IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

JANE DOE, et al.,

Plaintiffs,

v. Case No. 4:23-cv-00114-RH-MAF

JOSEPH A. LAPADO, et al.,

Defendants.
_____/

NOTICE OF FILING CLOSING DEMONSTRATIVE

Consistent with this Court's instructions, Tr.625:16-25, the State files its closing demonstrative.

Dated: December 22, 2023

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ATTORNEY GENERAL

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Respectfully submitted by:

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LOCAL RULES CERTIFICATION

I certify that this notice complies with this Court's word count, spacing, and formatting requirements.

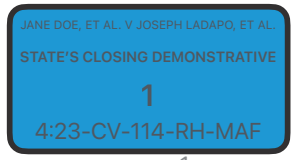
/s/ Mohammad O. Jazil
Mohammad O. Jazil

CERTIFICATE OF SERVICE

I certify that on December 22, 2023, the foregoing was filed using the Court's CM/ECF, which will serve a copy to all counsel of record.

/s/ Mohammad O. Jazil
Mohammad O. Jazil

Doe v. Ladapo Closing



Intentional Discrimination

- Test: Plaintiffs must establish that the at-issue laws were passed "because of," and not merely "in spite of," their unconstitutional effects. *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979).
- Must prove that the Board of Medicine and Board of Osteopathic Medicine and the Surgeon General and the Florida Department of Health and the House and the Senate and the Governor acted "because of" transgender animus.
  - Different than acting because of a concern over low-quality evidence and after weighing risks and benefits of treatments.

Intentional Discrimination

- Dr. Shumer: Tr.197:18 – 198:23

You agree with me that there are some endocrinologists who are reluctant to use gender-affirming care to treat gender dysphoria; right?
A. There are some. However, the body of endocrinologists represented by our professional organizations recognize that hormonal intervention for gender dysphoria is effective.
Q. So you personally have no doubts about the efficacy of puberty blockers and cross-sex hormones to treat gender

dysphoria?
A. I personally have no what?
Q. No doubts about the efficacy of using puberty blockers and hormones to treat gender dysphoria?
A. I don't have a doubt that appropriately assessed and managed patients do better with access to this type of care, yes.
Q. Let me ask you this then: Do you think there's room for good faith doubt among other endocrinologists about the use of puberty blockers and cross-sex hormones to treat gender dysphoria?
A. I think that there's -- I think that there's enough evidence to support the notion that gender-affirming care is safe and effective. You know, if there's an endocrinologist that is in good faith questioning that, I would like to have a conversation with that person about the evidence and understand why they're feeling that way, but I would disagree with them.
Q. Do you believe that there are endocrinologists out there who aren't bigots, who don't say that transgenders don't exist, but who just think that using puberty blockers and cross-sex hormones is inappropriate when treating gender dysphoria?
A. Well, certainly I wouldn't call experts on the other side in this case bigots and yet I disagree with them.
Q. Understood.
Doctor, thank you for your time. No further questions.

Intentional Discrimination: Factors

- Presumption of Good Faith

- Impact, Foreseeability, Knowledge
- Historical Background
- Legislative/Administrative History
- Departures from Procedures
- Statements from Key Legislators, Board Members
- Less Discriminatory Alternatives

Intentional Discrimination: Impact, Knowledge, Foreseeability

- Not every transgender person has gender dysphoria.
  - *Dekker* Tr.115:5-119:22 (Dr. Karasic)
- Regardless, "impact alone is not determinative" of discriminatory animus. *Arlington Heights*, 429 U.S. 252, 266 (1977).

Intentional Discrimination: Historical Background

Legislation	Notes
Senate Bill 1028	• Provisions relating to sports are small part of the omnibus education bill. • "The Legislature finds that maintaining the fairness for women athletic opportunities is an important state interest." • Judge Lagoa: "it is neither myth nor outdated stereotype that there are inherent differences between those born male and those born female and that those born male, including transgender women and girls, have physiological advantages in many sports." *Adams v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791, 819 (11th Cir. 2022) (en banc) (specially concurring).

Intentional Discrimination: Historical Background

Legislation	Notes
House Bill 1557	• Schools should focus on reading, math, and science. • "Classroom instruction by school personnel or third parties on *sexual orientation* or gender identity may not occur in kindergarten through grade 3 or in a manner that is not age appropriate or developmentally appropriate for students in accordance with state standards." • Challenged but not enjoined. *See M.A. v. Fla. State Bd. of Educ.*, 4:22-cv-134 (N.D. Fla. Feb. 15, 2023); *Cousins v. Sch. Bd. of Orange Cnty.*, 6:22-cv-1312 (M.D. Fla. Oct. 20, 2022)
House Bill 1069	Schools should focus on reading, math, and science.
House Bill 1521	"A covered entity that maintains a water closet must, at a minimum, have: (a) A restroom designated for exclusive use by females and a restroom designated for exclusive use by males; or (b) A unisex restroom."

Intentional Discrimination: Historical Background

Legislation	Notes
House Bill 1438	" 'Adult live performance' means any show, exhibition, or other presentation in front of a live audience which, in whole or in part, depicts or simulates nudity, sexual conduct, sexual excitement, or specific sexual activities as those terms are defined in s. 847.001, lewd conduct, or the lewd exposure of prosthetic or imitation genitals or breasts . . . ."

Intentional Discrimination: Administrative History

- Surgeon General Ladapo (PX23 11:1-14):

effectiveness is completely uncertain. I mean, maybe it is effective, but the scientific studies that have shown -- been published to date do not support that. They're just -- you know, they happen to be entirely observational studies. There are issues with confounding. It is impossible to conclude that there is a benefit from the scientific studies that have been published.

This is not to take away from any particular individual's experience, you know, having gone through or not gone through some of the therapies that we'll be discussing today, but it does have to do with what exists currently in the scientific literature.

Intentional Discrimination: Administrative History

- Surgeon General Ladapo (PX23 12:12 – 13:6)

know, you look at standards of care, these procedures clearly fall into an area that is outside what we generally conduct and consider part of the standard of care for medical and surgical therapies. There is no question about that based on the available data. Could that change in the future? It's possible. I think it is very unlikely considering what I've reviewed, but it's possible. But based on what we know today, it clearly falls outside of the standard of care.

On top of that, one has to consider the ability of a minor to provide consent for something that is beyond the complexity of most adults to even competently provide consent. And this just adds an

enormous ethical issue that, again, as clinicians, we have training that tells us how to navigate issues where we don't feel that we can be confident that the patient in front of us is actually providing informed consent for the therapy that he or she is about to undergo.

Intentional Discrimination: Administrative History

- General Counsel Wilson (PX23 18:1-9):

The Legislature created the Board for this exact type of purpose, to gather some of the brightest medical minds in our state, get them together so when such a controversy presents itself, it can be decided by physicians, not politicians, not bureaucrats at the agency, but a group of keenly minded physicians that can exercise due diligence in the research that goes into such an important decision.

Intentional Discrimination: Administrative History

- General Counsel Wilson (PX23 14:21 – 15:2):

> I will let the keen clinical minds of both the Board and your public commenters reach into the research and explain that to you, but the Department's position at the end of the day is that there simply is not evidence that these experimental

> Page 15
> and irreversible treatments are effective for the treatment of gender dysphoria.

