

**THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division**

AUGUST DEKKER, et al.,

Plaintiffs,

v.

JASON WEIDA, et al.,

Defendants.

Case No. 4:22-cv-00325-RH-MAF

**DECLARATION OF ATTORNEY JOE LITTLE
IN SUPPORT OF PLAINTIFFS' OPPOSITION TO
DR. MIRIAM GROSSMAN'S MOTION TO QUASH SUBPOENA**

I, Joe Little, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am over the age of eighteen and make this declaration from my own personal knowledge.
2. I am an attorney with Pillsbury Winthrop Shaw Pittman LLP in Sacramento, California, and I have been retained by Plaintiffs as co-counsel in the above-captioned matter.
3. I was granted leave to appear in this case *pro hac vice* on September 15, 2022 (ECF No. 27).
4. I make this Declaration in support of Plaintiffs' Opposition to Dr. Miriam Grossman's Motion to Quash Subpoena (ECF No. 93).

5. In December 2022, I conducted public records searches which indicated that Dr. Grossman most recently resided in Los Angeles. The process server my firm employed was unsuccessful at serving Dr. Grossman at the Los Angeles address.

6. Dr. Grossman explained to Plaintiffs' counsel on January 5th, 2023 that she now lived in New York and that her attorney would be in touch soon.

7. Following communications with Dr. Grossman on January 5, 2023, Plaintiffs' counsel immediately caused the subpoena to be routed for service in New York.

8. On January 26th, I identified authority suggesting the need to reissue the subpoena due to geographical limitations on the place for production. So, I issued a second subpoena the next day. Attached as **Exhibit A** is a true and correct copy of Plaintiffs' second subpoena dated January 27, 2023, served on Dr. Grossman in Monsey, New York and which is the operative subpoena in this matter.

9. On Friday, February 3, 2023, the first mutually agreeable time for counsel to meet, I spoke on the phone with Dr. Grossman's counsel Daniel Nordby. Early in the call, I corrected Mr. Nordby's stated misconception that only one subpoena had been issued and served in this matter. Following my correction and Mr. Nordby's apparent acceptance of this correction, neither of us broached the issue again prior to Mr. Nordby's filing of the instant Motion. I expected that Mr. Nordby would inquire further with his client regarding the existence of a second subpoena, the service of

which moots both the jurisdictional and timing concerns raised in the Motion.

10. For the rest of this twelve-minute Friday afternoon call, Mr. Nordby and I discussed the remaining objections to the subpoena. I offered to relay the discussion to his co-counsel and to respond in writing by the coming Monday, clarifying that it was unlikely that I could achieve my co-counsel's consensus and formalize such consensus before Monday, though I would try. Mr. Nordby responded that this was acceptable. Strangely, the call ended with Mr. Nordby stating that he had been and was still contemplating filing a motion to quash in the unspecified near future solely to "preserve [Dr. Grossman's] rights." I appreciated the warning but did not anticipate that Mr. Nordby would file this Motion the morning of the very next business day, especially in light of my promise to narrow the requests by the next business day.

11. Dr. Grossman's counsel never communicated to me Dr. Grossman's position that there were two subpoenas but that they were identical.

12. Hours before this Opposition was filed in advance of tomorrow's hearing, I finally received the proof of service demonstrating that two nonidentical subpoenas were indeed served on Dr. Grossman. Attached as **Exhibit B** is a true and correct copy of the proof of service for Plaintiffs' subpoena dated January 27, 2023, served on Dr. Grossman in Monsey, New York.

13. This morning, I emailed Mr. Nordby the second subpoena, the proof of service, and the various concessions contained herein. I also requested that Mr. Nordby withdraw the Motion in light of my email's contents and attachments. I received no response prior to the filing of this Opposition. Attached as **Exhibit C** is a true and correct copy of an email from Attorney Joe Little to Attorney Daniel Nordby dated February 8, 2023.

