, cardio vascular disease, genital atrophy, diabetes, strokes and other confirmed risks, as minors.

The SAFE Act does not criminalize these procedures but instead makes medical professionals accountable to their licensing boards. We should be confident that practitioners will follow the law and experience no punitive consequences. The act does ensure that victims are able to pursue civil remedies for those who fail to follow the law, once again, ensuring that practitioners will be motivated to cease these experimental procedures. If they continue to experiment after the law is in place, the consequences are on them.

Much misinformation has been spread concerning what the SAFE Act does and does not do. I encourage you to read the legislation and the analysis with discernment. The frequently asked questions are extremely detailed and footnoted to provide the most comprehensive information possible. Please take the time to review them. As always, I am at your service to respond to any unanswered questions you may still have.

I thank you for your time and urge you to protect Ohio's children by committing your support to the Ohio SAFE Act. I am happy to answer your questions at this time.

What to Expect

Testimonies will be extremely passionate on both sides of this issue. You will hear from teenagers who have had positive and negative experiences. You will hear from parents who are passionate for and against. You will hear from adults who have transitioned and are happy about it. You will hear from adults who have transitioned and have certain regrets.

One group that you will not hear from is mature adults who transitioned as children. They do not exist. A child who transitioned at the age of nine when the clinic first opened in 2014 would be eighteen today. The average age of detransition is 24.

I would urge your support for House Bill 68 and I welcome your questions.

Representative Gary Click

Frequently Asked Questions

As is readily observable, this is a fact intense and complex issue overshadowed by sharp rhetoric and passionate activism. Therefore, I believe that it would be appropriate to address frequently asked questions through the lens of science, statistics and the stories that will express the lived experiences of those who have become the collateral damage of this experimentation. The fact base is substantial. However, due to a respect for the committee's time and the desire to ask questions, chose to keep my testimony brief and supplement it with these frequently asked questions. I trust that committee members will examine these contents, follow the footnotes, and reach out to me if any of your questions remain unanswered.

In addition to current testimony, which has been curated since, I will also refer committee members to both written[7] and oral[8] testimony provided during hearings in the 134th General Assembly. While additional materials and supportive information has surfaced since then, the essential facts have not changed.

Please expound on why the medical industry has been unable to self-regulate.

We all know the good that our children's hospitals do in many areas of life for many children and for that we are grateful. However, exceptional work in certain areas does not negate the harm done elsewhere, which is what I am here to address. A recent article addressing the criticism of legislators holding the medical industry accountable. Research analyst Leor Sapir writes, "recent testimony from pro-affirming medical professionals before the Texas legislature suggests the need for just such oversight. Delivering false or misleading testimony about minor surgery, mental health, and the evidence backing gender medicine, opponents of the ban inadvertently proved that it is justified." [9]

My research has led to three primary reasons that the industry has failed children experiencing gender dysphoria.

1. Reasons based on **Ideology**
2. Reasons based on **Financial Interest**
3. Reasons based on Tactics of **Intimidation**

These three primary reasons have led to a national and even international phenomenon of abandoning the science in favor of widespread pressure to conduct experimental procedures on the most vulnerable population: children. However, as the devastating results of this experiment have started pouring in, European nations (where the experiments began) are pulling back rapidly. Approximately a dozen states have applied the brakes, some of which have been following our model. Another twenty or so are in the process and they are watching Ohio to see if we will protect the children.

Before I delve into specifics, please allow me the courtesy of expounding on the three reasons that the industry cannot self-regulate. These are the reasons that it is imperative for the legislature, as the last line of defense, to intervene on behalf of the children

[7] file:///H:/134th%20GA/Bills/SAFE/454%20Sponsor%20current%20cites.pdf
[8] https://www.ohiochannel.org/video/ohio-house-families-aging-and-human-services-committee-2-17-2022?start=26:28
[9] https://www.city-journal.org/article/making-the-case-for-the-other-side

Ideology

Cincinnati Children's Hospital has produced webinars in which they spoke disparagingly of Catholic, Evangelical and other religious groups and their beliefs concerning gender, while suggesting that children get screened for gender dysphoria as soon as they can speak and annually afterwards. Their purpose was to normalize the concept of a gender identity distinct from an individual's sex.[10] However, this is merely the speculation of researchers who have not provided any evidence-based data to prove their theory. Until then, it is merely an idea.

The Gender Unicorn material has been provided on the Ohio Library Council website and is utilized in schools to promote similar concepts to Ohio's youth. [11][12] Additionally, the Ohio School Board Association advocates using the Gender Bread Person.[13] These are nonscientific ideologies that are being presented as fact through some of our most trusted institutions in the name of diversity.[14] They have abandoned biology in the name of equality in order to condition children to recognize gender as an option distinct from sexual reality.

Everyone, including educators and medical professionals, is entitled to their own personal system of belief. However, our academic and healthcare institutions should not be co-opted by an ideology in the name of equality.

We should also be mindful that gender theory is the one portion of the LGBTQIA+ that comes with internal conflict. This is a sore subject of division within the community and has spurred spin off groups such as the LGB Alliance. [15] It should be remembered that 100% of the victims, specifically detransitioners, are members of the LGBTQIA+ community. A vast number of them continue to identify as gay or lesbian and feel betrayed. Some continue in their trans identities. They are avid supporters of the SAFE Act.

Neither ideology nor theories should be the basis for medical interventions laden with such adverse consequences. However, many want to make this a debate over ideology and suggest that any prohibitions are tantamount to hate, discrimination, or "targeting trans youth." These are diversions from the reality that these medical interventions are not evidence based but simply experiments on Ohio's youth. No one's personal beliefs regarding gender theory are up for debate or under attack in the SAFE Act. Nothing in this bill addresses the choices that adults make**. Our only concern is for the physical safety and mental health of children that are incapable of providing informed consent.** There is no place for ideology or activism in this debate.

Nevertheless, children's hospitals have gone out of their way to normalize children changing their sex. Dr. Lee Ann Conard suggests that pediatricians screen children as soon as they can speak and doing so

[10] https://www.dropbox.com/s/ozdzv716yc4dogu/Conard%20-%20Screening%20at%20well%20visits.mp4?dl=0
[11] http://olc.org/intellectual-freedom/the-gender-unicorn/
[12] https://noahwebstereducationalfoundation.org/school-gender-unicorn-research-transgenderism-children-transparency/
[13] https://www.ohioschoolboards.org/sites/default/files/Clark_0.pdf
[14] https://www.facebook.com/groups/ohioprie/posts/3128989650704469/?paipv=0&eav=AfZtZHV-eWWMJn6Jy325RjxzUSvzah7YK5kH4gFJ8X3Y1ajlImRHpn6T1K2oXx6QUqY&_rdr
[15] https://lgbausa.org/

annually in order to normalize cross-sex identification. She states that this is a "normal developmental variant", and that people should know that it is normal.[16] Living with Change (affiliated with Cincinnati Children's Hospital) highlights the video game Sims for allowing scars from top surgery to be added to players in an effort to normalize sex change operations.[17]

Financial Interest

Despite claims to the contrary, so-called gender affirmation services have proven to be very profitable.

The Gender Identity Development Services (GIDS) of the Tavistock was responsible for an ever-increasing portion of their bottom line. In fact, they were pivotal in maintaining the financial viability of the Tavistock. They accounted for **5.9%** of revenues in 2015/16**, 13.5 %** in 2018-19, and ultimately **21.8%** before the GIDS was ruled "unfit for service" in an internal report stating that children's needs were being met in a "woefully inadequate manner."[18]

Dr. Rachel Levine advocated for children's services in a conversation acknowledging that the hospital would receive a return on investment once the child turned eighteen and pursued surgeries.[19] It must be taken into consideration that once a child begins transition, they become a patient for life, and thus an ongoing revenue stream.

Vanderbilt University was exposed for revealing the profitability of their gender conversion services for minors. Dr. Shayne Taylor itemized the costs stating that "female to male chest reconstruction could bring in forty thousand dollars," and "a patient just on routine hormone treatment who we are only seeing a few times a year can bring in several thousand dollars a year from visits and labs and actually makes money for the hospital." She goes on to say that vaginoplasties bring in $20,000 but suggests that this is an underestimate noting that it does not include hospital stays or post-op visits. "That does not include your anesthesia, your OR, so I would think that this has to be a gross underestimate." She continues "the female to male bottom surgeries are huge money makers. And again, I think this has to be a huge underestimate. They're quoting near $20,000 for a phalloplasty. There are different things that I have read that said it could be up to a hundred thousand dollars...They make money. They make money for the hospital."[20]

This says nothing about the generous corporate donations that flood in specifically to support this cause.

[16] https://www.dropbox.com/s/ozdzv716yc4dogu/Conard%20-%20Screening%20at%20well%20visits.mp4?dl=0
[17] https://www.facebook.com/LWCorganization/posts/pfbid02xpmubV99VDoBbjpoDoaYLoYHCbiSg38P3F9dubp9hPXvPjMUTGuTe9CGKUug1Zr6l
[18] Barnes, Hannah. Time to Think (p. 235). Swift Press. Kindle Edition.
[19] https://www.theohiopressnetwork.com/news/us/discovered-rachel-levine-discusses-potential-revenue-from-child-sex-change-procedures-in-emails/article_0e24a12c-b146-11ed-93a6-dbf799da9456.html
[20] https://twitter.com/MattWalshBlog/status/1572313523232931840?s=20

Intimidation

At the same meeting with Vanderbilt executives, Dr. Ellen Clayton warned that conscientious objections are not without consequences and should not be without consequences. She added, "If you don't want to do this kind of work, don't work at Vanderbilt."[21]

Some practitioners have quietly walked away from posts at our local children's hospitals in Ohio when faced with similar demands. Others have inquired if there are any protections for whistleblowers. Some have sought permission to testify but have been denied by their employers due to political ramifications.

Several medical professionals have stated that they and their colleagues are "reluctant to speak publicly against transgender ideology for fear of both professional and personal retaliation."[22] In a world of professionalism, one ought to be able to expect rigorous debate. Anyone confident in their supposition would welcome it.

During the course of the last General Assembly, not only where both my professional and my youthful witnesses treated poorly and harassed in committee but a "group of activists and organizers", with the aid of activist Ken Schneck and the Buckeye Flame, sought to intimidate a seasoned medical professional, not for actively testifying but merely because his academic research was quoted.[23] These folks are unwilling to debate on the merits and are very deliberate about silencing academic debate. Reliable science cannot flourish in such environments. I feel compelled to quote Hamlet in believing that they "protest too much" to be trusted.

Reasonable people want to cut through the rhetoric and talk about the facts. However, that has not been the position of the opposition. They have used tactics of intimidation and delay to stall the SAFE Act while attempting to isolate advocates and target moderate ones with misinformation.[24] They hope to wear down the will of the legislature and the witnesses. However, the will to protect children has only strengthened.

I have personally watched victims of gender ideology be re-victimized through bullying and intimidation for simply telling their stories. A number of detransitioners have asked me to keep up the fight on their behalf but have expressed that they cannot testify due to their own personal mental health challenges. This is the end goal of the "activists and organizers."

It would be remiss not to take note of the assault on Riley Gaines due to her advocacy for women's rights. She is the female swimmer forced to compete with a Lia Thomas who has the blatant advantage of a male body. While this event was based more on concepts surrounding the Save Women's Sports Act, the intimidation factor is the same. Riley was physically assaulted and locked in a room for hours simply for expressing herself. Yet media outlets and even the president of San Francisco State University portrayed those who assaulted her as the victims.[25] [26]

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[21] https://twitter.com/MattWalshBlog/status/1572313566589468672?s=20
[22] https://www.foxnews.com/us/doctors-slam-levines-claim-gender-affirming-care-fear-speaking-in-hiding
[23] https://thebuckeyeflame.com/2022/03/28/open-letter-levine/
[24] https://youtu.be/5UE5W67ruAc?t=1261
[25] https://www.foxnews.com/sports/riley-gaines-details-harrowing-situation-sfsu-feared-my-life-moment
[26] https://www.kron4.com/news/bay-area/sfsu-president-says-riley-gaines-event-was-deeply-traumatic-for-trans-community/

There is an old adage among lawyers that says, "If you have the facts on your side, pound the facts; if you have the law on your side, pound the law; if you have neither the facts nor the law, pound the table." Evidently, they chose to pound on Miss Gaines instead.

What are the Dutch Protocols?

The Dutch are known to be open-minded and tolerant people. It was no surprise to anyone that they were early adopters of transitioning children. American practitioners soon began following in their footsteps believing that in so doing they were following the science. After all, if the Dutch can do it, so can we.

The Dutch protocols were an established set of guidelines followed by everyone engaged in the sex change industry. However, the long-term results of these experiments, by definition, take a long time. The results were devastating and just at the time some Americans began stepping on the gas following the Dutch Protocols, the Dutch were slamming on the brakes! Sweden's National Board of Health and Welfare declared that there was insufficient evidence to justify the use of puberty blockers and opposite-sex hormone on minors.[27] [28]

Aren't European Countries Pulling Back?

As European countries are pulling back, American practitioners want to push forward. Hannah Barnes documents the abrupt closure of the Gender Identity Development Services (GIDS) division of the Tavistock Trust of England in her recent book, Time to Think.[29] Barnes dove deeply into the Bell Report as did others.[30] The Bell report was an internal investigation fraught with obstacles, intimidation, and harassment but which ultimately was addressed in the high court, which concluded:

> It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers.

And

> In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment. Given the long term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognize that clinicians may well regard these as cases where the authorization of the court should be sought prior to commencing the clinical treatment.[31]

[27] https://segm.org/segm-summary-sweden-prioritizes-therapy-curbs-hormones-for-gender-dysphoric-youth
[28] https://segm.org/Sweden_ends_use_of_Dutch_protocol
[29] https://www.amazon.com/Time-Think-Collapse-Tavistocks-Children-ebook/dp/B0BCL1T2XN
[30] https://www.theguardian.com/society/2021/may/02/tavistock-trust-whistleblower-david-bell-transgender-children-gids
[31] https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf

> The GIDS division of the Tavistock has since been shuttered and faces charges of clinical negligence for its practices.[32] [33]

Barnes documents Dr. Bell's concerns that are similar to what we see in Ohio. Clinicians are afraid to speak up and that's just the way the hospitals and activists like it.