Intentional Discrimination: Administrative History

- General Counsel Wilson (PX23 16:4-9)

> to treat gender dysphoria. And number two, because the Florida statutes require that a petitioner asking the Board to initiate rulemaking provide their proposed resolution for the rulemaking process. Our request today, as you highlighted, is simply to begin this process. By doing that, the

Intentional Discrimination: Administrative History

- Doc.190 at 15

  - "There is no literature about what is the natural cause of adolescent onset gender dysphoria." PX24 60:17-19 (Dr. Kaltiala).
  - Age guidelines for gender-dysphoria treatments are based on "capacity," not "anatomic physiology." PX23 41:21 – 42:9 (Dr. Dayton).
  - Gender dysphoria is "not as common as many other medical diagnoses, so there are limited data. And it forces us to develop guidelines without often having core randomized control trials like we'd all like." PX23 49:18-23 (Dr. Haller).
  - European countries "have a limited data set as everybody does, because this is the cutting edge of medicine, the data are the data." PX23 45:13-21 (Dr. Haller).

Intentional Discrimination: Administrative History

- Doc.190 at 15

> We don't have an active registry of our [gender-dysphoric] patients currently. . . .
>
> We don't have ongoing trials with our patients, but we are working, like, on things like registries of our patients. But no specific, like, investigational trials. . . . I do think something like a larger database throughout the country is not only important to have, but actually is something that our pediatric endocrine society has been working toward doing with all the clinics in the country. So it's not yet fully operational, but it is something that a lot of physicians are going to do. . . . [W]e're not necessarily, you know, systematically collecting like surveys from our patients and things like that to do a more prospective. But I do agree that that would be a really great next step that we need to pursue.

PX24 27:9-13; PX23 50:19-22, 51:6-13, 58:16-21.

Intentional Discrimination: Administrative History

- Doc.190 at 16

I consider it of utmost importance [that] severe psychiatric disorders first be treated into remission.

Very seldom we see patients where you could think that the mental health comorbidities would only be secondary and mild. It is often stated in the literature. . . .

I have also myself reviewed the literature and the evidence for—because it is often stated that the gender reassignment will also help in the mental health difficulties and the functional impairments. This is not the case. There is no evidence base for such claims.

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

PX24 56:5 – 57:11.

Intentional Discrimination: Administrative History

- Doc.190 at 17-18

PX24 57:17 – 59:13, 61:1-5.

[Y]ou may be wondering why I seem to have a different evidence from the American speakers. Yes, this is an interesting question, but I have myself reviewed the evidence for the impact of medical gender reassignment on the mental health in children and adolescents. . . . And this is really my sincere understanding that the evidence is lousy.

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

And the other treatment studies after the Dutch study have been even worse. They only have a handful of patients; the follow up times is up to one or two years only; they have been using a variety of instruments; and they mainly have not been able to demonstrate any improvement of mental health or functional capacity—functional abilities; and they have also not reported who were the patients who were not included in the study. So there is no basis for critical (indiscernible) what kind of group is the treatment group representative of.

So evidence is lousy in general regarding mental health and adolescent progress and adolescent development in particular. . . . There as almost all of the other claims of their effectiveness is questionable, based on questionable quality studies. . . .

[T]herefore, I personally think that actually hormonal treatments on gender dysphoria indication for children and adolescents should preferably be limited into the context of formal research studies at the moment.

Intentional Discrimination: Administrative History

- Doc.190 at 19

> In the example we always use in oncology is back in the 1990s, thousands and thousands of women with locally advanced breast cancer were undergoing bone marrow transplant and a very, very toxic, very difficult procedure. And everyone thought it ought to work. The data from South Africa purported that it did work. And guess what? It didn't work. And it was a terrible experience.

PX23 51:23 – 52:6.

Intentional Discrimination: Legislative History

- Doc.190 at 20-21

> I had several comorbidities that the doctors failed to rule out or address. I was previously diagnosed with ADHD, but it actually turned out later that I'm actually on the spectrum. And it was actually the gender specialist, the same one who referred me to surgery, who about a year afterward told me that I had some pretty key symptoms of autism, that I should be screened for it. And even if I was diagnosed with autism, my doctors still would have transitioned me.
>
> PX27 47:8-17.

Intentional Discrimination: Administrative History

- Doc.190 at 23-24
  - (PX39 66:11 – 67:25)

Attorney McNulty: Thank you. And then the second item on that same page is . . . where it requires the DEXA scan. But the other forms say annual. Is there a length of time you want that DEXA scan, like what period of time? Or just—the other forms say like annual bone scan but I'm not sure—

Dr. Ackerman: Other forms said a bone scan. It's a DEXA scan, not a bone scan.

Attorney McNulty: It says, "Bone DEXA scan."

Dr. Ackerman: No, no. It's a DEXA scan, it's not a bone scan.

Dr. Benson: It's a bone density scan.

Attorney McNulty: So what should the right—

Dr. Ackerman: A bone scan is a nuclear study that looks at osteoblastic changes in the bones. A DEXA scan is basically a low dose x-ray of the bone to look at the bone density. So it should be—it's a DEXA scan, it's not a bone scan.

Dr. Benson: You could put a bone density scan or something.

Dr. Ackerman: Yeah. Bone density scan, yeah. Bone density scan. Don't use—so I move that we change all of that terminology to say, "Bone density scan (DEXA)."

Attorney Dierlman: Do you want it to say annual across all—

Dr. Ackerman: No, no. I didn't get there yet.

Intentional Discrimination: Administrative History

- Doc.190 at 23-24

Attorney Dierlman: Okay.

Dr. Ackerman: We'll go with that in a second. Let's clarify what it is. "Bone density scan (DEXA scan)."

Unidentified Speaker: Yeah, yeah.

Dr. Ackerman: Because I get this—it happens to me all the time that a patient needs a DEXA scan, and they get a bone scan. No, no. Because—all the time.

PX39 66:11 – 67:25.

Dr. Ackerman: Box six, "I understand my surgery—risk factors." Those are breast cancer, right, the breast cancer risk factors one?

Chairman Romanello: Yes.

Dr. Ackerman: So it says, "I.e." bracket one, bracket to [sic]. Technically, it should be "E.g."

Chairman Romanello: Okay.

Dr. Ackerman: For example, not that is. I.e. is that is, meaning those are the only two. E.g. is for example. There's more than just those two.

PX39 128:1-11.

Intentional Discrimination: Administrative History

- Doc.190 at 24

[R]emind[] me of a lot of the consent forms that I use in my practice when I have patients that are involved in cancer treatment, especially ones that are involved with getting multiple different drugs and radiation. In that it's not just a general consent form where you're signing away—you're signing not waiver. You're signing saying, "I accept puberty blockers." But it's

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going through each of the benefits, and risks of those puberty blockers, and what one could accept over time."

PX39 16:14-24

Intentional Discrimination: Historical Background

- Senator Yarborough on SB254's custody provision (PX29 7:6-17):

> The PCS amends Florida's child custody statutes to give courts in this state jurisdiction to enter, modify, or stay a child custody determination relating to a child in this state to protect the child from being subjected to sex reassignment prescriptions or procedures.
>
> Next, the provision gives courts broad discretion to determine whether and how to protect a child, but the provision does not require a court to take any specific action or require a court to ignore a child custody determination made by a court of another state.