14. Defendants' document collection efforts so far have yielded few documents featuring Dr. Grossman. However, not only was a motion to compel necessary for Plaintiffs to get relevant documents from Defendant AHCA, but the production of documents pursuant to agreed-upon search terms remains pending. Indeed, Defendants have represented that their document collection efforts have been subject to error, with Defendants citing corrupted documents, missing custodian records, and the like. Defendants continue to experience significant trouble exporting emails from their system.

15. The Rule 30(b)(6) deposition, which is ongoing as of the time of this filing, has already revealed that AHCA consulted extensively with Dr. Grossman as it undertook its GAPMS review and that AHCA undertook its GAPMS review in response to a direct request of the Governor and not in response to the FDOH's April 20, 2022 guidance.

16. Attached as **Exhibit D** is a true and correct copy of public information for a purchase order issued by Florida's Chief Financial Officer for services rendered by Dr. Grossman related to the GAPMS Process, which I accessed on February 7, 2023.

17. Attached as **Exhibit E** is a true and correct copy of an email from Dr. Grossman dated July 7, 2022 produced by Defendants in this litigation.

18. Attached as **Exhibit F** is a true and correct copy of an email from Dr. Grossman dated July 9, 2022 produced by Defendants in this litigation.

19. Attached as **Exhibit G** is a true and correct copy of an email from Dr. Grossman dated July 8, 2022 produced by Defendants in this litigation.

20. Attached as **Exhibit H** is a true and correct copy of an email from Jason Weida dated July 19, 2022 produced by Defendants in this litigation.

21. Attached as **Exhibit I** is a true and correct copy of Dr. Grossman's biography, which I pulled from the website **www.miriamgrossmanmd.com** on February 7, 2023.

22. Attached as **Exhibit J** is a true and correct copy of an *amicus curiae* brief filed by Dr. Grossman and others before the Eleventh Circuit Court of Appeals in *Adams v. School Board of St. Johns County, Florida*, No. 18-13592.

23. Attached as **Exhibit K** is a true and correct copy of the webpage titled *Gov. DeSantis appoints ADF Senior Counsel Denise Harle to Florida Faith-Based and Community-Based Advisory Council*, published on December 23, 2021,

<https://tinyurl.com/kfcxudpr>.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on February 8, 2023.

By: /s/ Joe Little

Joe Little (*pro hac vice*)
500 Capitol Mall, Suite 1800
Sacramento, CA 95814
(916) 329-4700
joe.little@pillsburylaw.com

AO 88B (Rev. 02/14) Subpoena to Produce Documents, Information, or Objects or to Permit Inspection of Premises in a Civil Action

UNITED STATES DISTRICT COURT

for the

Northern District of Florida

AUGUST DEKKER, et al.,

Plaintiff

v.

JASON WEIDA, et al.,

Defendant

Civil Action No. 4:22-cv-00325-RH-MAF

**SUBPOENA TO PRODUCE DOCUMENTS, INFORMATION, OR OBJECTS
OR TO PERMIT INSPECTION OF PREMISES IN A CIVIL ACTION**

To:

Mirian Grossman MD
32 S Monsey Road, Monsey, NY 10952

(Name of person to whom this subpoena is directed)

Production: **YOU ARE COMMANDED** to produce at the time, date, and place set forth below the following documents, electronically stored information, or objects, and to permit inspection, copying, testing, or sampling of the material: See attached

Place: Veritext Legal Solutions, 7 Times Square, 16th Floor, Suite 1604, New York, NY 10036	Date and Time: February 14, 2023
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Inspection of Premises: **YOU ARE COMMANDED** to permit entry onto the designated premises, land, or other property possessed or controlled by you at the time, date, and location set forth below, so that the requesting party may inspect, measure, survey, photograph, test, or sample the property or any designated object or operation on it.

Place:	Date and Time:
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The following provisions of Fed. R. Civ. P. 45 are attached – Rule 45(c), relating to the place of compliance; Rule 45(d), relating to your protection as a person subject to a subpoena; and Rule 45(e) and (g), relating to your duty to respond to this subpoena and the potential consequences of not doing so.