> 'They all brought very similar preoccupations,' Bell explains, 'some people emphasizing one thing more than another, but in terms of the main preoccupations that they brought, they were similar. And they most certainly did not have a rehearsed quality… It wasn't like that at all.' Some staff, but not all, were 'extremely distressed', he says. 'One person wasn't sleeping… because they kept thinking about the children they put on the [medical] pathway and felt that they'd done damage.' He felt 'disturbed' by what he was hearing, he says, and 'that this was all part of something called the Tavistock'. What's more, he was struck by the fact that these clinicians felt afraid. 'Nine of the ten didn't come to speak to me in my office,' Bell explains. Instead, they met him off-site. He says some staff 'felt they were under surveillance'.[34]

What is the SAFE Act?

SAFE stands for Saving Adolescents from Experimentation. The SAFE Act recognizes that sex change procedures[35] on children is experimental at best and acknowledges that children are incapable of providing informed consent for such risky procedures.

The SAFE Act regulates surgical and pharmaceutical procedures as applied to minors primarily by restricting these procedures until an individual reaches the age of majority when they are more capable of evaluating the risks and rewards that accompany such procedures.

The Ohio Safe Act has the advantage of being carefully curated over the course of time. It was first introduced at the behest of families who have been traumatized through these experimental procedures. I examined similar bills that had been introduced in other states and customized our version to fit Ohio. The bill before you represents the third and best version of this bill and is unique to Ohio, though many have looked to us as we have to others for input and guidance.

The issues we face are no different than those in others states across the nation and even internationally. Ideologically driven beliefs have subtly and quietly crept into our medical institutions without much fanfare until victims began lifting their voices and advocating for reform. Legislatures around the nation have slowly begun listening and attempting to understand these issues and responding to the cries for legislative protections. The SAFE Act is our response and our responsibility.

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[32] https://www.bmj.com/content/378/bmj.o2016.full

[33] https://www.wionews.com/world/nhs-brings-down-the-shutters-on-its-three-decades-old-gender-identity-institute-501749

[34] Barnes, Hannah. Time to Think (pp. 230-231). Swift Press. Kindle Edition.

[35] Understandably, the industry prefers the terms "gender affirmation" or "gender confirmation surgery" over more accurate terminology because it cloaks the harsh reality of what they are actually attempting to do. However, for purposes of this legislation it is more appropriate to use scientifically accurate descriptions than inaccurate euphemisms.

Can children and families provide Informed Consent?

Informed consent is a legal term and a requirement before clinicians can provide care. Minors are incapable of providing informed consent.

How can a child between the ages of 8-12 consent to the loss of fertility? Can they consent to sacrificing the ability to enjoy sexual intimacy? Are they able to comprehend the severe medical risks of pubertal suppression that are documented in this list of frequently asked questions? Obviously not.

Reflecting on his prior work, "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults,"[36] Dr. Levine, who once chaired the 5th edition of WPATHs Standards of Care for transgender individuals and helped establish early protocols reflects,

> We asserted that the consent process for youth gender transition is so problematic in much of the Western world that it can no longer be considered "informed."

He adds,

> We reflected on how the entire field of gender medicine has drifted from the principles of evidence-based medicine and the scientific method. Attempts to study the sharp rise of gender dysphoria in previously gender-normative teens are met with consternation by the gender-medicine establishment,

And

> Perhaps the most problematic, the information shared by gender-clinicians with patients and families about "gender-affirming" interventions is markedly skewed: it overstates the demonstrated benefits of hormones and surgeries and trivializes their risks and the uncertainties of future outcomes.[37]

So, according to one of the early pioneers in early transgender medicine, the information presented to families is not evidence-based and therefore cannot be considered informed.

What is Gender Identity?

In its original context, *gender* was simply a linguistic term to describe parts of speech as masculine, feminine, or neuter. However, Dr. John Money borrowed the word to describe an individual's inner sense of sexual identity and socialization. He hypothesized that an individual's sex stereotypes were merely the product of socialization rather than biology. This included the theoretical belief that individuals could have an inner identity distinct from their biological reality.[38] He found the perfect opportunity to validate his theory when he discovered a set of twins, Bruce and Brian.

Bruce was the unfortunate child who was the victim of a botched circumcision. Money seized the moment to experiment on twins and convinced his parents to raise him as a girl. They agreed, changed

[36] https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2046221
[37] https://www.tandfonline.com/doi/abs/10.1080/0092623X.2022.2136117?journalCode=usmt20
[38] While Money believed that this identity could be altered through socialization, today's advocates argue that it is an immutable part of one's being. It is indisputable that some individuals have desires to live as the opposite sex. However, redefining a desire as an innate or immutable "identity" is a theory, not a scientifically observable reality. Thus acting upon such a theory is merely experimental.

Bruce's name to Brenda, consented to surgery on the young child, and constantly compared him to his brother, Brian. Money reported favorably on what became known as the John/Joan case.

However, the truth was not so lovely. Brenda never adapted and could never understand why she didn't fit in with the other girls. As an early teenager, her father took her out for an ice cream and told Brenda the truth. He was both angry and relieved at the same time. He immediately returned to his male identity but chose the name David after the biblical legend that defeated Goliath. However, his story did not end so successfully. Due to the stress and abuse by Dr. Money, both boys and their mother attempted suicide. Only their mother survived.[39]

Despite their unfortunate and untimely deaths, Dr. Money's fantasy of gender identity lives on as a theory but not as fact. Science has never demonstrated that an individual may possess a gender that is or can be distinct from their sex. This does not negate the fact that some individuals experience dissatisfaction with their sex and desire to live as the opposite sex. However, what is commonly described as gender is not scientifically measurable and merely describes an individual's state of mind, wishes, and feelings rather than a measurable and quantifiable biological status.

Rolling Stone Magazine was the first to cover this story which the author, John Colapinto ultimately developed into the book, "As Nature Made Him." [40] His conclusion is informative for our discussion:

> Ultimately, the story of David Reimer is the story of how credulous we can be toward authority, and how we owe it to ourselves and our society to retain a healthy skepticism no matter how trustworthy those in power may seem. And, of course, it is also the story of how we carry our own inherent nature deep inside us and how we cannot be flipped from male to female and back again as if we were so many light switches.[41]

What is Gender Dysphoria?

The antonym of euphoria is dysphoria.[42] Gender dysphoria describes individuals who experience an incongruence between their perception of their gender and their physical sex. It is sometimes described in spiritual terms such as having a boy's spirit in a girl's body or two-spirited.[43] Other times you will hear someone say, "I have a girl's brain in a boy's body," which may feel like an accurate description to some but is not biologically accurate.[44]

This condition may be independent from sexual attraction as it is more about personal identity and often sets in before children are sexually aware. Some children have been known to experience early onset gender dysphoria prior to school age.

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[39] https://slate.com/technology/2004/06/why-did-david-reimer-commit-suicide.html
[40] https://www.amazon.com/As-Nature-Made-Him-Raised/dp/0061120561
[41] https://www.arclaw.org/book-reviews/as-nature-made-him-the-boy-who-was-raised-as-a-girl
[42] Those experiencing dysphoria are promised euphoria through apps like Euphoria and Plume that offer services including prescriptions for hormone therapy and letters for surgery via online apps.
[43] https://youtu.be/A4lBibGzUnE
[44] https://www.transgendertrend.com/born-in-the-wrong-body/

What is ROGD?

ROGD stands for Rapid Onset Gender Dysphoria. This condition was identified by medical researcher Dr. Lisa Littman.[45] ROGD describes a social contagion that occurs later in childhood, usually around the teenage years or just prior and is more prominent in females. ROGD typically occurs in females who demonstrated no early symptoms but have been influenced by their peers and/or social media. Abigail Shrier took Dr. Littman's research and expanded on it in a useful book entitled "Irreversible Damage."[46]

What is Gender Identity Disorder (GID)?

Gender Identity Disorder is the former diagnosis now labeled as Gender Dysphoria in the Diagnostic and Statistical Manual for Mental Health Disorders. It was changed between volumes IV and V (2013) in order to shed stigma. While many will deny that it is a mental health issue, the diagnosis continues to be listed in the Diagnostic and statistical Manuel for Mental Health Disorders. The reality is that this is not the only mental health issue that we should not stigmatize. Everyone deserves love, respect, and dignity regardless of their inner-personal struggles.

What Causes Gender Dysphoria?

There is no simple answer to this question. Some will propose theories that it is biologically based on questionable data from brain scans. However, scientific studies have been inconsistent and inconclusive.

> Much progress has been made over the past 25 years trying to detect the neurobiological underpinnings of gender dysphoria and identifying the existence of a brain gender. Nonetheless, many findings remain inconsistent. [47]

If gender dysphoria is hardwired in the brain, clinicians have not done so well in diagnosing, as the vast number of detransitioners would reveal. However, it is more likely that a child's dysphoria is affected by outside influences in the same manner as eating disorders or other forms of body dysmorphia.

Statistics reveal a consistent influence of comorbidities associated with gender dysphoria such as depression, anxiety, suicidal ideations, autism, and eating disorders. Furthermore, abuse and molestation have been known to be contributing factors as Erin Brewer testified last year.[48] Gender dysphoria can become the escape from oneself that struggling youth may be longing for.

Before closing the GIDS in Great Britain, internal investigations describe the same lack of response to comorbidities that appears to be common everywhere.

> 'The social situation was so chaotic that the idea that you would just jump in with hormones and start treating, without social-work input, without liaising with the school, the key worker, you know, it was clearly potty.' Several children had been in and out of care, had no family support for transition or had severe autism. A number weren't attending school. There were cases where there was physical abuse in the family, alcohol and drug misuse – both by family

[45] https://littmanresearch.com/publications/
[46] https://a.co/d/4qvse92
[47] Kiyar, Meltem, Collet, Sarah, T'Sjoen, Guy and Mueller, Sven C.. "Neuroscience in transgender people: an update" *Neuroforum*, vol. 26, no. 2, 2020, pp. 85-92. https://doi.org/10.1515/nf-2020-0007
[48] https://www.youtube.com/watch?v=lti0CFSn6r8

> members and sometimes by the young person themselves – and 'certainly a lot of homophobia', O'Shea says. Some files referenced 'allegations of sexual abuse' too, according to Paul Moran. But they then did not show whether this had been explored or any conclusion reached. The Tavistock reports might say 'it's a complicated situation', Moran explains, 'but there seemed to be a big rush to commence treatment'.[49]

Because comorbidities are likely to influence any child's state of mind, they should be addressed prior to embarking on an expensive and demanding medical journey to convert a child's sex. Resolving those issues has been known to aide in resolving a child's apprehensions about their authentic sex. However, in the rush to affirm a child in the opposite sex, some suggest that changing a child's sex will alleviate their comorbidities. However, rushing into a lifelong medical journey when other less elaborate and risky options are available to validate a child and strengthen their mental health, seems to defy best practices in favor of an ideologically driven outcome. Consider this ideologically driven advice:

> The mental health concern may not subside until the dysphoria is addressed, as it is the underlying factor for some teens. It is common with non-binary and transgender youth for the mental health issues to be driven by the gender issue. Once the gender issue is dealt with and congruence measures have begun, the co-occurring psychological issues often lessen or resolve.[50]

It is very common for detransitioners to reflect on their journey and question why practitioners did not address their comorbidities first. It wasn't until after life-alter gender conversion procedures that they realized that their gender dysphoria was simply the manifestation of other issues. The transition failed to meet the need and instead added complication to an already complicated life.

Prisha was a young girl with an eating disorder and gender dysphoria. Unfortunately, she was medicalized and operated on before dealing with the eating disorder. While she has overcome her eating disorder, she suffers great harm from the gender conversion therapy. You can listen to her describe the outcome here.[51]

What is Deadnaming?

Referring to a transitioning individual by their birth name is called deadnaming and is considered to be offensive. This would be like calling Caitlyn Jenner by the name Bruce, or Jazz Jennings, Jared. It is generally polite to refer to an individual by their name of choice. However, this is sometimes difficult for parents or people who have longstanding relationships.

However, one has to wonder about the choice of this moniker. Why don't they call it former naming, past naming, or old naming? This seems to be an unhealthy manner of describing this act. It's as if they have animosity towards their former identity and have buried that person. Their new identity appears to be an escape from their authentic selves in search of a new person.

What do AMAB and AFAB stand for?

[49] Barnes, Hannah. Time to Think (pp. 296-297). Swift Press. Kindle Edition.
[50] Brill, Stephanie; Kenney, Lisa. The Transgender Teen (Kindle Locations 3171-3174). Cleis Press. Kindle Edition.
[51] https://youtu.be/-kjsZ3UHg5s

AMAB is short for assigned male at birth. AFAB represents assigned female at birth. This manipulative moniker has become standard language for many. Sex is acknowledged at birth and is not an assignment. It is unprofessional and unreasonable to use these unscientific terms outside of the context of those with disorders of sexual development. The use of such language by professionals in medically inaccurate, deceptive and confusing to children. Nevertheless, it happens frequently.

What is a DSD?

Disorders of Sexual Development (DSD) are rare conditions when a child is born with ambiguous genitalia.[52] This often occurs due to a chromosomal abnormality but can also occur in response to a metabolic condition knowns as congenital adrenal hyperplasia (CAH). Other times it may be chromosomal.[53] I am aware of one young person who grew up as a female but discovered that she actually had male chromosomes, after utilizing one of the popular do it yourself DNA kits.

The term assigned gender at birth was first utilized by physicians and parents who were compelled to make a choice on how to raise a child diagnosed with a disorder of sexual development. Disorders of Sexual Development are physical developmental anomalies and distinct from an individual's perception of gender as related to Gender Dysphoria.

Nothing in this bill affects individuals with DSD.

What is Gender Affirming Care?

It is important to understand that the language surrounding sex change procedures has changed over the years to sound less harmful and give the presumption that these procedures are not indeed attempts to change one's sex, but rather a correction. The evolved language is intended to normalize what remains a risky and experimental procedure. Thus, you will hear language such as "gender affirming" rather than sex change and discussions will revolve around using bathrooms, locker rooms, and playing sports that "match their gender identity" rather than boys in girls' spaces.[54] While this language feels softer, kinder, and less controversial, it is not scientifically accurate.[55]

A liberal Hollywood producer with a trans child produced and extremely helpful documentary, Affirmation Generation, revealing the harms of so-called gender affirming care stemming from personal experience. You can watch both the trailer and the full documentary featuring specialists and victims here.[56]

Gender affirming care is a misnomer as is much of the language surrounding gender conversion treatments. As already discussed, the concept of a gender that is distinct from one's sex is an ideological

[52] Sometimes called Disorders of Sexual Differentiation.
[53] https://urology.ucsf.edu/patient-care/children/genital-anomalies/disorders-of-sex-development
[54] In discussions concerning Save Women's Sports you will hear opponents discuss young athletes playing on teams that "align with their gender identity" rather that the reality of young men playing on teams that do not match their sex.
[55] There is a fine line between being polite and being dishonest. While language should not be used as a weapon to intentionally offend, neither is inappropriate to be forced into a language contrary to fact, just to reinforce an individual's misconceptions. You will likely discover people like myself who are someone inconsistent in the use of language surrounding this issue out of mixed sense of trying to be polite while also attempting not to use inaccurate language, not to mention, it can sometimes simply be confusing.
[56] https://affirmationgenerationmovie.com/

belief rather than a scientific reality. Clinicians are in fact affirming and enhancing a child's dysphoria. In the gender affirmative model, healthcare providers insist that both providers and parents agree with the child's perception that they are indeed the opposite sex and treat them as such including the use of preferred pronouns. Pubertal suppression and opposite sex hormones are provided as well and may be followed by "gender confirmation" surgery.