Intentional Discrimination: Alleged Departures

- Plaintiffs say that the Florida Department of Health sought rulemaking without complaints or deaths.
- § 120.54(7)(a) PETITION TO INITIATE RULEMAKING.—
- *Any person* regulated by an agency or having substantial interest in an agency rule may petition an agency to adopt, amend, or repeal a rule or to provide the minimum public information required by this chapter. The petition shall specify the proposed rule and action requested. Not later than 30 calendar days following the date of filing a petition, the agency shall initiate rulemaking proceedings under this chapter, otherwise comply with the requested action, or deny the petition with a written statement of its reasons for the denial.

Intentional Discrimination: Alleged Departures

- Plaintiffs note the out-of-order public comment during one hearing
  - Chair Diamond (PX25 50:2-11)

CHAIRMAN DIAMOND: Very good. At this point we're going to transition to comment. What we're going to do is the following. First, I understand we have two representatives of the people here. Mr. Nathan Bruemmer, who is an assistant to the Commissioner of Agriculture, Nikki Fried. And we're going to invite Mr. Bruemmer to speak for three minutes. And then I understand that we have State Representative, Anna Eskamani and we're going to invite her to speak for three minutes.

Intentional Discrimination: Alleged Departures

- Plaintiffs omit that pro-treatment experts testified at the August 5, 2022 and October 28, 2022 hearings
  - August 5:
    - Dr. Haller (PX23 19:22)
  - October 28:
    - Dr. Dayton (PX24 18:4)
    - Dr. Janssen (PX24 33:12)
    - Dr. Kaltiala (PX24 47:7)
    - Dr. McNamara (PX24 73:14)

Intentional Discrimination: Alleged Departures

- PX75

10/28/22

Invited/Confirmed

Michael Biggs, PhD – Associate Professor of Sociology and Fellow of St Cross College, University of Oxford (virtual)

James Cantor, PhD – Clinical psychologist, Director of the Toronto Sexuality Centre

Michael Laidlaw, M.D. – Board certified in internal medicine and the subspecialties of endocrinology, diabetes, and metabolism

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Invited/Not Confirmed

Caroline Davidge-Pitts, M.D. – Board certified in internal medicine and endocrinology; Co-chair of the Endocrine Society Special Interest Group for Transgender Research and Medicine

Kristin Dayton, M.D. – Board certified in pediatrics and pediatric endocrinology, Clinical Assistant Professor at the University of Florida

Jonathan Poquiz, PhD – Pediatric psychologist, Clinical Director of the Gender Affirming Care Clinic at Johns Hopkins All Children's Hospital

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Potential Invitees

Detransitioner

Invited/Declined

Riittakerttu Kaltiala, M.D. – Adolescent and forensic psychiatrist, Chief of the Department of Adolescent Psychiatry at Tampere University Hospital (invited to 9/30 workshop only)

Alejandro Diaz, M.D. – Board certified in pediatrics and pediatric endocrinology, Chief of the Division of Pediatric Endocrinology at Nicklaus Children's Pediatric Specialists

Suzanne Jackman, M.D. – Board certified in pediatrics and pediatric endocrinology, Interim Medical Director at Johns Hopkins All Children's Hospital, Division of Endocrinology and Diabetes

Sean Iwamoto, M.D. – Specializes in endocrinology, transgender health, obesity, and aging; Co-chair of the Endocrine Society Special Interest Group for Transgender Research and Medicine

Endocrine Society

Intentional Discrimination: Alleged Departures

- Plaintiffs state that no pro-treatment expert spoke during the Fine hearings (PX27 39:1-20)

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

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

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

Intentional Discrimination: Alleged Departures

- Plaintiffs state that Governor DeSantis appointed anti-transgender board members to the board.
  - Plaintiffs produce no evidence as to why Dr. Creegan or Dr. Coffman, for example, were appointed to the Florida Board of Osteopathic Medicine.
  - As for Dr. Mortensen (Depo 125:9-24):