Date: 1/27/2023

CLERK OF COURT

OR

Signature of Clerk or Deputy Clerk

/s/ Jennifer Altman

Attorney's signature

The name, address, e-mail address, and telephone number of the attorney representing *(name of party)* AUGUST DEKKER, et al., who issues or requests this subpoena, are:
Jennifer Altman, 600 Brickell Ave., Suite 3100, Miami, FL 33131, jennifer.altman@pillsburylaw.com, (786) 913-4831

Notice to the person who issues or requests this subpoena

If this subpoena commands the production of documents, electronically stored information, or tangible things or the inspection of premises before trial, a notice and a copy of the subpoena must be served on each party in this case before it is served on the person to whom it is directed. Fed. R. Civ. P. 45(a)(4).

Civil Action No. 4:22-cv-00325-RH-MAF

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 45.)

I received this subpoena for *(name of individual and title, if any)* _____
on *(date)* _____ .

I served the subpoena by delivering a copy to the named person as follows: _____

_____ on *(date)* _____ ; or

I returned the subpoena unexecuted because: _____

Unless the subpoena was issued on behalf of the United States, or one of its officers or agents, I have also
tendered to the witness the fees for one day's attendance, and the mileage allowed by law, in the amount of
\$ _____ .

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ _____ 0.00 _____ .

I declare under penalty of perjury that this information is true.

Date: _____

Server's signature

Printed name and title

Server's address

Additional information regarding attempted service, etc.:

Federal Rule of Civil Procedure 45 (c), (d), (e), and (g) (Effective 12/1/13)**(c) Place of Compliance.**

(1) For a Trial, Hearing, or Deposition. A subpoena may command a person to attend a trial, hearing, or deposition only as follows:

- (A) within 100 miles of where the person resides, is employed, or regularly transacts business in person; or
- (B) within the state where the person resides, is employed, or regularly transacts business in person, if the person
 - (i) is a party or a party's officer; or
 - (ii) is commanded to attend a trial and would not incur substantial expense.

(2) For Other Discovery. A subpoena may command:

- (A) production of documents, electronically stored information, or tangible things at a place within 100 miles of where the person resides, is employed, or regularly transacts business in person; and
- (B) inspection of premises at the premises to be inspected.

(d) Protecting a Person Subject to a Subpoena; Enforcement.

(1) Avoiding Undue Burden or Expense; Sanctions. A party or attorney responsible for issuing and serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The court for the district where compliance is required must enforce this duty and impose an appropriate sanction—which may include lost earnings and reasonable attorney's fees—on a party or attorney who fails to comply.

(2) Command to Produce Materials or Permit Inspection.

(A) *Appearance Not Required.* A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition, hearing, or trial.

(B) *Objections.* A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, testing, or sampling any or all of the materials or to inspecting the premises—or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

- (i) At any time, on notice to the commanded person, the serving party may move the court for the district where compliance is required for an order compelling production or inspection.
- (ii) These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

(3) Quashing or Modifying a Subpoena.

(A) *When Required.* On timely motion, the court for the district where compliance is required must quash or modify a subpoena that:

- (i) fails to allow a reasonable time to comply;
- (ii) requires a person to comply beyond the geographical limits specified in Rule 45(c);
- (iii) requires disclosure of privileged or other protected matter, if no exception or waiver applies; or
- (iv) subjects a person to undue burden.

(B) *When Permitted.* To protect a person subject to or affected by a subpoena, the court for the district where compliance is required may, on motion, quash or modify the subpoena if it requires:

- (i) disclosing a trade secret or other confidential research, development, or commercial information; or

- (ii) disclosing an unretained expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party.

(C) *Specifying Conditions as an Alternative.* In the circumstances described in Rule 45(d)(3)(B), the court may, instead of quashing or modifying a subpoena, order appearance or production under specified conditions if the serving party:

- (i) shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and
- (ii) ensures that the subpoenaed person will be reasonably compensated.

(e) Duties in Responding to a Subpoena.

(1) Producing Documents or Electronically Stored Information. These procedures apply to producing documents or electronically stored information:

(A) *Documents.* A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

(B) *Form for Producing Electronically Stored Information Not Specified.* If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(C) *Electronically Stored Information Produced in Only One Form.* The person responding need not produce the same electronically stored information in more than one form.