While the suggestion that we are affirming children may feel good it is misleading. There is no other instance where professionals affirm a child's misconception of themselves. It would be highly inappropriate to affirm an eating disorder by agreeing with the child that they are overweight and prescribing diet pills or bariatric surgery. We do not affirm other body dysmorphic conditions by amputating healthy body parts or by medically or surgically altering children to conform to their misconceptions. However, because this concept is ideologically and politically driven, practitioners have been forced to make an exception.

It would be more appropriate to affirm the child as their authentic selves. They are perfect just as they are. Cosmetic changes and inaccurate information are not necessary for them to be loved or affirmed. A skilled therapist would look for why a child thinks they need to change. They would attempt to discover underlying comorbidities and learn what the child is running or hiding from and teach them coping strategies.

Every child deserves to be loved as they are. Scalpels and syringes are not necessary to live their authentic lives.

What are "Gender Affirmation" Procedures?

Not everyone who transitions goes all the way. Some will limit the process to taking puberty blockers and or opposite sex hormones which are the first steps. Some will never advance beyond this. However, those who transition in childhood are more likely to advance further through the process.

The most common surgery for minors is top surgery according to Scott Liebowitz of Nationwide Children's Hospital and others.[57] For females this means a double mastectomy or chest masculinization. For males this often includes implants since artificial hormones are not always capable of completing the desired effect.

Bottom surgery is more complex. Ladies will occasionally choose to have a complete hysterectomy sending them into premature menopause. Some women will also opt for phalloplasty which takes skin from the forearm to create a male appearing prosthetic. This is a very complicated procedure that has left many with severe complications and scarring.[58]

Men will frequently opt out of bottom surgery. However, some will choose penile inversion and vaginoplasty to simulate female genitals. However, pubertal suppression and opposite sex hormones

[57] https://www.pediacastcme.org/supporting-transgender-and-gender-diverse-youth-in-pediatric-practice-pediacast-cme-066/

[58] Bottom surgery is not regulated for minors in Ohio. For the time being, however, it appears that only top surgery is common. Bottom surgery is typically reserved for when a child reaches the age of 18. However, childhood hormonal interventions pave the way for a teenager to embark on this dangerous procedure the moment they do turn 18.

often lead to penile atrophy which reduces the amount of material available to successfully complete the process.[59]

Experienced practitioners and individuals who have undergone the process report that transitioning in a child's youth results in the inability to experience sexual intimacy later in life.

What is the Difference between a Desister and a Detransitioner?

Both desisters and detransitioners are individuals who have experienced gender dysphoria and have ultimately resolved the perceived incongruity between their authentic sex and their perceived gender. The difference between the two is whether their dysphoria resolves prior to surgery or after. Detransitioners are folks who began the process of changing sex through medical intervention. Desisters and detransitioners are both individuals who have experienced gender identity disorder. The difference describes whether they came into congruence with their authentic biological selves before or after medicalized sex change procedures.

Individuals who have struggled with their sexual identity but resolved without medical interventions are known as desisters. While results may vary with each study, evidence based research reveals that 85-95% of children will naturally desist after experiencing natural puberty. In these cases, it is the body that helps heal the mind all by itself. This class of individuals often grow up to be gay or lesbian while others live out their lives as straight, marry, and have families. Seldom do they share their stories and few people ever learn of their childhood struggles.

> "Of the 139 participants, 17 (12.2%) were classified as persisters and the remaining 122 (87.8%) were classified as desisters."[60]
>
> "For most children with GDC, whether GD will persist or desist will probably be determined between the ages of 10 and 13 years, although some may need more time. Evidence from the 10 available prospective follow-up studies from childhood to adolescence (reviewed in the study by Ristori and Steensma) indicates that for 80% of children who meet the criteria for GDC, the GD recedes with puberty."[61]
>
> "Only very few trans- kids still want to transition by the time they are adults. Instead, they generally turn out to be regular gay or lesbian folks. The exact number varies by study, but roughly 60–90% of trans- kids turn out no longer to be trans by adulthood."[62]
>
> "At the time of follow-up in adolescence or adulthood, these studies showed that, for the majority of children (84.2%; n ¼ 207), the GD desisted."[63]

Detransitioners are those who have embarked in medically altering their body to mimic the opposite sex with regrets and have proactively chosen to return to living as their authentic selves to the extent possible. Everyone has a different story but with nuanced and individual differences.

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[59] https://www.thefp.com/p/top-trans-doctors-blow-the-whistle?s=r
[60] https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full
[61] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5841333/
[62] www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html
[63] https://www.transgendertrend.com/wp-content/uploads/2017/10/Steensma-2013_desistance-rates.pdf

Some have gone to great lengths and lived convincingly as the opposite sex for several years but ultimately concluded that life as the opposite sex was inauthentic. They realized that despite what everyone else perceived, they were still the same person of the same sex they began life with. [64] They were passing in the eyes of others, but they knew differently.[65]

Many realized after great expense and traumatic experiences that this was merely a mask for their other mental health disorders and that transitioning did not live up to their expectations. Others complain about being lied to by their therapists and misled by their physicians. As young people mature and their brains develop into mature adulthood, they are incredulous that doctors would allow them to choose their gender long before they could make other life altering choices.

Some are extremely angry while others are simply sad. Several feel compelled to tell their stories to anyone who will listen via social media. A few have taken to giving public testimony and speaking at events. While they are welcomed by some they are extremely vilified by others. In their bravery, they speak for many others like them who are still healing inside and out. Most detransitioners are quietly but bravely working at processing the gender rollercoaster ride that has had devastating effects on both their physical and mental health. They have often lost friends twice. They were the victims of bullying and discrimination when they identified as transgender only to be forsaken, ridiculed, and harassed by members of the LGBTQ community for telling their own stories when they resumed their authentic identities. One individual I spoke with strongly considered giving testimony but ultimately chose to focus on mental health recovery rather than reliving their traumatic experiences publicly. One can hardly blame him.

A recent academic study on detransitioners published in the Archives of Sexual Behavior notes:

> Reasons for detransitioning were varied and included: experiencing discrimination (23.0%); becoming more comfortable identifying as their natal sex (60.0%); having concerns about potential medical complications from transitioning (49.0%); and coming to the view that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition (38.0%). Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed by 23.0% as a reason for transition and subsequent detransition. The majority (55.0%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition and only 24.0% of respondents informed their clinicians that they had detransitioned. There are many different reasons and experiences leading to detransition.[66]

Is Pubertal Suppression a Neutral Act?

No.

Promoters of pubertal suppression falsely claim that that this simply places a pause on puberty to give children a chance to discover who they really are. In reality, this is not a neutral intervention. It proactively directs the child towards gender conversion. Studies reveal that 85-95% of children who go

[64] https://youtu.be/EVTYhfWr9u0?t=193
[65] Passing is the term used for living convincingly before others as the opposite sex.
[66] https://link.springer.com/content/pdf/10.1007/s10508-021-02163-w.pdf

through puberty will naturally resolve and identify with their natural sex. Even WPATH (The World Professional Association of Transgender Health) acknowledges this reality.

> Gender dysphoria during childhood does not inevitably continue into adulthood. Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children. Boys in these studies were more likely to identify as gay in adulthood than as transgender... Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood.[67]

In contrast, 98% of children receiving pubertal suppression will advance to opposite sex hormones and more.[68] In the largest study of its kind, at least 704 of 720 children given puberty blockers continued to opposite sex hormones.[69] Based on their methodology, the remaining sixteen were simply lost track of. This suggests that given a cohort of 100 children with gender dysphoria, all but perhaps 10 of them will naturally resolve without intervention. However, with intervention this number increases to 98 that will persist on the path of medicalization. This means that roughly 88 children for every 100 will have the course of their life drastically altered and become medically dependent as a result of pubertal suppression. This is a key reason that some practitioners have been willing to compromise as long as they retain the option of pubertal suppression. They are willing to delay so long as they are still able to influence long-term outcomes.

This is unconscionable especially when we consider the adverse health risks.

Pubertal suppression was initially designed for young girls experiencing precocious puberty which comes with its own health risks. Puberty was delayed only until such a time as puberty was natural and healthy for young girls. However, when used for gender conversion, the effects are just the opposite. This practice prevents puberty from occurring during the natural and healthy stage of a child's development and typically prevents children from ever experiencing natural puberty or delaying puberty to an unnatural and unhealthy time in a child's life.[70]

The use of puberty blockers for gender conversion purposes is an off-label application and has not been approved by the FDA.

Are Puberty Blockers and Opposite Sex Hormones Safe?

They are not safe.

Even when used according to manufacturer's instructions, puberty blockers contain severe health risks. A 2017 Kaiser Health News article reports:

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[67] World Profession Association for Transgender Health, Standards of Care, Version 7, p. 11.
[68] https://www.npr.org/2022/10/26/1131398960/gender-affirming-care-trans-puberty-suppression-teens
[69] https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(22)00254-1/fulltext#%20
[70] Some have argued that if puberty blockers can be used for precocious puberty they should be available for gender conversion purposes and that otherwise it is discrimination. However, the FDA approved use corrects an unnatural biological disorder. The second use prevents a natural biologically healthy occurrence. The first application is corrective while the second is more cosmetic.

> Women who used Lupron a decade or more ago to delay puberty or grow taller described the short-term side effects listed on the pediatric label: pain at the injection site, mood swings, and headaches. Yet they also described conditions that usually affect people much later in life. A 20-year-old from South Carolina was diagnosed with osteopenia, a thinning of the bones, while a 25-year-old from Pennsylvania has osteoporosis and a cracked spine. A 26-year-old in Massachusetts needed a total hip replacement. A 25-year-old in Wisconsin, like Derricott, has chronic pain and degenerative disc disease.
>
> "It just feels like I'm being punished for basically being experimented on when I was a child," said Derricott, of Lawton, Okla. "I'd hate for a child to be put on Lupron, get to my age and go through the things I have been through."[71]

Reports of increased suicidal ideation were among other side effects reported. These young ladies were only on a three-year treatment plan which is significantly shorter than for children whose puberty is suppressed until an orchiectomy (castration) or hysterectomy would eliminate the need.

According to an article in the Journal of Medical Ethics the adverse outcomes of puberty blockers include:

- Reduced bone density, increasing risk of osteoporosis and fractures.
- Impaired fertility.
- Impaired sexual functioning (which may include vaginal atrophy and pain during vaginal intercourse for birth-assigned females).
- Fusion of bone growth plates will be impaired, resulting in increased final height.
- Possible increased risk of developing hypertension, cardiovascular disease and metabolic disorders such as obesity, high cholesterol and type 2 diabetes.
- Distress associated with any physical harms that eventuate.
- Could result in difficulty finding a romantic partner.
- Reduced libido.
- Later regret.
- Social stigma, which may have a negative impact on psychological functioning.
- Concerns about puberty suppression may lead to or increase attempted self-harm and/or suicide.
- Potential negative impact on brain development. [72]

Despite their acknowledgement of harm, the authors suggest that puberty blockers should be provided for ideological purposes of justice and equity. It is hardly reasonable to suggest that harming individuals promotes justice or equity, especially in minors who are incapable of informed consent.

Despite these known facts, idealogues and health journals suggest that puberty blockers are reversible, safe, and lifesaving.[73] Families are swamped with misinformation while simply trying to navigate through critical moments and make the best choices for their children.

[71] https://www.statnews.com/2017/02/02/lupron-puberty-children-health-problems/
[72] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7656150/
[73] https://www.healthline.com/health/are-puberty-blockers-reversible#if-discontinued

Professor Michael Biggs informs us that after a year on puberty blockers "children reported greater self-harm, and the girls also experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria."[74]

The FDA warning label advises against use of Lupron in excess of 12 months "due to concerns about adverse impact on bone mineral density." They also add convulsions, clinical depression, neuromuscular disorders and more to the list.[75]

The known medical and psychological risks from pubertal suppression outweigh the potential cosmetic benefits that are hoped for or financial gain for big pharma and other medical providers.

> Justice Department officials announced a civil and criminal settlement with Lupron's then-maker. Prosecutors said the Lupron sales team rewarded doctors prescribing the drug … with ski trips, golf outings and bribes. In a court document, one gynecologist said a salesperson told him he "could earn $100,000 annually" by treating the women in his practice with Lupron.[76]

Pubertal suppression is not safe, is not merely a pause button, is not reversible, and should not go unregulated in Ohio.

Are Surgeries Happening on Minors in Ohio and How Easy is it?

Yes, and very accessible.

As noted previously, Dr. Scott Liebowitz addressed the issue on a podcast for Nationwide Children's Hospital and advised listeners that top surgery (a double mastectomy) was the most requested surgery for minors. [77]

The Children's Hospital Association has been very coy about this in public testimony. When pressed with evidence from one of their own hospital's moderated social media accounts, they simply responded that they were unaware of surgeries "within their hospitals." Cincinnati Children's Hospital hosts their own moderated Facebook page where parents talk freely about their experiences. Leaked conversations reveal families talking openly about receiving referrals and obtaining surgeries for their minor children. While referrals seem to come from the hospitals, it appears that the surgeries are most likely performed at clinics. (See attached images at the end of this document.)

Since then, leaked phone conversations have surfaced revealing that Cleveland Plastic Surgery provides top surgery for minors at the age of sixteen or slightly sooner.[78] Stratus Plastic Surgery of Columbus offers similar services but added that getting the required letter from a mental health counselor was the most difficult part. That letter could be obtained in a single visit; however, they preferred up to three visits which could be accomplished within three weeks or up to three months. The receptionist provided

[74] https://acpeds.org/transgender-interventions-harm-children
[75] https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/020708s038lblrpl.pdf
[76] https://www.pbs.org/newshour/health/women-fear-drug-they-used-to-halt-puberty-led-to-health-problems
[77] https://www.pediacastcme.org/supporting-transgender-and-gender-diverse-youth-in-pediatric-practice-pediacast-cme-066/
[78] https://www.dropbox.com/s/wzflznj0mmvmbaq/Top%20Surgery%20Audio%2012.mpeg?dl=0

recommendations for three local mental health providers known to provide the necessary documentation.[79]

Should the Legislature Come in between Families and their Physicians?