Monica Mortensen, D.O
September 28, 2023

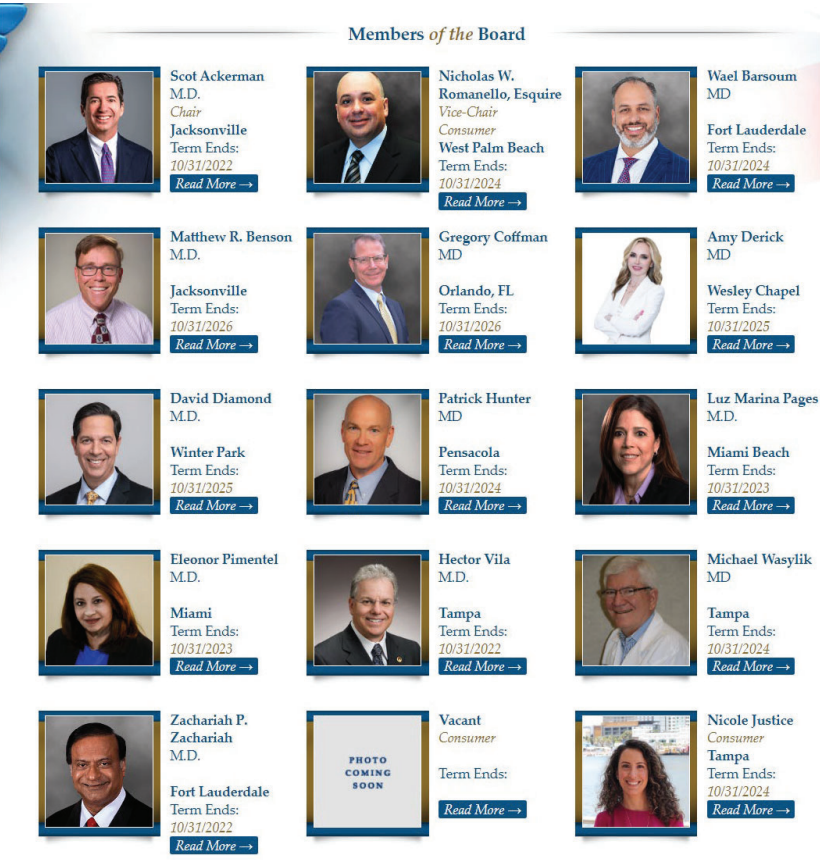
Page 125

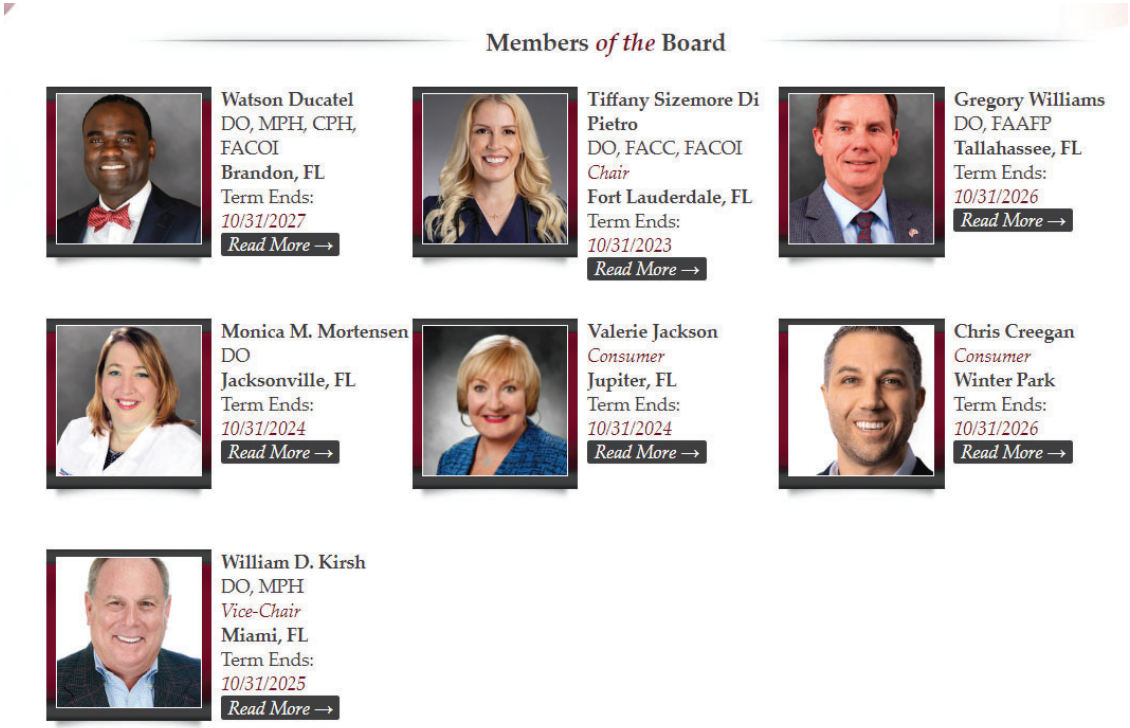
Q I apologize. The process of you being -- I assume there are more candidates, that everybody who applies doesn't get appointed to the Board?
A I would assume as well.
Q What goes into how they decide who will be appointed to the Board?
A You have to ask them, I'm not part of the decisionmaking process of who gets to be on the Board.
Q Okay. Do you have any idea why you were selected?
A I believe because there's no one doing pediatrics on the Board. I also had worked at a federally qualified health center that worked with family practice, we did funding, we did a lot of QI, so I have a QI background. I did pediatrics, as well as pediatric endocrinology also, and as part of doing that job we looked at standards of care for screening for breast cancer, heart disease, vaccinations, and I've also, as you had mentioned earlier, that I'm, you know, certified to read densitometry, so that's also big for women's health, a women's health issue as well. So I have a pretty vast background, so I've been doing it for a while, so I would assume that would have played a role in it.
Q Did anyone other than Dr. Benson encourage you

Intentional Discrimination: Statements

- Dr. Hunter: PX 25 27:25 – 28:2 (“Children and youth with gender dysphoria are suffering. They need care, the best possible care, excellent care.”)
- Representative Rudman: PX30 88:8-9 (“And because I do care deeply for these patients, I’m up on your bill”).
- Representative Bell: PX30 92:2-3 (“we’re not trying to hurt them; we’re trying to help them”)
- Representative Fine: PX36 45:13-22 (“Members, they are begging us to help them. I agree with the back rows on one thing. Every so-called transgender person begged us for help in committees. Ralph and I have talked about it. They are not evil. They are victims. I don't hate them. My heart breaks for what has been done to them. I'm haunted by the stories of the children I have talked to who were told this was a good idea and then have had their lives destroyed as a result. I fight for those children.”).

Intentional Discrimination: Statements





Intentional Discrimination: Statements

CS/SB 254, 1st Eng. Passage

Yeas - 83 | Nays - 28 | Not Voting - 8

Presiding - Payne

Yeas	Nays	Not Voting
Y Abbott-5	N Eskamani-42	Y Overdorf-85
Y Altman-32	Y Esposito-77	Y Payne-20
Y Alvarez-69	Y Fabricio-110	Y Perez-116
Y Amesty-45	Y Fernandez-Barquin-118	Y Persons-Mulicka-78
Y Anderson-57	Y Fine-33	Y Plakon-36
Y Andrade-2	Franklin-8	Y Plasencia-37
N Antone-41	N Gantt-109	Y Porras-119
N Arrington-46	Y Garcia-115	Rayner-Goolsby-62
Y Baker-17	Y Garrison-11	Y Renner-19
Y Bankson-39	Y Giallombardo-79	Y Rizo-112
Y Barnaby-29	Y Gonzalez Pittman-65	Y Roach-76
N Bartleman-103	Y Gossett-Seidman-91	N Robinson, F.-104
Y Basabe-106	N Gottlieb-102	Y Robinson, W.-71
Y Bell-49	Y Grant-75	Y Rommel-81
Y Beltran-70	Y Gregory-72	Y Roth-94
Benjamin-107	Y Griffitts-6	Y Rudman-3
Y Berfield-58	N Harris-44	Y Salzman-1
Y Black-15	N Hart-63	Y Shoaf-7
Y Borrero-111	Y Hawkins-35	N Silvers-89
Y Botana-80	N Hinson-21	Y Sirois-31
Y Brackett-34	Holcomb-53	N Skidmore-92
Bracy Davis-40	N Hunschofsky-95	Y Smith-38
Y Brannan-10	Y Jacques-59	Y Snyder-86
Y Buchanan-74	Joseph-108	Y Stark-47
Y Busatta Cabrera-114	Y Killebrew-48	Y Steele-55
N Campbell-99	Y Koster-66	Y Stevenson-18
Y Canady-50	Y LaMarca-100	N Tant-9
Y Caruso-87	Y Leek-28	Y Temple-52
N Casello-90	N López, J.-43	Y Tomkow-51
N Cassel-101	Y Lopez, V.-113	Y Trabulsy-84
N Chambliss-117	Y Maggard-54	Y Tramont-30
Y Chaney-61	Y Maney-4	Y Truenow-26
Y Clemons-22	Y Massullo-23	Y Tuck-83
N Cross-60	Y McClain-27	N Valdés-64
N Daley-96	Y McClure-68	N Waldron-93
Daniels-14	Y McFarland-73	N Williams-98
N Driskell-67	Y Melo-82	N Woodson-105
Y Duggan-12	Y Michael-16	Y Yarkosky-25
N Dunkley-97	Y Mooney-120	Y Yeager-56
Edmonds-88	N Nixon-13	

CS/SB 254
Returning Messages

Yeas - 26 | Nays - 13 | Not Voting - 1

Presiding - President Passidomo

Yeas	Nays	Not Voting
Y Albritton-27	Y DiCeglie-18	N Polsky-30
Y Avila-39	Y Garcia-36	N Powell-24
Y Baxley-13	Y Grall-29	Y Rodriguez-40
N Berman-26	Y Gruters-22	N Rouson-16
N Book-35	N Harrell-31	Y Simon-3
Y Boyd-20	Y Hooper-21	N Stewart-17
Y Bradley-6	Y Hutson-7	N Thompson-15
Y Brodeur-10	Y Ingoglia-11	N Torres-25
Y Broxson-1	N Jones-34	Trumbull-2
Y Burgess-23	Y Martin-33	Y Wright-8
Y Burton-12	Y Mayfield-19	Y Yarborough-4
Y Calatayud-38	N Osgood-32	Y President Passidomo-28
Y Collins-14	Y Perry-9	
N Davis-5	N Pizzo-37	