(D) *Inaccessible Electronically Stored Information.* The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

(2) Claiming Privilege or Protection.

(A) *Information Withheld.* A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

- (i) expressly make the claim; and
- (ii) describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

(B) *Information Produced.* If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information under seal to the court for the district where compliance is required for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

(g) Contempt.

The court for the district where compliance is required—and also, after a motion is transferred, the issuing court—may hold in contempt a person who, having been served, fails without adequate excuse to obey the subpoena or an order related to it.

Confidential Attachment to Subpoena

AUGUST DEKKER, et al. v. JASON WEIDA, et al.

N.D. Fla. Civil Action No. 4:22-cv-00325-RH-MAF

You are commanded to produce at the time, date and place set forth in the accompanying subpoena, the following documents, electronically stored information (ESI), or objects, and to permit inspection or copying of the material.

DEFINITIONS

1. "Anti-transgender ideas" means any view which expresses the idea that being transgender is wrong, or that transgender people are suspect, immoral, or not deserving of rights or protections. It also means any view advocating for the curtailing of any medical treatment of gender dysphoria by private or public medical organizations.

2. "Communication" has the full scope and meaning of the term appearing in the Federal Rules of Civil Procedure and any applicable local rules and also means: any written, oral, or electronic exchange or transmission of information by any means, including face-to-face conversation, in-person meeting, mail, telephone, electronic mail, facsimile, instant message, social media, and the Internet.

3. "Document" has the full scope and meaning of the term appearing in the Federal Rules of Civil Procedure and any applicable local rules and also means: the complete original or a true, correct, and complete copy and any non-identical

copies of any written, recorded, or graphic material, no matter how produced, recorded, stored, or reproduced, including any writing, letter, envelope, telegram, electronic mail, attachment to electronic mail, facsimile, message, instant message, voicemail, meeting minute, memorandum, statement, book, publication, record, survey, map, study, report, handwritten note, drawing, working paper, chart, tabulation, graph, tape, data sheet, data processing card, printout, microfilm, microfiche, photograph, index, scientific notebook, appointment book, diary, diary entry, calendar, desk pad, telephone message slip, and any other data compilation in Your possession, custody, or control. The term “Document” includes, without limitation, Communications. A draft, version, or non-identical copy is a separate Document within the meaning of this term.

4. “GAPMS Memo” refers to June 2022 publication titled “Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria” by the Florida Agency for Health Care Administration.

5. “Gender Dysphoria” refers to the clinically significant distress or impairment related to the incongruence between one’s experienced/expressed gender and their assigned sex at birth, including their primary and/or secondary sex characteristics. For purposes of these Requests, “Gender Dysphoria” shall include: (a) the diagnoses for “Gender dysphoria in adolescents and adults” and “Gender

dysphoria in children,” as defined within *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) and the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR); (b) the diagnosis for “gender identity disorder,” including any subcategories such as “Gender Identity Disorder in Adolescents and Adults,” “Gender Identity Disorder in Children,” and “Gender Identity Disorder Not Otherwise Specified,” as defined within the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) and the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR); (c) the diagnosis for “gender identity disorder,” including any subcategories such as “Gender Identity Disorder in Children,” “Transsexualism,” and “Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type,” and Gender Identity Disorder not Otherwise Specified,” as defined within the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revision* (DSM-III-TR); (d) the diagnosis for “gender identity disorder,” including any subcategories such as “Gender Identity Disorder in Children,” “Transsexualism,” and “Atypical Gender Identity Disorder,” as defined within the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III); and (e) the diagnoses for “gender incongruence of adolescence and adulthood” and “gender incongruence of childhood,” as defined within the *International Classification of Diseases, Eleventh Revision* (ICD-11); and the diagnoses for

“transsexualism” and “gender identity disorder,” including any subcategories, as defined within the *International Classification of Diseases, Tenth Revision* (ICD-10) and *International Classification of Diseases, Ninth Revision* (ICD-9).