No one is above the law and the allegation that the legislature is coming in between families and their physicians is a false and manipulative narrative. The legislature has an obligation to provide for the safety of all of Ohio's citizens, young and old, by establishing ethical boundaries for our medical practitioners when necessary. The legislature's authority rests above that of the medical industry rather than somewhere between the providers and the parents and the SAFE Act is not without precedent.

Senate Bill 214 passed unanimously through both houses in the 132nd General Assembly banning female genital mutilation (FGM), which is a cultural practice among some immigrants from African countries.[80] [81] Neither cultural practices nor parental consent were barriers to this legislation which received bipartisan support. While some are offended by the word "mutilation," the sciences are indifferent to our feelings, and it would be irresponsible of us not to acknowledge the facts. Pubertal suppression especially when coupled with opposite-sex hormones, mutilates a child's genitals to the point of severe pain, sexual dysfunction, and more. Confusion over one's gender should provide no more of an excuse than the cultural or religious expression of our valued immigrants. It would be indiscriminate to ban one atrocity while permitting another.

Furthermore, parents are not permitted to deny a life-saving blood transfusion to their children based on religious practices. In such cases, the courts will assume temporary custody of the minor in order to authorize the procedure. While parents' rights should be highly valued, they are not without limits when children's safety is at risk. Parents do not have the right to demand unethical procedures. Precedent has already been established to recognize the state's duty to intervene, oversee, and regulate medical procedures that may pose harm to minors.

Certainly, no one would argue in favor of physicians sterilizing children simply because a twelve-year-old states that they do not wish to be a father or mother and they have their parents' consent. It is no more reasonable to suggest that practitioners can engage in a similar, if not more risky, process (gender conversion) with even more severe side effects, simply because they have convinced the parents to approve. While parental rights are and ought to be significant, they are not entitled to regulate or deregulate the healthcare industry. This is the purview of the legislature and medical licensing boards.

Do all Professionals Agree?

They do not. This may be the longest FAQ provided because it is important to counter the narrative that the gender affirmation model is evidence-based, well-established, and agreed on by all professionals. It is not. No form of science, especially medicine, should be dominated by activism. It should be dictated by science.

[79] https://www.dropbox.com/s/oxbzrafr58t0f2h/Top%20Surgery%20Audio%2013.mp4?dl=0
[80] https://www.daytondailynews.com/news/ohio-may-ban-female-genital-mutilation/CXq2BvglRUPHwQxW2L6H4L/
[81] https://www.legislature.ohio.gov/legislation/132/sb214

Activists, however, injected themselves into this field long before mainstream clinicians understood what was happening. They defined the terms, established protocols, and claimed universal consensus long before less political but well-established clinicians became aware of what was even happening and had opportunity to weigh in. Today, it is frequently and falsely claimed that gender conversion practices are well-established, evidence-based, and universally recognized. They are not.[82]

Without the slightest hint of evidence or irony, Dr. Rachel Levine, the highest-ranking transgender individual in the federal government, falsely claimed, "there is no argument among medical professionals – pediatricians, pediatric endocrinologists, adolescent medicine physicians, adolescent psychiatrists, psychologists, etc. – about the value and the importance of gender-affirming care." Levine's blatant bias did not go unchecked. Endocrinologist Dr. William Malone, a member of the Society for Evidence Based Gender Medicine responded,

> "They're trying to make it seem that the evidence base is a done deal and is settled science, and that's just simply not the case….And so the language that they're using does not reflect the actual medical evidence." [83]

CNN reports that 200 medical professionals including nurses, physicians, counselors and social workers condemn bills like the SAFE Act. They failed to report on the multitudes of physicians who support the mission of the American College of Pediatricians, who support bills such as this.[84]

> The American College of Pediatricians (ACPeds) is a national organization of pediatricians and other healthcare professionals dedicated to the health and well-being of children. It was founded by a group of concerned physicians who saw the need for a pediatric organization that would not be influenced by the politically driven pronouncements of the day. The ACPeds bases its policies and positions upon scientific truth within a framework of ethical absolutes.[85]

Nothing is more obvious than that we will discover physicians and organizations on both sides of this issue. Implications that there is no debate are only designed to silence debate. True science never shuns debate and discovery.

The Society for Evidence Based Gender Medicine represents another group of medical professionals with a more specific interest in the gender question. This organization provides current research and evidence-based analysis on the latest developments in gender medicine, free from political, religious, and financial influences, according to their mission statement.

> We are an international group of over 100 clinicians and researchers concerned about the lack of quality evidence for the use of hormonal and surgical interventions as first-line treatment for young people with gender dysphoria. We represent expertise from a range of clinical disciplines.

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[82] https://www.aclu.org/news/lgbtq-rights/doctors-agree-gender-affirming-care-is-life-saving-care
[83] https://www.foxnews.com/us/doctors-slam-levines-claim-gender-affirming-care-fear-speaking-in-hiding
[84] Dr. Andre Von Mol represented this institution with expert testimony last year. However, rather than discussing the merits of his testimony, members attempted to assassinate the character of the institution based on the judgement of left-wing activist organizations. We ought to be more focused on the science than the politics of this issue.
[85] https://acpeds.org/about

> Our objectives include evaluating current interventions for gender dysphoria, providing balanced evidence summaries, promoting the development of effective and supportive psychosocial approaches for the care of young people with gender dysphoria and generating good, answerable questions for research.
>
> Young people with gender dysphoria deserve respect, compassion, and high-quality care. Please join us in our mission to promote evidence-based care for children, adolescents, and young adults that prioritizes life (i.e. measures of mortality), quality of life, long-term outcomes, and fully informed consent. SEGM is free from political, ideological, religious, or financial influences.[86]

The Gender Care Consumer Action Network (GCCAN), is an organization of gender care consumers who dispute the quality of care they are receiving. While some are detransitioners others continue living as the opposite sex.

> GCCAN is a consumer rights group for any person who has previously or is currently receiving gender care related services. Our aim is to empower consumers of gender-transition related care to get the best health care possible.
>
> GCCAN was founded by gender care consumers because we determined that the level of care we receive during or after gender care treatment is inadequate to achieve healthy mental and physical outcomes. Members of our group have been subject to harms from inadequate gender care services, and our goal is to reduce or mitigate similar harms to other consumers. The current delivery of care does not match established best-practice protocols. Established institutions often fail to balance the interests of consumers with the interests of gender care providers. We seek improvements to accountability, provider education, holistic care protocols, medical research, and public policies. We deserve better.[87]

Corinna Cohn, one of their board members, began transition at the age of 18 and has lived as a transwoman for about twenty years. She testified in favor of the SAFE Act last year and authored an article for the Wall Street Journal titled, "What I wish I'd known when I was 19 and had sex reassignment surgery." She begins,

> I know now that I wasn't old enough to make that decision. Given the strong cultural forces today casting a benign light on these matters, I thought it might be helpful for young people, and their parents, to hear what I wish I had known. [88]

Leslie Stahl featured their president, Grace Lidinsky-Smith, on a segment of 60 Minutes featuring detransitioners.[89]

GCCAN does not support every bill that regulates gender affirming care, especially if they criminalize providers. Our bill, however, strikes the right balance to earn their support.

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[86] https://segm.org/about_us
[87] https://www.gccan.org/mission
[88] https://www.washingtonpost.com/opinions/2022/04/11/i-was-too-young-to-decide-about-transgender-surgery-at-nineteen/
[89] https://www.cbsnews.com/video/transgender-health-care-60-minutes-video-2021-05-23/#x begin at 5:00.

Local physician Dr. Leroy Essig pulled no punches when he expressed dissatisfaction with the current state of gender care for adolescents in an op-ed in which he expressed, “As a doctor and dad, I am ashamed by how horribly my field mistreats kids with 'gender-affirming' therapies.” He continues,

> Twenty-five years ago, when I was a young medical student on one of my first hospital rotations, the soft-spoken senior physician leading our team asked us one day on rounds, "what is all medication?" Met with blank stares, he then answered for us: "Poison. All medication is poison." He didn’t mean that the drugs we were giving our patients were killing them, but that we had a responsibility to be cautious when using them, as they also have the potential to harm.
>
> It’s a lesson many of my physician colleagues are ignoring in their opposition to burgeoning legislation in several states that would prohibit "gender-affirming" therapies for children with gender dysphoria, including Ohio HB 454, currently the subject of contentious debate in my home state.[90]

Ohio’s own, Dr. Stephen Levine, as noted earlier, was threatened by activists for providing professional, evidence-based research. Dr. Levine was an early proponent and participant in sex reassignment procedures and is an internationally recognized clinical professor of psychology and well-published expert on gender related issues. However, his professional experience coupled with improved research led him to change his position. When asked, “Why do you believe so many therapists have adopted the “affirmative” model, with the notion that these children need to change their bodies, rather than doing the actual work of therapy to explore what is underlying the distress?” he responded,

> Well, it is much simpler in the short run because it pleases the adolescent or adult and makes the therapist into an ally of the patient’s emerging inner self of gender identity that privileges this over all other considerations. It also is what they have been taught or indoctrinated to believe by teachers who have not looked into the subject in a scholarly way. It is also a politically correct “liberal” thing to do to add to the growing sense that this is the new civil rights issue I can be part of by being supportive. It is the product in part of the idea that the object of intervention is the patient, not the family. Of course, it is short-sighted and ignores what is well known about the problems of adult trans communities.[91]

It is worth noting that Dr. Levine was the chair of the 5th edition of The World Professional Association of Transgender Health’s Standards of Care which advocate for watchful waiting.

Levine dogmatically refutes any claims that current practices are evidence based in “The Myth of “Reliable Research” in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed.”

> Two Dutch studies formed the foundation and the best available evidence for the practice of youth medical gender transition. We demonstrate that this work is methodologically flawed and

[90] https://www.foxnews.com/opinion/doctor-dad-ashamed-horribly-field-mistreats-kids-gender-affirming-therapies
[91] https://genspect.org/qa-with-dr-stephen-levine/

> should have never been used in medical settings as justification to scale this "innovative clinical practice."[92]

Gender Spectrum is an international forum for clinical professionals to openly and freely collaborate on gender related issues. While they do not discourage transition, they do tend to oppose the affirmation model of care. It's best to allow them to describe their position.

> We want to see schools, colleges and higher education establishments hold neutral space for students as they explore their gender, sexual orientation and identity formation. We value supportive environments for students, so they feel neither encouraged nor discouraged to follow certain paths.
>
> We advocate for an evidence-based approach to gender distress, and we would like health care professionals to take the time and care to evaluate the low-evidence base for the current affirmative approach, looking more closely at the harms that medical treatment paths can cause. We recognize the high occurrence of comorbidities such as autism and ADHD among children and young people who are questioning their gender.
>
> We would like to raise public awareness of the issues facing gender-questioning children and young people. We wish to help create a society that supports gender non-conformity — one which doesn't require the heavy burden of medical treatment. We acknowledge that gay, lesbian and bisexual youth are often gender non-conforming; rather than suppressing hormonal urges with medication, we support an approach that allows adolescents to explore their sexuality with freedom and acceptance.[93]

In just over a week, (April 27-29, 2023) Gender Spectrum will be hosting an international conference of professionals to discuss gender related issues. "Attendees will meet experts from many fields holding a myriad of perspectives: eminent scientists, researchers, lawyers, doctors, psychologists, psychiatrists, psychotherapists, sociologists, educators, feminists, and some well-known detransitioners will challenge the evidence base for gender medicine and describe the widespread damage that gender identity ideology has wrought."[94] You can view many of their informative interviews and past events here.[95]

WebMD examines the benefits of gender conversion while acknowledging the extreme consequences in an article entitled, Transgender Docs Warn About Gender-Affirmative Care for Youth, which reveals some of the top advocates, consumers, and providers for such care pumping the brakes.[96]

A Cincinnati neurologist, Christopher Wood, recently wrote an article entitled that there is "No strong evidence to back trans care for kids."

> When discussing the evidence for gender-affirming care in children, especially when critiquing public policy, one should be cautious to represent the evidence fairly and accurately. That means being honest about the lack of evidence and not projecting a false certainty. Some of

[92] https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2150346
[93] https://genspect.org/position/
[94] https://genspect.org/genspect-press-release-the-bigger-picture-conference/
[95] https://www.youtube.com/channel/UCnh6D3XXC0Qji6njBOvvxbA
[96] https://www.webmd.com/sex-relationships/news/20211129/transgender-docs-gender-affirmative-care-youth

> what Khalyleh describes as "myths" about transgender care are actually well-substantiated concerns.
>
> State legislation may be an imperfect way to regulate the care of transgender children. Critics have every right to argue and lobby for alternative policy. However, we would do well to keep in mind the limits of what we currently know and an appreciation that, at least in some ways, Kentucky's law is not far from the evidence-based policies of multiple peer nations.[97]

Clearly, the consensus does not exist to support transitioning children to the opposite sex. Anyone who says otherwise is either dishonest or confused about so-called gender affirming care.

What about the AAP and APA?

Neither the American Academy of Pediatrics nor the American Psychological Association fully represent their memberships. The American Academy of Pediatricians cancelled an appointment with me when they learned that I was going to question their methodology. Neither appeared to testify. Their official recommendations are made by a few people at the top and not representative of all members. In fact, those that I have spoken to one on one have grave concerns about this practice. However, most are not permitted by their employers to speak out on this issue. Several of their members, however, did speak out proposing a resolution to urge a more cautious approach. However, neither debate nor discussion ensued for political reasons, and they were systematically shut down by the AAP.[98] [99] [100]

James Cantor is a member is a member of the APA, as well as a member of the LGBTQ community.[101] He is a neurosurgeon specializing in the science of sex and wrote critically of the AAP's policy revisions on treatment for gender-diverse children.[102]

> As I read the works on which they based their policy, however, I was pretty surprised…rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.