Intentional Discrimination: Statements

- Doc.190 at 22

- Protecting patients. *E.g.*, PX30 88:8-9 (March 22, 2023, House Healthcare Regulation Subcommittee) ("because I do care deeply for these patients, I'm up on your bill"); PX30 92:25 – 93:2 ("our primary role as legislators, as lawmakers of Florida, or any state, is to protect our citizens").
- The need for the Florida Legislature to "draw the line when drastic life-altering gender dysphoria therapies and surgeries are being prescribed for our children." PX29 5:11-14 (March 13, 2023, Senate Health Policy Committee); PX29 117:20-24 (same).
- A concern that "given the seriousness of the" at-issue "procedure[s]," consultations and informed-consent discussions "should be done with a doctor in person." PX30 31:17-19; *see also* PX31 10:22 – 11:2 (March 23, 2023, Florida Senate Fiscal Policy Committee) ("The treatments have the potential for life-altering effects and should be provided by our most highly educated and trained health care practitioners, as well as being regulated in a heightened manner and differently than most other medical treatments.").
- A worry that the medical profession was not doing right by their patients. PX36 20:17-24 (April, 19, 2023, House Session) ("[A]s we learned from the situation up at Vanderbilt, we now know there are plenty of doctors who are not guided by conscience but by the fact that these surgeries pay a lot of money. . . . The art of medicine is not for sale.").

Intentional Discrimination: Alternatives

House Bill 1421	Senate Bill 254
Contained a birth-certificate provision	No birth-certificate provision
Prevented public *and private* insurance from covering certain gender-dysphoria treatments	Prevented only public insurance from covering certain gender-dysphoria treatments
Contained a grandfather provision for minors who obtained puberty blockers and cross-sex hormones before bill enactment; grandfather provision would end December 31, 2023	Contained a grandfather provision for minors who obtained puberty blockers and cross-sex hormones before bill enactment; no end date

Eknes-Tucker: Rational Basis Met

- "First, the record evidence is undisputed that the medications at issue present *some* risks. As the district court recognized, these medications can cause loss of fertility and sexual function. The district court also acknowledged testimony that several European countries have restricted treating minors with transitioning medications due to growing concern about the medications' risks." 80 F.4th 1205, 1225
- "Second, there is at least rational speculation that some families will not fully appreciate those risks and that some minors experiencing gender dysphoria ultimately will desist and identify with their biological sex. . . . That connection would be sufficient under rational basis review." 80 F.4th 1205, 1225

Eknes-Tucker: Rational Basis Met

- Plaintiffs fight with the *Eknes-Tucker* three-judge panel
- Lead Counsel:
  - "The experts are going to testify about the lack of medical justification" for the at-issue laws. Tr.923-24.

State Supports Cautious Approach

- Doe: Tr.43:2-11

she felt comfortable.
Q. Okay. So in that initial consultation with the pediatrician, did the pediatrician recommend that you facilitate the social transition or that you sort of take a wait-and-see approach? Which did the physician suggest to you?
A. During the very first time, it was just kind of a wait-and-see, and then the -- we brought her back and it was persisting, and that's when he said, you know, like, This is going to pass or it's not. Either way it's going to be okay. It's causing her a lot of anxiety, so allow her to dress as she's comfortable.

State Supports Cautious Approach

- Hamel: Tr.92:10 – 93:16

And you mentioned that Dr. Hudson started you with what I'll call a cautious dose. You correct me if I'm wrong.

A. That's a good way to say it, yes.

Q. Okay. So he started you on a cautious dose, half the level of testosterone you would otherwise use; right? And that continued for several months, if I understood that right?

A. Yes.

Q. And was that informed consent process one conversation? Was it an ongoing conversation? How did that transpire?

A. For pretty much all of those initial visits before I received a full regular dose of testosterone, we talked about it pretty much every single visit, yeah. We talked about the risks associated with taking testosterone, you know, especially after I began taking those cautious doses, as you said. We talked about how am I feeling. You know, this could -- you know, does this feel okay? Do you feel normal? How is your emotional level? Because, you know, hormones, they do affect your emotions, and we discussed all of that at length. So I would say every visit.

And even after I received my regular dose, I was once again kind of walked through that informed consent of, like, you know, this is what these changes are; these are the permanent changes; these are, you know, what can change if your doses change or anything like that. So every visit I was walked through informed consent, yes, to some degree.

State Supports Cautious Approach

- Doe: Tr.41:24 – 42:5

24 Q. And when she began identifying with the female gender
25 identity, did you, your husband, your family go all in on the

1 social transition, refer to her by the female pronoun, etc.?
2 A. Are you asking if we did that very initially?
3 Q. Yes, ma'am. From the 2 to 3 age, did you do that then?
4 A. We didn't do it the first couple of months. We did it
5 after quite some time.

Goe: Tr.63:16-22

16 Ms. Goe, if I understand this right, your son began
17 identifying with the male gender at age 4; right?
18 A. Yes.
19 Q. And that's the point at which you also began the process of
20 social transition, using the preferred pronouns, getting the
21 haircut he liked; right?
22 A. Yes.

State Supports Cautious Approach

- *Dekker* DX24, ES_12

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence

Dekker DX24, ES_15

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that

Informed Consent Forms

- Plaintiffs seek to constitutionalize the WPATH and Endocrine Society Guidelines
- Dr. Janssen: Tr.133:9-18

treatment.

Do you recognize this statement?

A. I do.

Q. Do you know what HRT refers to?

A. I do, hormone replacement therapy.

Q. And where does this statement come from?

A. This comes from the consent form for feminizing medications for adults.

Q. Is it required that a person receiving hormone replacement therapy, whether it be testosterone or a feminizing medication, be under the care of a licensed mental health care professional while undergoing that treatment?

A. No. We have a myriad of medicines in our field that impact mood, and this is not a requirement for any of those.

Q. Is it required under the WPATH Standards of Care?

A. It's not.

Q. Is it required under the Endocrine Society guidelines?

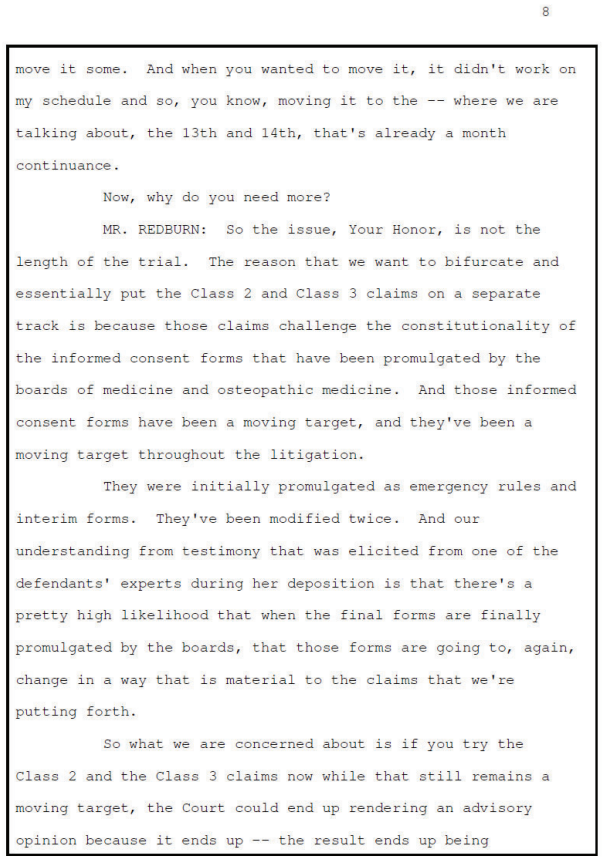
A. It is not.