6. The term “person” means any natural person, partnership, association, corporation, joint venture, trust, community group, government or subdivision of any government (including any instrumentality, bureau, department, office, or agency of any government), not-for-profit enterprise, or other business entity, and all present and former officers, directors, agents, administrators, managers, representatives, contractors, consultants, employees, or other persons acting or purporting to act on behalf of such person.

7. The terms “related to,” “relating to,” “referring,” or “concerning” mean discussing, describing, reflecting, involving, including, containing, analyzing, studying, reporting, referring, showing, supporting, embodying, identifying, commenting, evidencing, constituting, setting forth, considering, recommending, concerning, pertaining, or in any way logically or factually connected with the matter discussed, in whole or in part.

8. “You” and “Your” means you individually, as well as your present or former attorneys, agents, employees, officers, representatives, successors, predecessors, assigns, beneficiaries, executors, administrators, successors, partners,

heirs, affiliates, and legal representatives, and any other person who is in possession, or who has obtained, information on your behalf.

INSTRUCTIONS

1. All responses to these Requests should be directed to: Jennifer Altman, Pillsbury Winthrop Shaw Pittman LLP, 600 Brickell Avenue, Suite 3100, Miami, FL 33131, Email: jennifer.altman@pillsburylaw.com, cc: soraya.garcia@pillsburylaw.com.

2. Unless otherwise specified, the time period covered by these Requests is January 1, 2015 to the present. If it is necessary to refer to periods of time prior to January 1, 2015 to respond to a Request, please do so.

3. Documents relevant and responsive to the Requests shall be gathered from all professional as well as personal files, computers and electronic devices, including personal and professional email, instant messaging, and cloud-based storage accounts.

4. All Documents are to be produced in electronic form pursuant to a protocol that may be agreed to among the parties.

5. If there is an objection to any Request, the grounds for objecting to the Request shall be set forth with specificity, including the reasons, and must state whether any responsive materials are being withheld on the basis of that objection.

6. If there is an objection to any part of a Request, You shall specify each part of the Request to which there is an objection; set forth with specificity the grounds for objecting to each such part of the Request, including the reasons; state whether any responsive materials are being withheld on the basis of that objection; and otherwise respond to all parts of the Request to which there are no objections.

7. If You maintain that any document was previously but is now no longer in existence, in Your possession, or subject to Your control, state whether it: (i) is missing or lost; (ii) has been destroyed; (iii) has been transferred, voluntarily or involuntarily to others; or (iv) has been otherwise disposed of. In each instance, set forth the contents of the document and the location of any copies of the document, and describe the circumstances surrounding its disposition, stating the date of its disposition, any authorization therefor, the person(s) responsible for such disposition, and the policy, rule, order or other authority by which such disposition was made.

8. If You cannot answer a Request in whole or in part, answer to the extent possible, specifying: (i) the reason(s) for Your inability to answer the Request or part thereof; (ii) whatever information or knowledge is in Your possession Concerning the unanswered portion; (iii) Your efforts to secure the unknown information; and (iv) the name, business address, residential address, and occupation of any Person consulted by You in an effort to answer the Request.

9. If, in response to any Request, there are any Documents which are not produced because of a claim of privilege or “work product,” describe each such Document by providing the following information: (a) its approximate date; (b) a general description of its subject matter; (c) author, recipient, participant, present custodian, or other Person with knowledge of the information; (d) the basis for asserting privilege; and (e) sufficient additional information to allow Plaintiffs and the Next Friends to assess the objection, and otherwise comply with the Request to the extent to which it is not subject to the objection.

10. For purposes of interpreting or construing the scope of these Requests, all terms shall be given their most expansive and inclusive interpretation. This includes, without limitation, the following:

- a. Construing “and” as well as “or” in the disjunctive or conjunctive, as necessary to make the Request more inclusive;
- b. Construing the singular form of the word to include the plural, and the plural form to include the singular;
- c. Construing the masculine to include the feminine, and vice versa;
- d. Construing the term “including” to mean “including but not limited to” and construing the term “all” to mean “any and all,” and vice versa;
- e. Construing the term “each” to include “every,” and construing “every” to include “each”;

- f. Construing the use of a verb in any tense as the use of the verb in all other tenses; and
- g. Construing and interpreting all spelling, syntax, grammar, abbreviations, idioms, and proper nouns to give proper meaning and consistency to their context.