Cantor adds,

> As they make clear, every follow-up study of GD children, without exception, found the same thing: By puberty, the majority of GD children ceased to want to transition. AAP is, of course, free to establish whatever policy it likes on whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.[103]

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[97] https://www.cincinnati.com/story/opinion/contributors/2023/04/10/opinion-no-strong-evidence-to-back-trans-care-for-kids/70080843007/
[98] https://www.dailymail.co.uk/news/article-11099561/Leaked-internal-files-pediatricians-angry-professional-bodys-transgender-policy.html
[99] https://www.wsj.com/articles/the-american-academy-of-pediatrics-dubious-transgender-science-jack-turban-research-social-contagion-gender-dysphoria-puberty-blockers-uk-11660732791
[100] https://www.medscape.com/viewarticle/979262
[101] https://www.apa.org/monitor/2009/06/random
[102] https://pubmed.ncbi.nlm.nih.gov/31838960/
[103] http://www.sexologytoday.org/2018/10/american-academy-of-pediatrics-policy.html

The APA recently and frequently enlists the services of Jack Turban, who just completed his residencies in 2020 and 2022. His role is to support their gender affirmative model. However, his questionable research is frequently debunked by research specialists like Leor Sapir who critiques Turban's work,

> The article, it should be noted, was published after health authorities in Sweden, Finland, and the U.K. had conducted systematic reviews of evidence for puberty blockers and cross-sex hormones and concluded, unanimously, that the risks and uncertainties outweigh any known benefits. Sweden and Finland have already severely limited the practice, and the U.K. seems to be moving in the same direction following the damning Cass Report. Medical authorities in France and New Zealand have also sounded the alarm, with France's National Academy of Medicine now urging "the greatest caution" when using hormones to treat gender-related distress in minors.[104]

Clearly any claims of settled science in favor of "gender affirmation" are robustly overstated and gender conversion practices remain highly controversial within the professional community. Politics and idealism are alive and well on the inside of the AAP, APA and many of our hospitals and clinics.

What is FDIA and is it a factor?

Factitious Disorder in Another was once labeled as Munchausen Syndrome by Proxy. According to the Cleveland Clinic this is a condition where an individual, usually a parent, makes false medical claims in another, usually a child, in order to gain attention and sympathy by being seen as unique and compassionate.

> FDIA is most often seen in mothers — although it can also happen with fathers — who intentionally harm or describe non-existent symptoms in their children to get the attention given to the family of someone who is sick. A person with FDIA uses the many hospitalizations as a way to earn praise from others for their devotion to the child's care, often using the sick child as a means for developing a relationship with the doctor or other healthcare provider.[105]

Amber Bingle receives a significant amount of attention on the circuit talking about her child who, in her words, identified as trans "literally from the womb."[106]

Jeanette is the mother of the world's most famous transgender teen, Jazz Jennings. The choice to live out her child's transition from Jared to Jazz on national television from the age of five to twenty seems like an excessive amount of overexposure for a child engaged in a deeply personal experience.[107] In the process, many have looked to Jeanette rather than Jazz as the primary driver of this transition. It appears to have come at great emotional expense to Jazz.[108]

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[104] https://www.realityslaststand.com/p/the-distortions-in-jack-turbans-psychology
[105] https://my.clevelandclinic.org/health/diseases/9834-factitious-disorder-imposed-on-another-fdia#:~:text=Factitious%20disorder%20imposed%20on%20another%20(FDIA)%20formerly%20Munchausen%20syndrome%20by,Appointments%20866.588.2264
[106] https://youtu.be/t_gCASi58Ps?t=663
[107] https://go.tlc.com/show/i-am-jazz-tlc
[108] https://pjmedia.com/culture/megan-fox/2023/03/21/i-just-want-to-feel-like-myself-tearfully-admits-americas-most-famous-trans-kid-jazz-jennings-n1680077

A mother named Linda suffered from bipolar disorder, anorexia nervosa, and bulimia nervosa. By the time her daughter, Jessica, was a year old, Linda had sought a diagnosis of gender dysphoria. She not only sought it, but she also shopped for it. By the time Jessica entered kindergarten, Linda had found a diagnosis and informed the school that Jessica was a boy named Bridge.

One of the counselors that Linda sought, called a hotline to report possible child abuse and also expressed concerns about Munchausen Syndrome by Proxy. It was later determined that Linda did not meet the criteria for Munchausen Syndrome by Proxy, but the clinician noted that "she did share striking similarities with that diagnosis."

Jessica's father petitioned the court and won. The courts found in his favor and designated him as the residential parent.[109]

While there is no doubt that some mothers are heavily and emotionally invested in their child's transition, it would be inappropriate to conclude that this is the primary cause. Each case is different. While it may be true at times, it is not likely that this is usually the primary cause.

What is the truth about Suicide Risk?

There is a substantial difference between suicidal ideation and actual death by suicide. Individuals who transition are nineteen times more likely to end their lives than the general population.

Suicidal ideations, however, are sadly common among individuals experiencing gender dysphoria. Treating individuals for gender dysphoria without addressing the underlying causes only masks their depression, anxiety, and other comorbidities temporarily. Surveys of trans youth by activist organizations such as the Trevor Project are the primary sources that suggest affirming a child's preferred gender reduces the risk of suicide. It is common knowledge among ROGD kids that expressing thoughts of suicide is pivotal when asking for puberty blockers and opposite sex hormones.

What Do Ohioans Think?

A Baldwin Wallace poll from October 9, 2022, suggests that the majority of Democrats in Ohio support legislation like the SAFE Act. Ohioans were asked "Do you support or oppose laws or policies that do each of the following? - Allowing medical professionals to provide someone younger than 18 with medical care for a gender transition?"

Among Democrats only 38.6% said that they support medical treatment for gender transition while 46.4% oppose it. The remaining 15% had no opinion. Democrats clearly lean in favor of legislation like the SAFE Act.

Among Independents, 25.4% support medical treatment while 64.8% oppose it. The undecided are at 9.4%.

Only 31.4% of those with a college degree support medical treatment while 60.7% oppose it. Only 21.3% without a degree are supportive while 67.9% of those same respondents oppose medicalizing children with gender dysphoria. Republicans found 10.8% supporting medicalizing youth with 84.6% in opposition. Only 4.6% were undecided.

[109] https://www.gaylawnet.com/laws/cases/2011-CA-001568-ME.pdf

Support for legislation like the SAFE Act is overwhelming in Ohio. Overall, only 24.5% of Ohioans believe that we should be throwing drugs and surgery at our children with gender dysphoria while significantly more than twice that amount (65.6%) believe that we should allow children to grow up before thrusting life altering, irreversible hormone treatments and surgeries on minors. Although by varying degrees, every demographic but one opposes traumatizing children with medical interventions for gender dysphoria. The only outlier to surpass 40% in support were those who identified as liberal and they barely achieved 50%.

While the opposition to the SAFE Act may be well organized, energized, and politically savvy, they are not representative of the mainstream in Ohio. The complete polling data can be found here. Look for question 27.[110]

Is Discrimination a Factor?

Time to Think reveals the homophobia that gay clinicians experienced in the Tavistock. Often it was internalized homophobia from gay or lesbian kids who felt pressured to transition rather than to live same sex attracted. Other times, it was parents who could not cope with the idea of having a homosexual child.

Hannah Barnes records the reaction that gay and lesbian clinicians at the Tavistock that are frequently expressed about the homophobia surrounding gender conversion practices.

> Anastassis Spiliadis is just as critical. Homophobia was 'everywhere', he says, and manifested itself in many different ways. 'It could be completely silencing people who are gay,' he says. 'It could be dismissing the reality that sexuality can play a role in how someone identifies.' He says there were many 'negative comments about gay people'. He recalls families who remarked, 'Thank God my child is trans and not gay or lesbian.' 'We had this so many times, and we're like, do we take a position as a service when this comes up? You would surely say something if someone made a racial comment to a black clinician.'[111]

The trans community has developed a slur for lesbians. They are called TERFS or trans exclusionary radical feminists.[112] Many feminists experience discrimination because they are not thought to be good enough to be women. The LGB Alliance was born out of this discrimination.

Scott Newgent helped me to deliver the SAFE Act to the clerk's office. Scott identifies as a lesbian transman. Before transitioning, Scott was Kelly, a lesbian whose partner was ashamed of being a lesbian. As a result, Kelly was convinced to transition into at the age of 42. After many adverse consequences, Scott says that if she was incapable of discerning what was right for her at the age of forty-two, it's hard to perceive that a twelve- year-old can comprehend the consequences.

Sadly, Scott was largely ignored when visiting Ohio. She can get loud. Her motto is to scream and scream louder. While one part of me was tempted to calm her down the other side of me said that she had every right to tell her story her way. She is the one who has been harmed. She says that no one will

[110] https://www.bw.edu/Assets/community-research-institute/october_ohio_issues_poll%20final.pdf
[111] Barnes, Hannah. Time to Think (p. 204). Swift Press. Kindle Edition.
[112] https://www.nbcnews.com/feature/nbc-out/pro-lesbian-or-trans-exclusionary-old-animosities-boil-public-view-n958456

listen unless she screams. You can learn more about Scott and others who advocate at www.tresvoices.org.

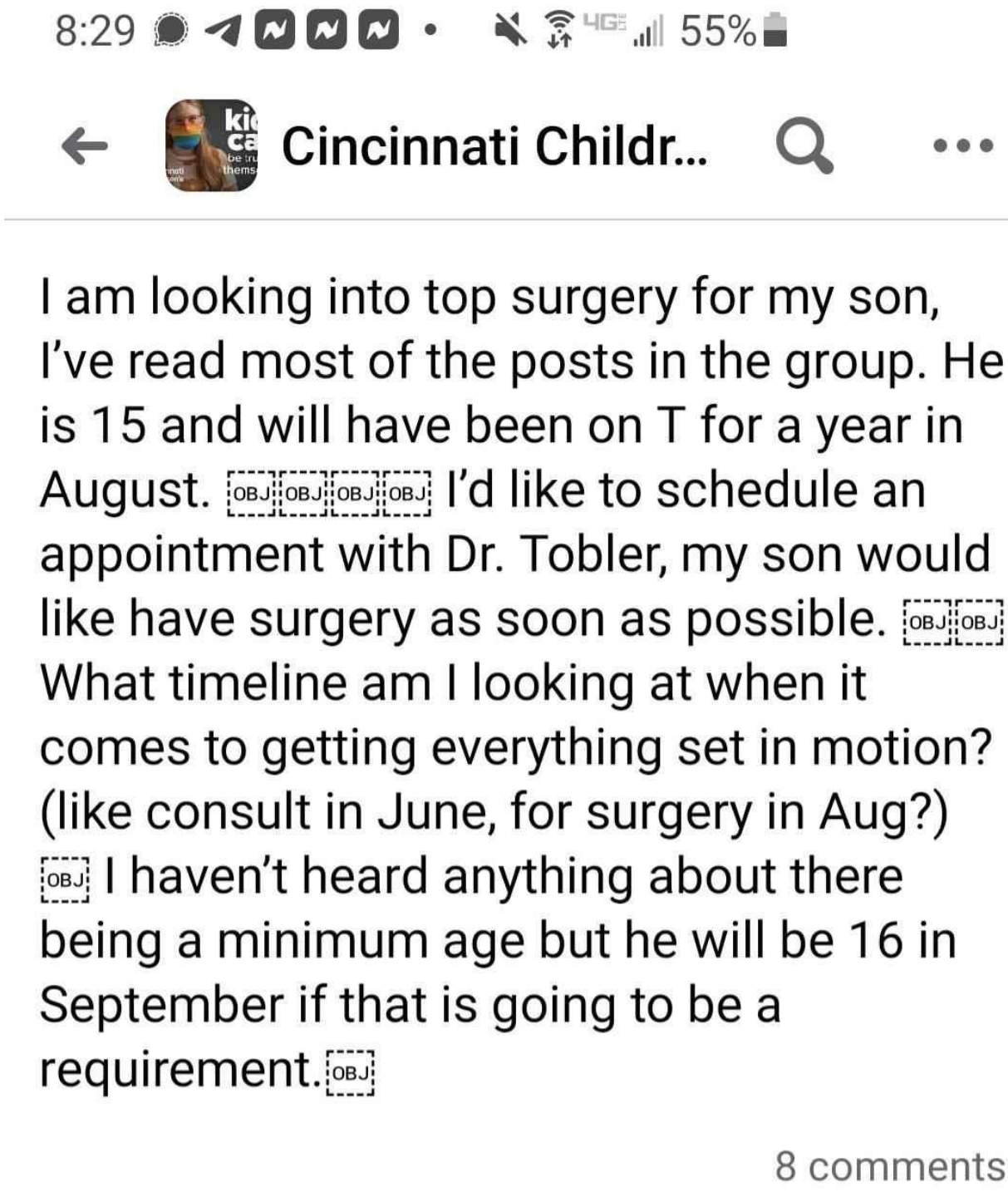
Are you done yet?