Informed Consent Forms

- (1) expedited (60 days to pass)
- (2) drafted by doctors and lawyers, not best wordsmiths
- (3) will be superseded by permanent rules

- Consider the medical marijuana informed consent forms (DX8)

Informed Consent Forms: Minor Forms Don't Matter (Oct. 16, 2023, Tr.8:6 – 10:19)



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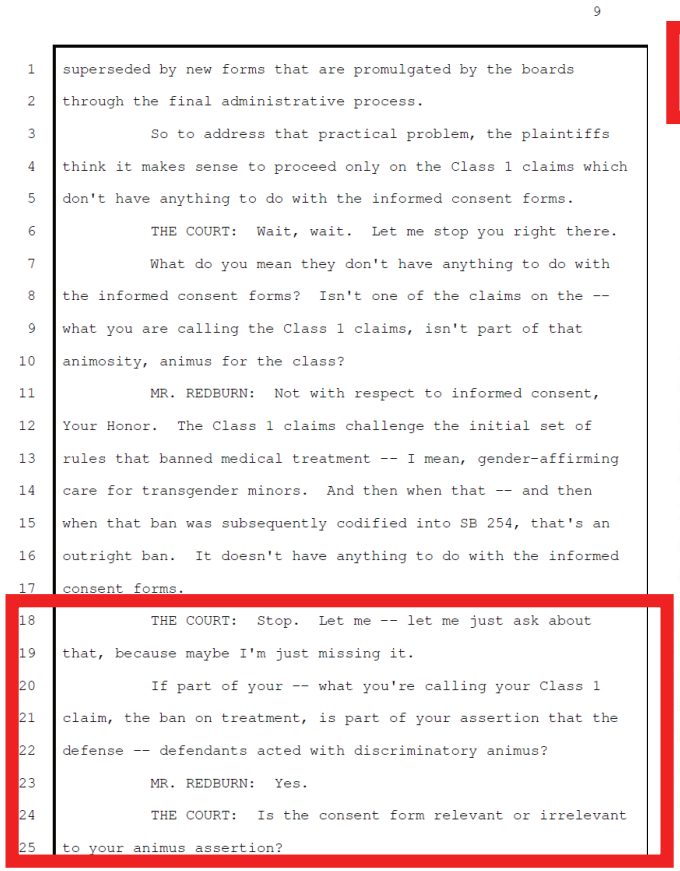
move it some. And when you wanted to move it, it didn't work on my schedule and so, you know, moving it to the -- where we are talking about, the 13th and 14th, that's already a month continuance.

Now, why do you need more?

MR. REDBURN: So the issue, Your Honor, is not the length of the trial. The reason that we want to bifurcate and essentially put the Class 2 and Class 3 claims on a separate track is because those claims challenge the constitutionality of the informed consent forms that have been promulgated by the boards of medicine and osteopathic medicine. And those informed consent forms have been a moving target, and they've been a moving target throughout the litigation.

They were initially promulgated as emergency rules and interim forms. They've been modified twice. And our understanding from testimony that was elicited from one of the defendants' experts during her deposition is that there's a pretty high likelihood that when the final forms are finally promulgated by the boards, that those forms are going to, again, change in a way that is material to the claims that we're putting forth.

So what we are concerned about is if you try the Class 2 and the Class 3 claims now while that still remains a moving target, the Court could end up rendering an advisory opinion because it ends up -- the result ends up being



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superseded by new forms that are promulgated by the boards through the final administrative process.

So to address that practical problem, the plaintiffs think it makes sense to proceed only on the Class 1 claims which don't have anything to do with the informed consent forms.

THE COURT: Wait, wait. Let me stop you right there.

What do you mean they don't have anything to do with the informed consent forms? Isn't one of the claims on the -- what you are calling the Class 1 claims, isn't part of that animosity, animus for the class?

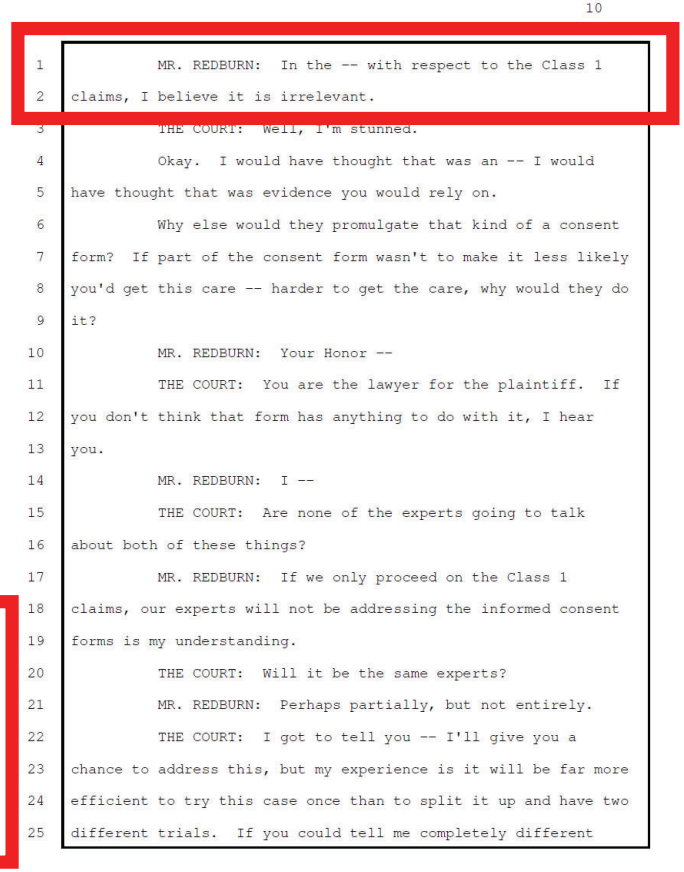
MR. REDBURN: Not with respect to informed consent, Your Honor. The Class 1 claims challenge the initial set of rules that banned medical treatment -- I mean, gender-affirming care for transgender minors. And then when that -- and then when that ban was subsequently codified into SB 254, that's an outright ban. It doesn't have anything to do with the informed consent forms.

THE COURT: Stop. Let me -- let me just ask about that, because maybe I'm just missing it.

If part of your -- what you're calling your Class 1 claim, the ban on treatment, is part of your assertion that the defense -- defendants acted with discriminatory animus?

MR. REDBURN: Yes.

THE COURT: Is the consent form relevant or irrelevant to your animus assertion?