REQUESTS FOR PRODUCTION

1. A list of all matters in which, during the previous 5 years, You have testified as an expert including, without limitation, at an administrative hearing, court hearing, trial, or deposition.
2. All transcripts for any testimony You have given, whether at a deposition, hearing, trial, or any other proceeding identified in response to Request No. 1 above that relate to transgender issues, gender identity, or Gender Dysphoria.
3. All expert reports or declarations You have submitted in any matter relating to transgender issues, gender identity, or Gender Dysphoria.
4. All Documents You reviewed in preparation of any expert reports or declarations You have submitted in any matter relating to transgender issues, gender identity, or Gender Dysphoria.
5. All Documents You reviewed in preparation for any hearing or proceeding relating to transgender issues, gender identity, or Gender Dysphoria.

6. All Documents You relied upon in preparation for any hearing or proceeding relating to transgender issues, gender identity, or Gender Dysphoria.

7. All Documents You relied upon in preparation of any expert reports or declarations You have submitted in any matter relating to transgender issues, gender identity, or Gender Dysphoria.

8. All Communications between You and any other person who has provided a declaration in the above-referenced matter.

9. All Communications between You and any other person who has provided a declaration or affidavit in any other action relating to transgender issues, gender identity, or Gender Dysphoria.

10. Any papers, opinions or other writings that You authored or co-authored relating to transgender issues, gender identity, or Gender Dysphoria.

11. All Documents sufficient to identify your affiliation with any of the following organizations: Alliance Defending Freedom; American College of Pediatricians; Catholic Medical Association; Christian Medical & Dental Associations; Ethics and Public Policy Center; GENSPECT; Heritage Foundation; Liberty Counsel; Moral Revolution; Person and Identity Project; Real Impact; and Society for Evidence-based Gender Medicine.

12. All Your publications relating to transgender people, gender identity, or Gender Dysphoria.

13. All Your social media posts, including those on Twitter, Facebook, Instagram, LinkedIn, and YouTube, relating to transgender issues, gender identity, or Gender Dysphoria. This includes, without limitation, any social media posts You have made under the Twitter account @Miriam_Grossman.

14. All presentations, speeches, or other speaking engagements You have given relating to transgender issues, gender identity, or Gender Dysphoria.

15. All notes, outlines, presentation slides, or documents related to the presentations, speeches, or other speaking engagements relating to transgender issues, gender identity, or Gender Dysphoria identified in response to Request No. 14 above.

16. Identify all honoraria, payments, or other compensation You have received in relation to any testimony, presentation, or speaking engagement relating to transgender issue, gender identity, or Gender Dysphoria by any individual or entity

17. All Documents and Communications You have submitted to the Florida Agency for Health Care Administration, relating to transgender issues, gender identity or Gender Dysphoria, including without limitation the report Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence.

18. All Documents You reviewed in the preparation of any of Documents submitted to the Florida Agency for Health Care Administration relating to transgender issues, gender identity or Gender Dysphoria or the GAPMS Memo.

19. All Documents You relied upon in the preparation of any of Documents submitted to the Florida Agency for Health Care Administration relating to transgender issues, gender identity, Gender Dysphoria or the GAPMS Memo.

20. All Communications You have had with any person at the Florida Agency for Health Care Administration relating to transgender issues, gender identity or Gender Dysphoria or the GAPMS Memo.

21. All Communications You have had with any person at the Florida Department of Health, including but not limited to Surgeon General Joseph A. Ladapo, relating to transgender issues, gender identity or Gender Dysphoria or the GAPMS Memo.

22. All Communications You have had with any person at the Office of Governor Ron DeSantis, relating to transgender issues, gender identity or Gender Dysphoria or the GAPMS Memo.

23. All Documents evidencing organizations, associations, and political action committees to which You have contributed money or services and that promote anti-transgender ideas.

24. All Documents evidencing Your participation in any protest, rally, or other gathering promoting anti-transgender ideas.