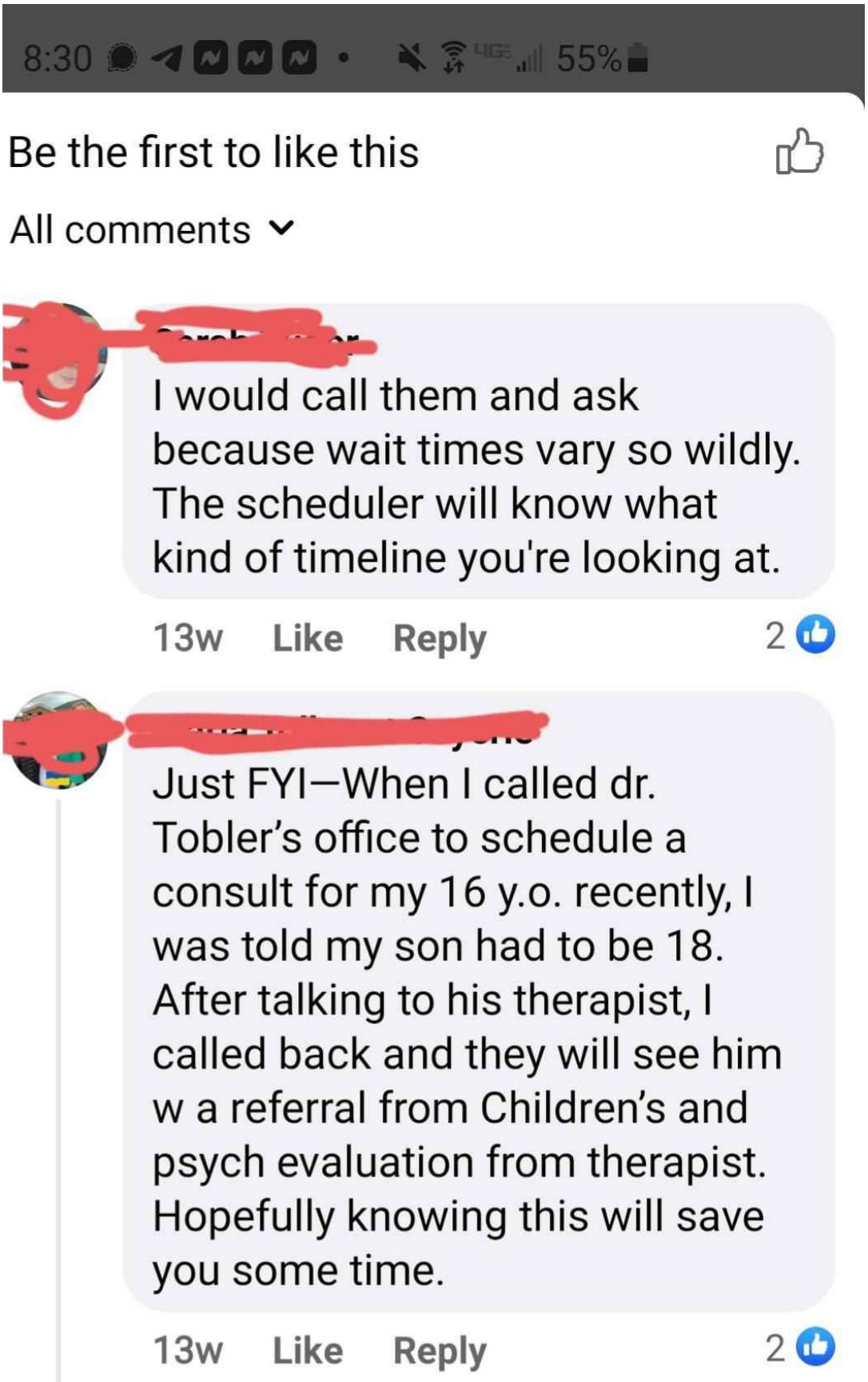
Yes!

For some, I've already been told, this is too much information. For others, I already know that too much is never enough. A number of people have already made up their minds and this information is unlikely to impact them. However, this issue is far more complicated than a ten-minute testimony accompanied by three pages of information can adequately address. An issue as impactful and contentious as this is has merited that I do extensive research and documentation, not just for me, but for decision makers as well as the citizens of Ohio who are paying attention. We cannot make decisions based on buzz words, rhetoric, or "assurances" from those who insist that we should trust them. It is incumbent upon us to have well-documented information with evidence based on science, statistics, the stories of those whose lives are most affected.

Despite over a hundred footnotes, I have just scratched the surface and am reminded of that feeling I get every time I leave the hotel room. Even though I've looked under the bed ten times and checked the bathroom and closet twice, I still I ask myself, "What am I leaving behind?" It just feels like I'm leaving something out. So please don't hesitate to reach out to me for further discussion or clarification.

OHIO Children's Hospital's Official and Moderated Social Media Posts


8:29
55%
Cincinnati Childr...
I am looking into top surgery for my son, I've read most of the posts in the group. He is 15 and will have been on T for a year in August. OBJ OBJ OBJ OBJ I'd like to schedule an appointment with Dr. Tobler, my son would like have surgery as soon as possible. OBJ OBJ What timeline am I looking at when it comes to getting everything set in motion? (like consult in June, for surgery in Aug?) OBJ I haven't heard anything about there being a minimum age but he will be 16 in September if that is going to be a requirement. OBJ
8 comments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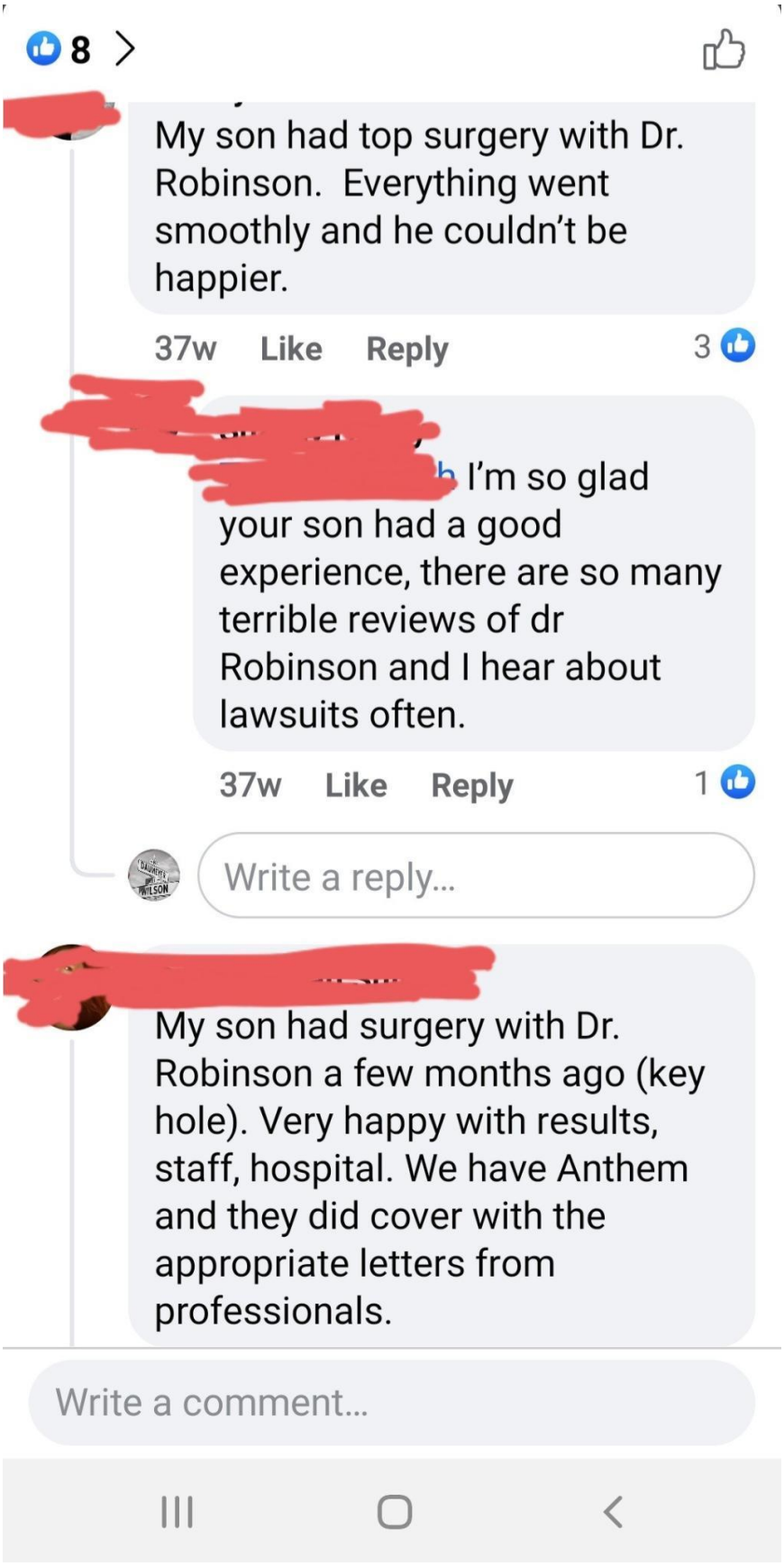
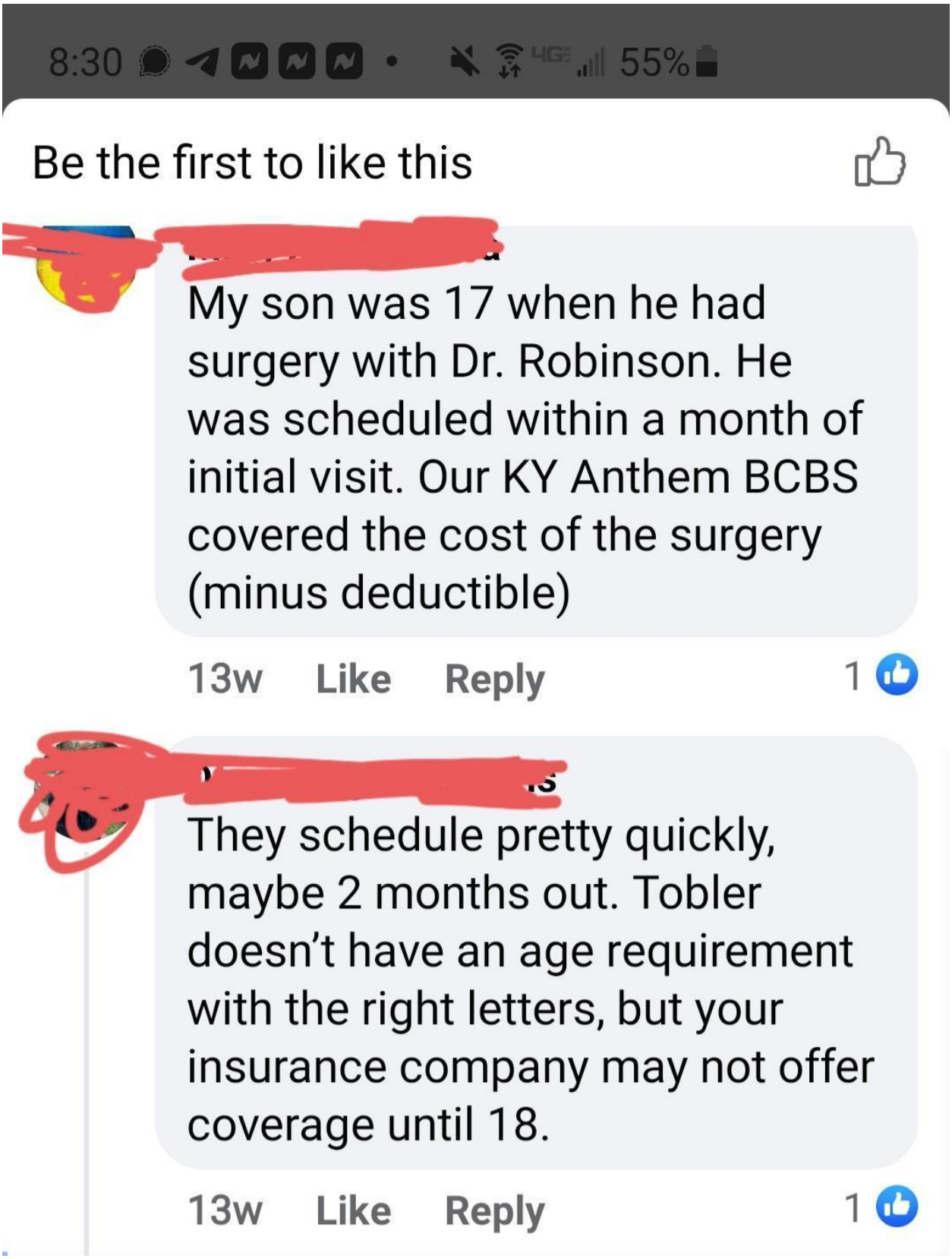
Be the first to like this
All comments
I would call them and ask because wait times vary so wildly. The scheduler will know what kind of timeline you're looking at.
13w Like Reply 2
Just FYI—When I called dr. Tobler's office to schedule a consult for my 16 y.o. recently, I was told my son had to be 18. After talking to his therapist, I called back and they will see him w a referral from Children's and psych evaluation from therapist. Hopefully knowing this will save you some time.
13w Like Reply 2


8
My son had top surgery with Dr. Robinson. Everything went smoothly and he couldn't be happier.
37w Like Reply 3
I'm so glad your son had a good experience, there are so many terrible reviews of dr Robinson and I hear about lawsuits often.
37w Like Reply 1
Write a reply...
My son had surgery with Dr. Robinson a few months ago (key hole). Very happy with results, staff, hospital. We have Anthem and they did cover with the appropriate letters from professionals.
Write a comment...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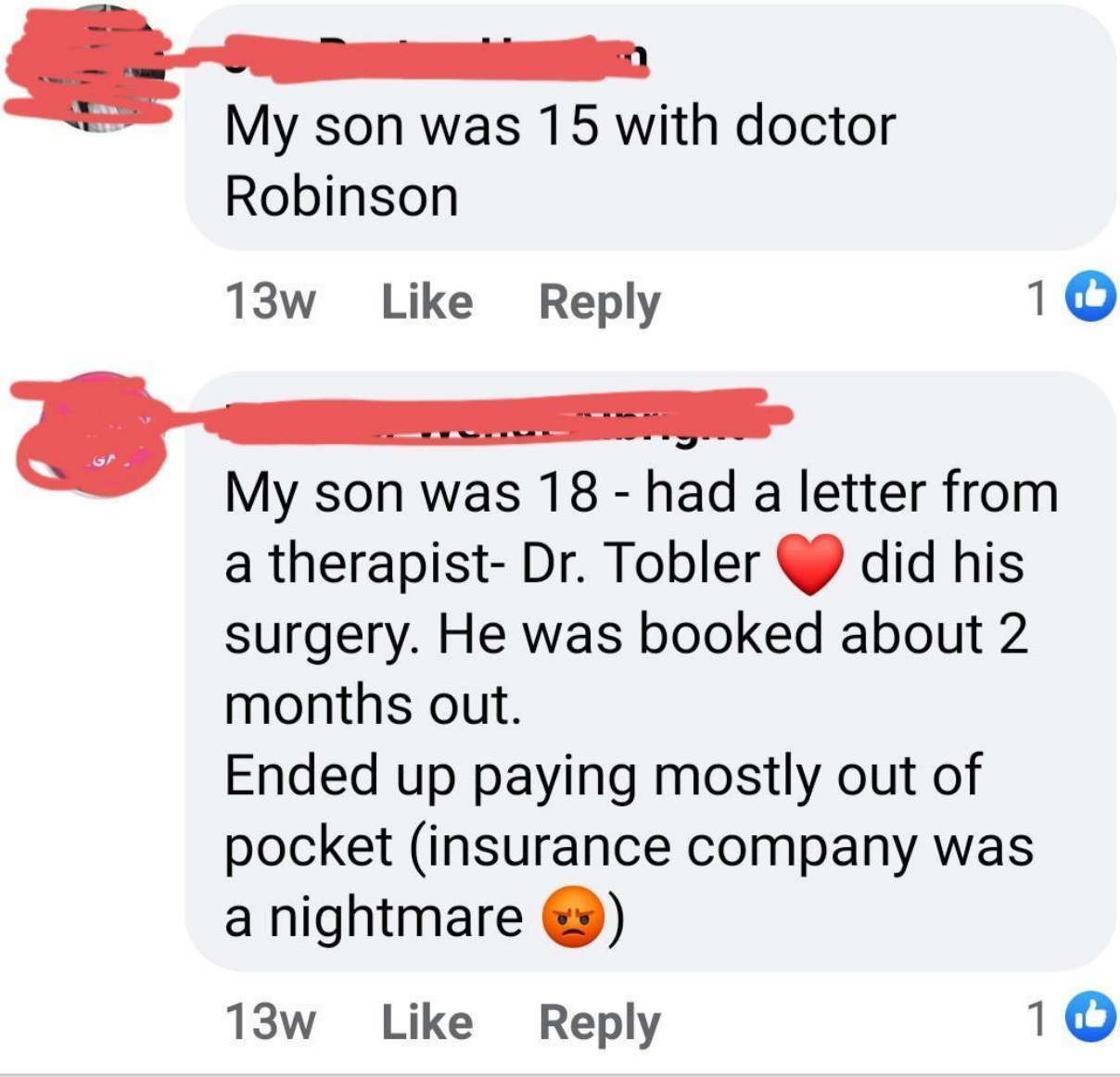
Be the first to like this
My son was 17 when he had surgery with Dr. Robinson. He was scheduled within a month of initial visit. Our KY Anthem BCBS covered the cost of the surgery (minus deductible)
13w Like Reply 1
They schedule pretty quickly, maybe 2 months out. Tobler doesn't have an age requirement with the right letters, but your insurance company may not offer coverage until 18.
13w Like Reply 1


My son was 15 with doctor Robinson
13w Like Reply 1
My son was 18 - had a letter from a therapist- Dr. Tobler ❤️ did his surgery. He was booked about 2 months out.
Ended up paying mostly out of pocket (insurance company was a nightmare 😡)
13w Like Reply 1
Write a comment...