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MR. REDBURN: In the -- with respect to the Class 1 claims, I believe it is irrelevant.

THE COURT: Well, I'm stunned.

Okay. I would have thought that was an -- I would have thought that was evidence you would rely on.

Why else would they promulgate that kind of a consent form? If part of the consent form wasn't to make it less likely you'd get this care -- harder to get the care, why would they do it?

MR. REDBURN: Your Honor --

THE COURT: You are the lawyer for the plaintiff. If you don't think that form has anything to do with it, I hear you.

MR. REDBURN: I --

THE COURT: Are none of the experts going to talk about both of these things?

MR. REDBURN: If we only proceed on the Class 1 claims, our experts will not be addressing the informed consent forms is my understanding.

THE COURT: Will it be the same experts?

MR. REDBURN: Perhaps partially, but not entirely.

THE COURT: I got to tell you -- I'll give you a chance to address this, but my experience is it will be far more efficient to try this case once than to split it up and have two different trials. If you could tell me completely different

Informed Consent Forms: Expert Help

- Dr. Shumer: Tr.183:4-9

Q. Assume for a moment that they are going through rulemaking and the rulemaking is soliciting comments from experts such as yourself.

Would you be willing to put forward your comments in the rulemaking process and explain why it is the forms can be improved upon and how they can be improved upon?

A. I would be happy to help with something like that, although I think a more appropriate form would be written by the providers that are providing the care.

Telemedicine

- Hamel (below): Tr.90:19-21
- Doe (right): Tr.46:16 – 47:7

Q. And was that diagnosis by a psychiatrist after an in-person consultation with a psychiatrist?
A. Yes, it was all in person.
Q. Was it one consultation or several where you discussed the list of things that you highlighted in your direct: The history of depression, anxiety, family, et cetera?
A. I had several meetings with my therapist and one full

Cross-Examination – Mr. Hamel 91

Q. And if we take a look at the progress notes, they discuss Susan's progression puberty-wise; right? Do I have that right?
They discuss enlargement of the scrotum and some peach fuzz. Did I read that right, ma'am?
A. Yes.
Q. And this evaluation was done by telemedicine, so my question is this: How is it that the physicians over Zoom could assess the progression towards puberty? Did they take your word for it? Did you describe it? Is that how it worked?
A. Yes.

Cross-Examination – Ms. Doe 47

Q. And if we go to the next page, the physical exam, it says that no vitals were taken. There was no height or weight.
Did the physicians ask you how tall Susan is, how much she weighs, etc.?
A. Is this the one over the phone?
Q. Yes, ma'am.
A. No.

Telemedicine

- Hamel: Tr.92:6-8

I came back to review my base labs. I had a third consultation, at which I was administered my first half dose of testosterone, and then -- that was in January. So from January, February, March, and April, I think it's about six -- five or six visits, I believe, to the best of my recollection.

Q. And how many of those visits were in person versus telehealth?

A. In person, all of them were.

Telemedicine

- Dr. Janssen: Tr.122:3-8

diagnosis and come up with a treatment plan that is much more tailored and effective.

Q. What are the drawbacks to using telehealth for your patients?

A. For some patients telehealth is not an effective way of engaging with their primary team, and for those kids, we ask them to come in if we're not able to get the information we need from telehealth.

Telemedicine

- Dr. Shumer: Tr.193:4-22

Q. So let me ask you this: Before you prescribe the medications to someone, you'd want to see them in person or have someone take their vital signs in person so that you know the right dose of testosterone or estrogen or whatever else it is that you're prescribing for the patient, right?

A. There are certain reasons that I definitely need to see a patient in person, right? Tanner Staging, for example. I'm not going to have them go to their primary care doctor to get Tanner-Staged. I'm going to do that myself.

So before starting on GnRH agonist, and if I need to know that they're in Tanner Stage 2, which I do, there will be an in-person visit. But then at the -- you know, at subsequent visits, there's a discussion about what we're going to need to do at those visits.

For some patients an in-person visit is going to be helpful, but if the only aspect of helpfulness of an in-person visit is obtaining vital signs or getting labs done, there's other ways to do that besides having them drive potentially four hours to Ann Arbor.

Telemedicine

- Dr. Shumer: Tr.193:23 – 194:3

Q. Got it. And so I'd like to follow up on that.
So when you're looking to see whether or not Tanner Stage 2 is developed -- and forgive me. I'm going to put this in

layperson's term -- you're trying to see whether, for a natal male, for example, the scrotum has started developing; right?
A. Sure.

Telemedicine

Dr. Shumer: Tr.194:4 – 195:20

Q. So let me ask you this: Before you prescribe the medications to someone, you'd want to see them in person or have someone take their vital signs in person so that you know the right dose of testosterone or estrogen or whatever else it is that you're prescribing for the patient, right?

A. There are certain reasons that I definitely need to see a patient in person, right? Tanner Staging, for example. I'm not going to have them go to their primary care doctor to get Tanner-Staged. I'm going to do that myself.

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For some patients an in-person visit is going to be helpful, but if the only aspect of helpfulness of an in-person visit is obtaining vital signs or getting labs done, there's other ways to do that besides having them drive potentially four hours to Ann Arbor.

screening labs are completely normal, then I might say to that patient, Do you have a preference for whether the next visit is in person or virtual and what's going to be easier for you to accommodate?

Q. And in the telehealth medicine visits that you do, do you use Zoom?

A. Yes.

Q. Does the signal sometimes drop?

A. That's happened before, yes.

Q. All right. And when you're doing these telehealth visits, is it fair to assume the patient's seeing you from the chin up?

A. That is fair to say.

Q. And you're seeing the patient chin up, right, most of the time?

A. That's true.

Q. And sometimes, you know, you're maybe looking at their elbow facing the camera and not their face?

A. This is all true, but I haven't found telemedicine to be less effective -- a less effective way of practicing medicine and sometimes more effective with certain patients.

Q. So when you're making the -- not you, your team is making the initial diagnosis for gender dysphoria, do they sometimes do the diagnosis via telehealth as well?

A. Yes.

Q. And when they're doing that, how do you pick up something

Nurses

- Dr. Janssen: Tr.119:3-13

provided by a primary care provider?
A. Yes.
Q. Are there other mental health conditions that are commonly treated by primary care providers?
A. Yes, thankfully, and it's one of the goals that we have in our field, is to train pediatricians, in particular, how to do more mental health care within their practices. There's a few of us child psychiatrists and nurse practitioners who work in mental health that it's really important to help educate others about identifying common psychiatric disorders early in their course. So we commonly train pediatricians, and pediatricians are expected to learn in their training programs how to treat ADHD, depression, anxiety, as examples.

Nurses

- Dr. Janssen: Tr.136:18-24

Q. What is that harm?

A. The harm is multifold. Number one is many pediatricians and internal medicine docs, nurse practitioners, and physician assistants who work outside of mental health aren't trained to do appropriate suicide risk assessments and so will often refer unnecessarily to emergency rooms which are already overcrowded and often bursting at the seams and unable to meet the needs of these patients.