Cincinnati Childr...

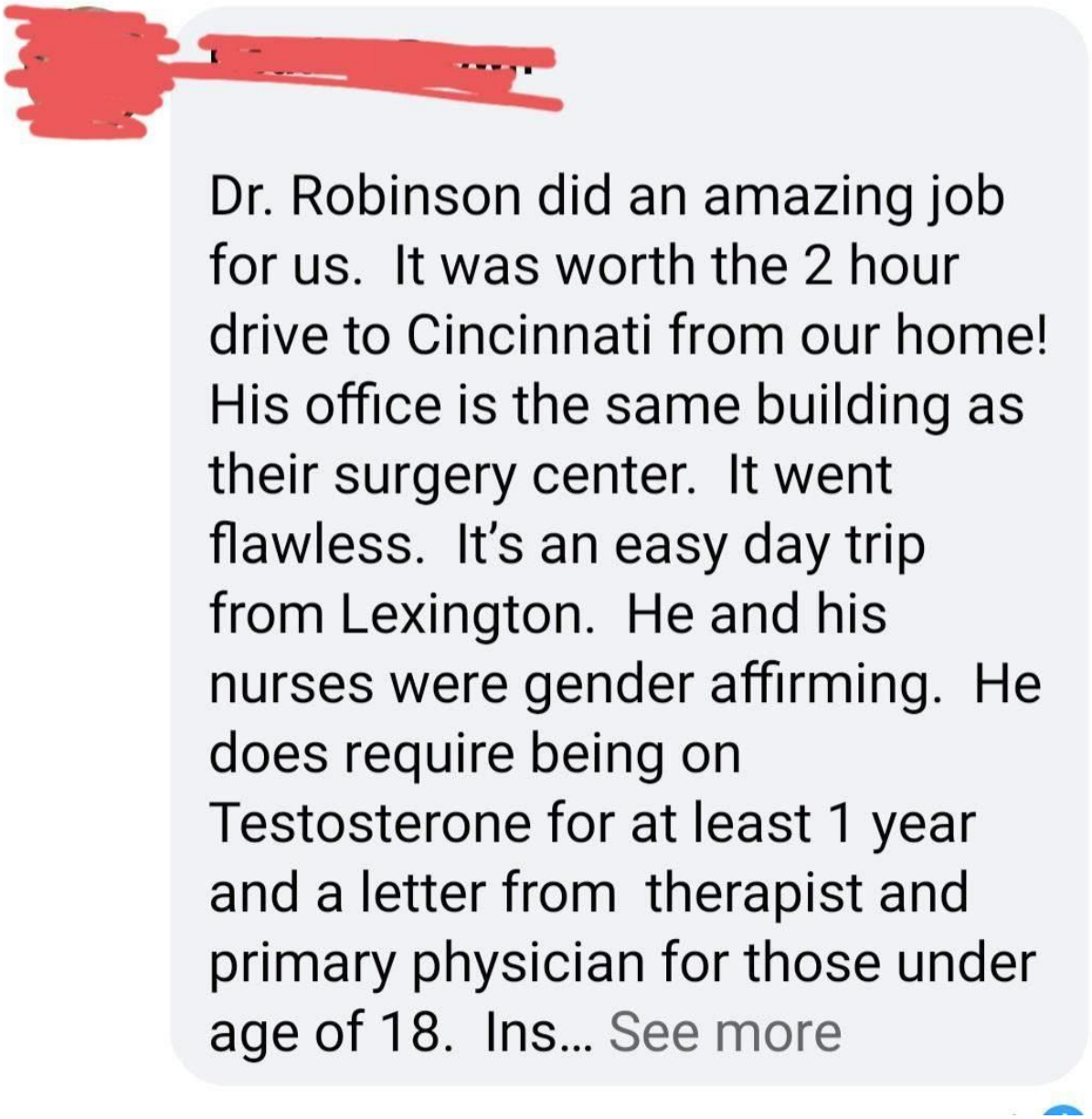
[redacted]

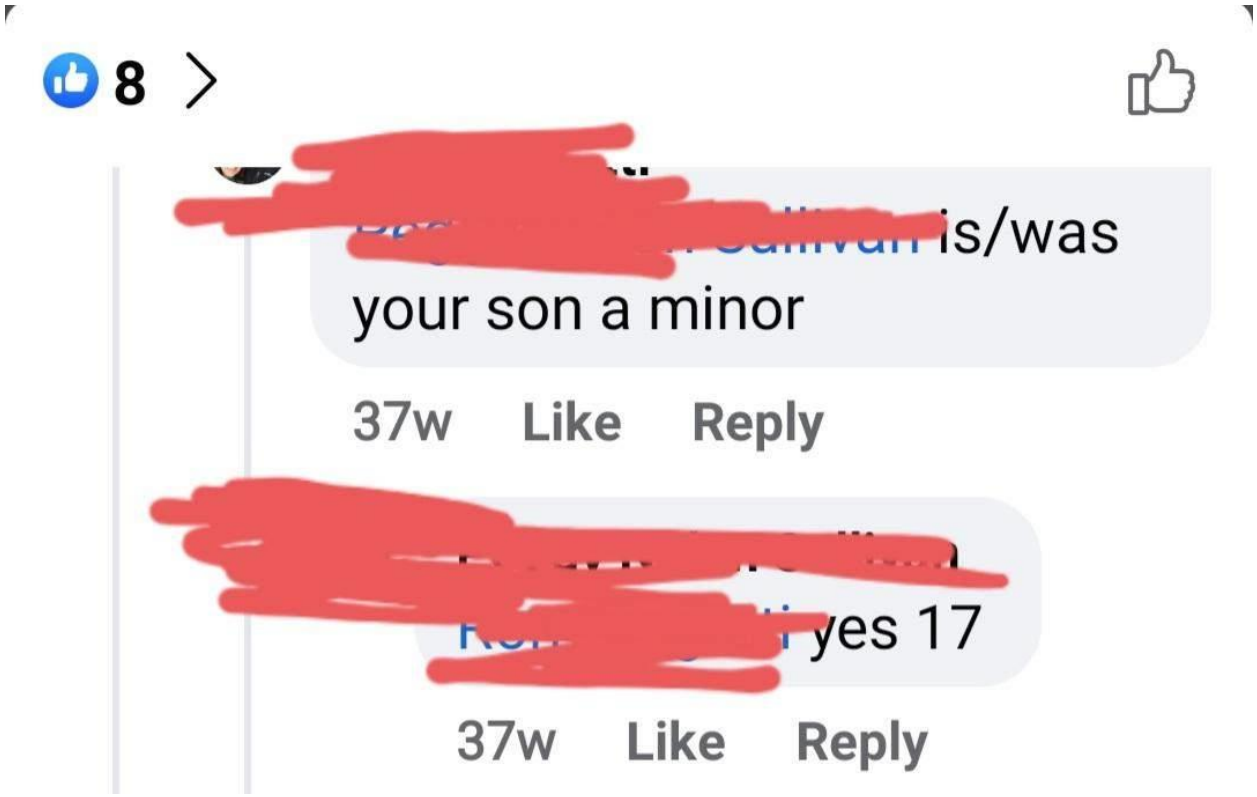
Aug 26, 2021 ·

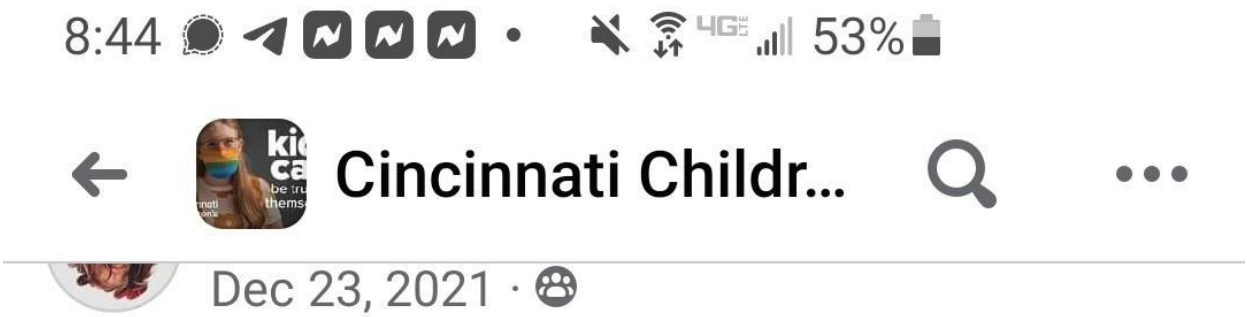
Hello, we are starting the process of top surgery for my ftm son who just turned 17. He is starting his senior year in high school this year and the goal is to have the surgery prior to starting college around this time next year. We reached out to Dr. Gobble but he does not perform surgery on minors.

Would love to get feedback from others that have gone before us on this journey. What about Dr. Robinson here in Cincinnati? We are willing to travel as well, closer the better from a logistics perspective. Your feedback is appreciated! Love to all!

8 21 comments

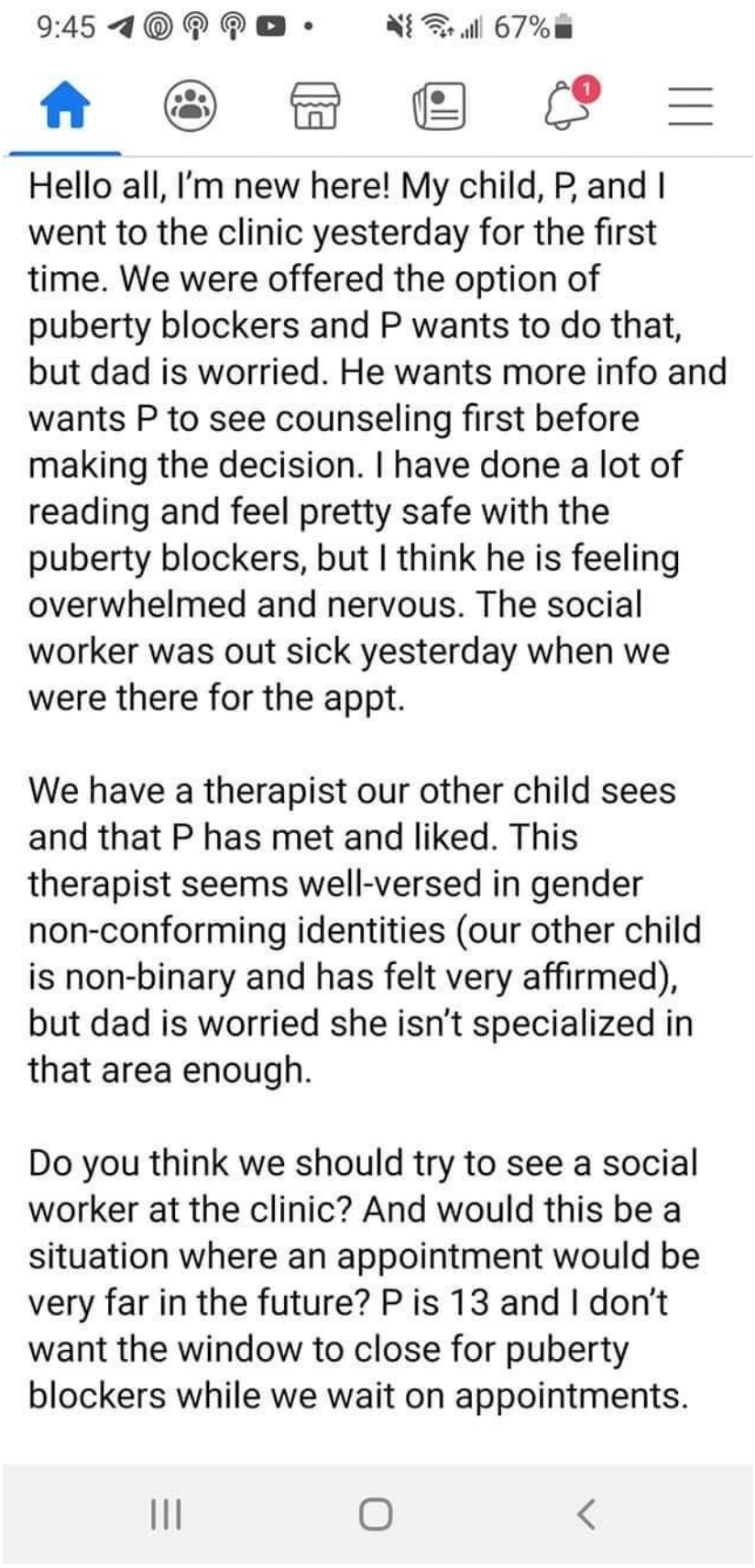

[redacted]
Dr. Robinson did an amazing job for us. It was worth the 2 hour drive to Cincinnati from our home! His office is the same building as their surgery center. It went flawless. It's an easy day trip from Lexington. He and his nurses were gender affirming. He does require being on Testosterone for at least 1 year and a letter from therapist and primary physician for those under age of 18. Ins... See more


8
[redacted] is/was your son a minor
37w Like Reply
[redacted] yes 17
37w Like Reply



[redacted] had her first appointment with Dr. Smith this week and is going to be starring estrogen and spironolactone. She's excited as I've seen her in ages and just a little nervous, though she said that came from finding out this could start in a matter of weeks rather than the months she was anticipating. Her mother and I could not be more happy to see her getting what she needs to feel comfortable in her own skin.

Every hat I own is off to Dr. Smith. Like everyone we've met at the clinic he was supportive, thorough, encouraging, and very warm and welcoming. I think we may have shocked him a bit with [redacted] and my rapport, at 17 years old she and I can



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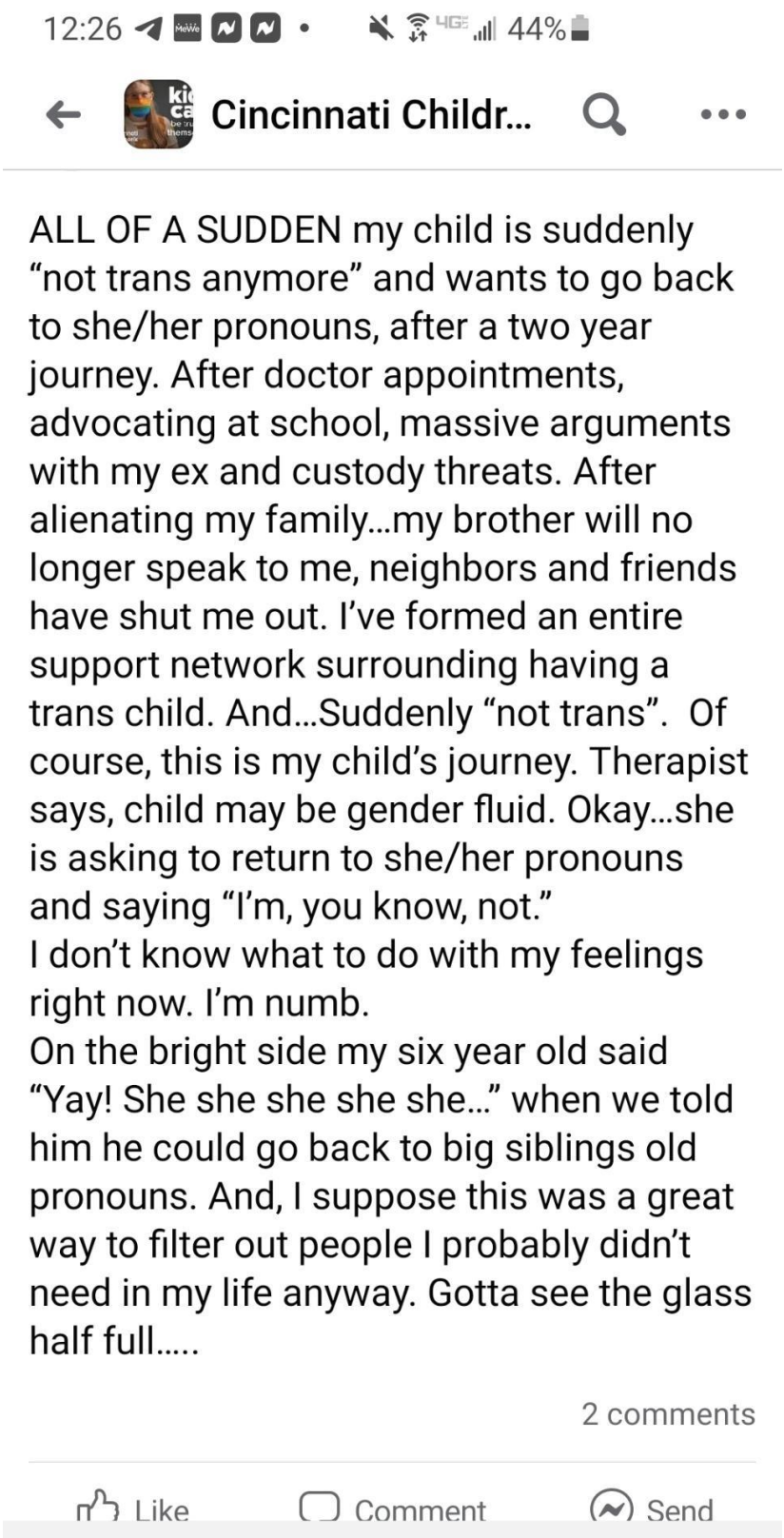
Hello all, I'm new here! My child, P, and I went to the clinic yesterday for the first time. We were offered the option of puberty blockers and P wants to do that, but dad is worried. He wants more info and wants P to see counseling first before making the decision. I have done a lot of reading and feel pretty safe with the puberty blockers, but I think he is feeling overwhelmed and nervous. The social worker was out sick yesterday when we were there for the appt.

We have a therapist our other child sees and that P has met and liked. This therapist seems well-versed in gender non-conforming identities (our other child is non-binary and has felt very affirmed), but dad is worried she isn't specialized in that area enough.

Do you think we should try to see a social worker at the clinic? And would this be a situation where an appointment would be very far in the future? P is 13 and I don't want the window to close for puberty blockers while we wait on appointments.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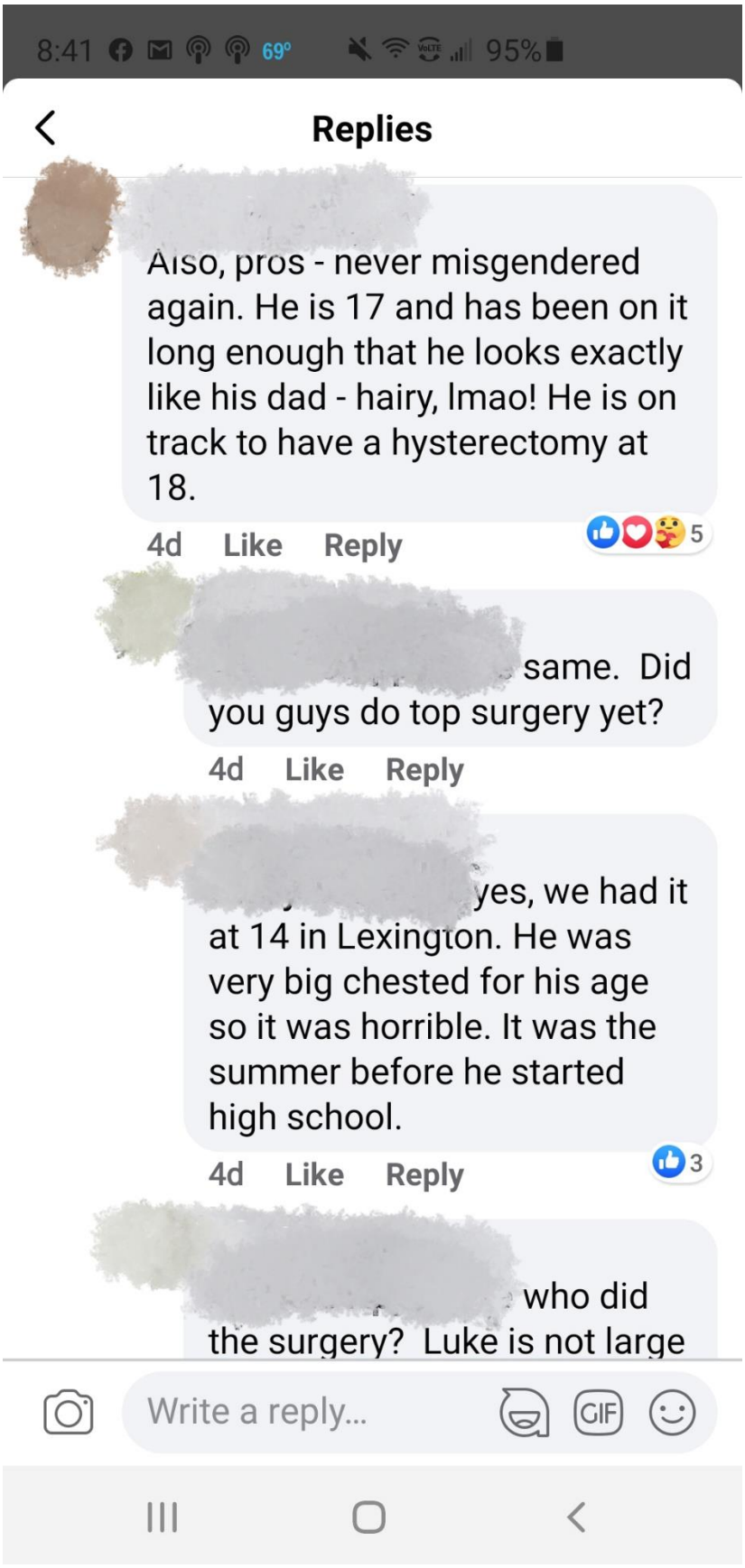
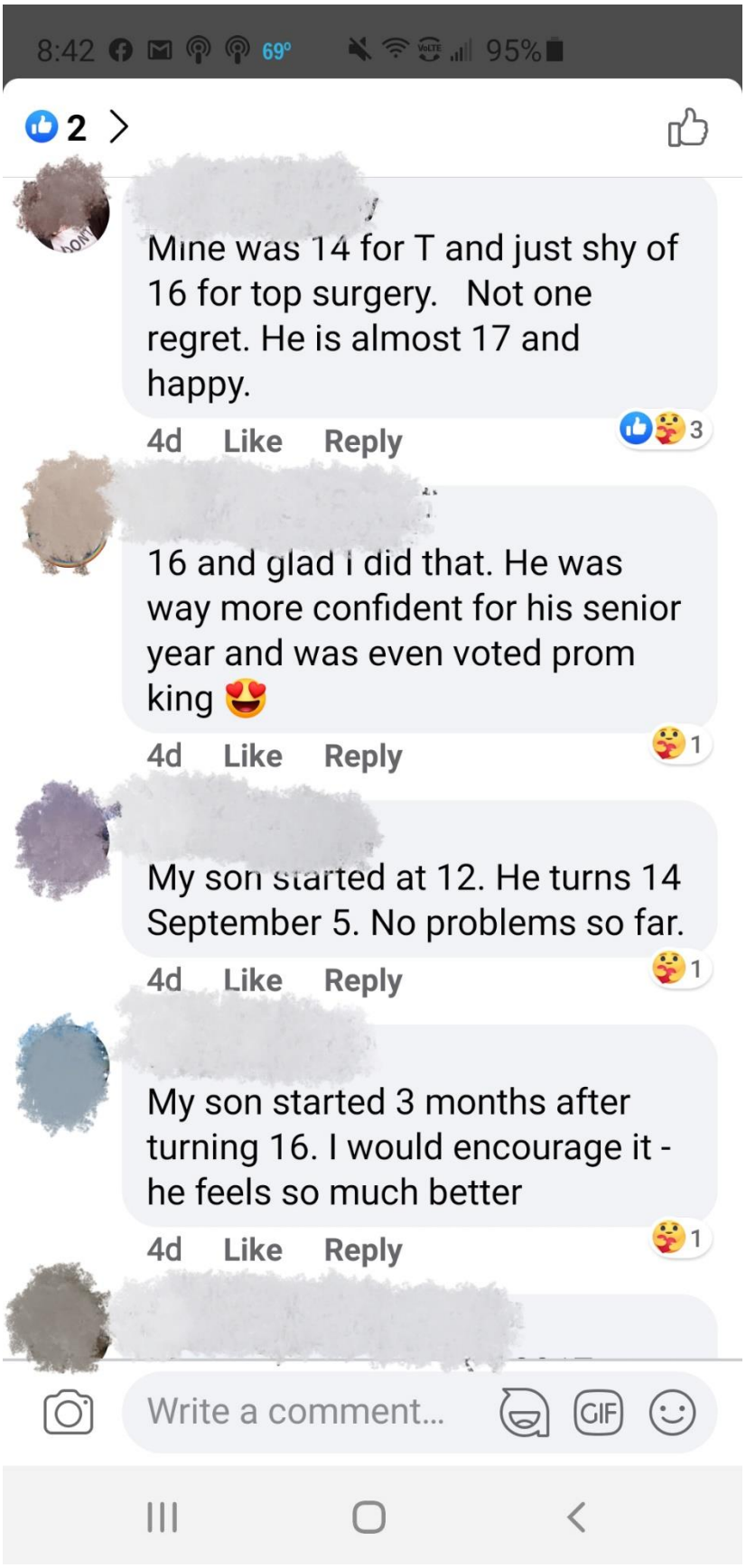
44%
Cincinnati Childr...
ALL OF A SUDDEN my child is suddenly "not trans anymore" and wants to go back to she/her pronouns, after a two year journey. After doctor appointments, advocating at school, massive arguments with my ex and custody threats. After alienating my family...my brother will no longer speak to me, neighbors and friends have shut me out. I've formed an entire support network surrounding having a trans child. And...Suddenly "not trans". Of course, this is my child's journey. Therapist says, child may be gender fluid. Okay...she is asking to return to she/her pronouns and saying "I'm, you know, not."
I don't know what to do with my feelings right now. I'm numb.
On the bright side my six year old said "Yay! She she she she she..." when we told him he could go back to big siblings old pronouns. And, I suppose this was a great way to filter out people I probably didn't need in my life anyway. Gotta see the glass half full.....
2 comments
Like
Comment
Send


8:41
69°
95%
Replies
Also, pros - never misgendered again. He is 17 and has been on it long enough that he looks exactly like his dad - hairy, lmao! He is on track to have a hysterectomy at 18.
4d Like Reply
5
same. Did you guys do top surgery yet?
4d Like Reply
yes, we had it at 14 in Lexington. He was very big chested for his age so it was horrible. It was the summer before he started high school.
4d Like Reply
3
who did the surgery? Luke is not large
Write a reply...
GIF


8:42 69° 95%
2
Mine was 14 for T and just shy of 16 for top surgery. Not one regret. He is almost 17 and happy.
4d Like Reply
3
16 and glad I did that. He was way more confident for his senior year and was even voted prom king 😍
4d Like Reply
1
My son started at 12. He turns 14 September 5. No problems so far.
4d Like Reply
1
My son started 3 months after turning 16. I would encourage it - he feels so much better
4d Like Reply
1
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