The second is that they are exposed to a line of

Nurses

- Dr. Shumer: Tr.185:25 – 186:3

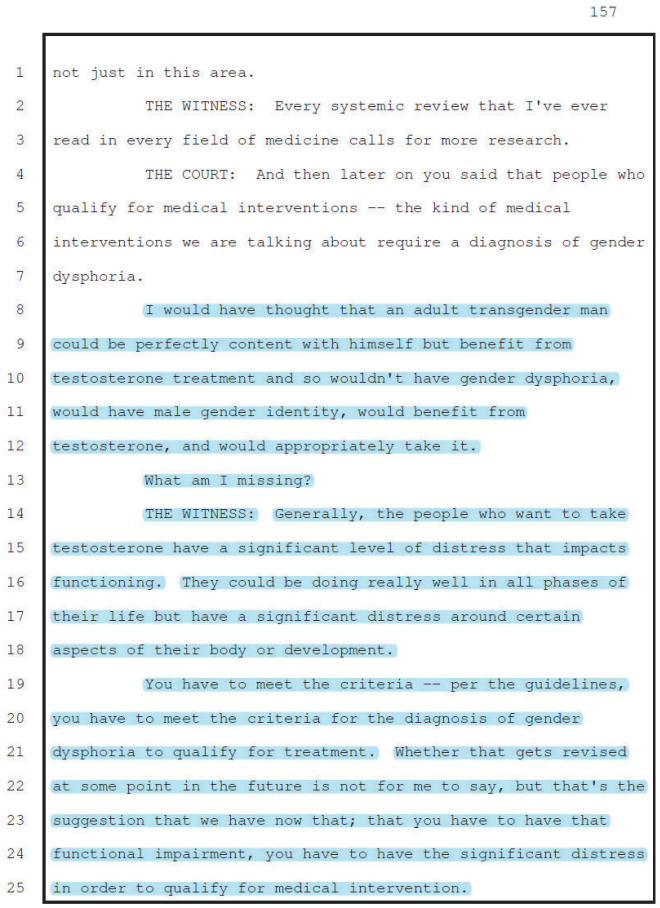
25 Q. Got it. So it's licensure in the field to be a social

1 worker generally, not licensure specific to the treatment and
2 diagnosis of gender dysphoria; right?
3 A. Correct.

Abbie Rolf: *Dekker* Tr.676:4 – 677:14

Q. The second letter that you mentioned, you said that you got that letter from someone you hadn't seen before.
Did I understand that right?
A. Yes.
Q. Was that someone named Abbie Rolf?
A. Yes.
Q. I'd like to --
MR. JAZIL: And this is not for the public screen. I'd like to pull up Plaintiffs' Exhibit 237A.
BY MR. JAZIL:
Q. Mr. Dekker, would you mind taking a look at that letter? And let me know if you'd like us to scroll down. It's two pages.
Sir, is that the letter you received, the second letter?
A. Yes.
Q. And it says here on the top: *My name is Abbie Rolf, MA, Registered Mental Health Counselor Intern.*
Do you see that, sir?
A. Yes.
Q. It goes on to say, last sentence of the first paragraph: *I have personally completed 10 hours of training specifically related to assessment and letter-writing for gender-affirming medical interventions and provide training to others on the same.*
Do you see that, sir?
A. Yes.
Q. The last paragraph on the first page, it says that: *It is my professional opinion that in this way, he meets the diagnostic criteria as defined in the Diagnostic and Statistical Manual Fifth Edition.*
Do you see that, sir?
A. Yes.

Need a Gender Dysphoria Diagnosis



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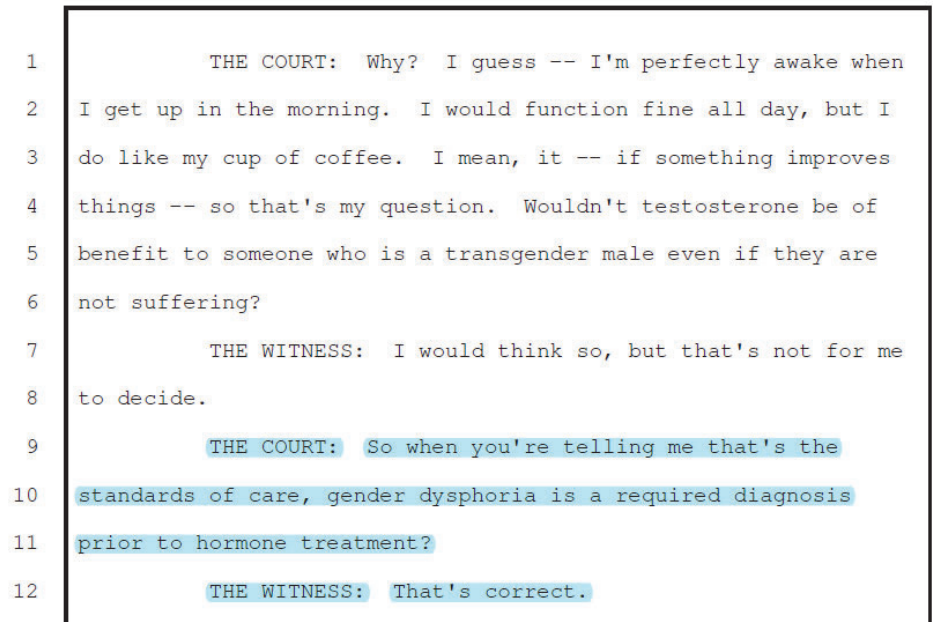
not just in this area.
THE WITNESS: Every systemic review that I've ever read in every field of medicine calls for more research.
THE COURT: And then later on you said that people who qualify for medical interventions -- the kind of medical interventions we are talking about require a diagnosis of gender dysphoria.
I would have thought that an adult transgender man could be perfectly content with himself but benefit from testosterone treatment and so wouldn't have gender dysphoria, would have male gender identity, would benefit from testosterone, and would appropriately take it.
What am I missing?
THE WITNESS: Generally, the people who want to take testosterone have a significant level of distress that impacts functioning. They could be doing really well in all phases of their life but have a significant distress around certain aspects of their body or development.
You have to meet the criteria -- per the guidelines, you have to meet the criteria for the diagnosis of gender dysphoria to qualify for treatment. Whether that gets revised at some point in the future is not for me to say, but that's the suggestion that we have now that; that you have to have that functional impairment, you have to have the significant distress in order to qualify for medical intervention.

- Dr. Janssen: Tr.157:8 – 158:12



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THE COURT: Why? I guess -- I'm perfectly awake when I get up in the morning. I would function fine all day, but I do like my cup of coffee. I mean, it -- if something improves things -- so that's my question. Wouldn't testosterone be of benefit to someone who is a transgender male even if they are not suffering?
THE WITNESS: I would think so, but that's not for me to decide.
THE COURT: So when you're telling me that's the standards of care, gender dysphoria is a required diagnosis prior to hormone treatment?
THE WITNESS: That's correct.

Threats Against Public Policy Makers

- Director Vazquez testified about a recent death threat
- Commentor: “Everyone in this room, and I promise you, your names, your emails, your phones, your emails, your phones, everything will be published, and you will not live the moment down. Every person that kills themselves because of this that I know, I will make sure their family contacts you. The blood is on your hands.” PX25 77:22 – 78:3.
- The rules are “dangerous, regressive, purposefully hateful, and another strong step towards fascism for the state of Florida.” PX25 86:11-13 .