25. All Communications You have had with any person at any of the following organizations relating to transgender issues, gender identity, Gender Dysphoria or the GAPMS Memo: Alliance Defending Freedom; American College of Pediatricians; Catholic Medical Association; Christian Medical & Dental Associations; Ethics and Public Policy Center; GENSPECT; Heritage Foundation; Liberty Counsel; Moral Revolution; Person and Identity Project; Real Impact; and Society for Evidence-based Gender Medicine.

Civil Action No. 4:22-cv-00325-RH-MAF

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 45.)

I received this subpoena for *(name of individual and title, if any)* Mirian Grossman, M.D.
on *(date)* 1/27/2023.

I served the subpoena by delivering a copy to the named person as follows: personally
to 32 So. Monsey Rd. Monsey, NY 10952
on *(date)* Jan 31, 2023; or
10:22 Am

I returned the subpoena unexecuted because: _____

Unless the subpoena was issued on behalf of the United States, or one of its officers or agents, I have also
tendered to the witness the fees for one day's attendance, and the mileage allowed by law, in the amount of
\$ _____.

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ 0.00.

I declare under penalty of perjury that this information is true.

Date: 2/6/2023

Geraldina Schiavone
Server's signature
Geraldina Schiavone, Process Server
Printed name and title



PPS
10 W. Prospect Street #19
Nanuet, New York 10954
845-548-7364
Server's address

Additional information regarding attempted service, etc.:
Place of production: New York City
Issue date: 1/27/2023

SERVED TO HOME ADDRESS:
MIRIAN GROSSMAN, M.D.
32 SO. MONSEY RD
MONSEY, NEW YORK 10952

SERVED : SUBPOENA AND CONFIDENTIAL
ATTACHMENTS TO SUBPOENA (14 PAGES)
FEMALE
AGE : 55-65
HEIGHT- 5'9"
SKIN- WHITE
WEIGHT- 155 LBS
HAIR- BLONDE- WAS BLACK ON PREVIOUS SERVE
WHITE CRV PARKED IN DRIVEWAY

From: Little, Joe
Sent: Wednesday, February 8, 2023 9:34 AM
To: Daniel E. Nordby
Subject: Motion to Quash
Attachments: 5694237_EPOS.pdf; Grossman SDT.pdf

Hi Daniel,

I received this morning a proof of service from our process server demonstrating that the second subpoena served on your client was different than the first. I attach the second subpoena here as well as the proof of service.

Moreover, as the opposition I'm preparing to file this AM sets forth, we agree to withdraw Request Nos. 4-7, 9, 11, 13, 16, 18-19, 21, 23-24, and 25. We also agree to limit Request Nos. 10, 12, and 14-15 to the two-year period preceding the July 8, 2022 hearing. For Request No. 8, we agree to limit the communications to those with Drs. Cantor, Van Meter, Van Mol, Lappert, and Donovan, beginning with the two-year period preceding the July 8, 2022 hearing and continuing through August 20, 2022.

In light of these concessions and the attached proof of service, I ask that you withdraw your motion promptly, and that we begin discussions on collecting and producing the significantly narrowed universe of documents.

Best,

Joe

Joe Little | Associate

Pillsbury Winthrop Shaw Pittman LLP

500 Capitol Mall, Suite 1800 | Sacramento, CA 95814-4741

t +1.916.329.4731 | m +1.916.704.4853

joe.little@pillsburylaw.com | website bio

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MIAMI NASHVILLE NEW YORK NORTHERN VIRGINIA PALM BEACH
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SILICON VALLEY TAIPEI TOKYO WASHINGTON, DC





Purchase Order Information

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Summary

Agency Name: AGENCY FOR HEALTH CARE ADMINISTRATION **Purchase Order Number:** C0550C
Purchase Order Title: 6840 - FY22/23 - M Grossman - Medical Expert **Vendor Name:** MIRIAM GROSSMAN
 Witness
Total Purchase Order Amount: \$34,500.00 **Total Budgetary Amount:** \$34,500.00
Total Payment To Date: \$2,750.00 **Order Date:** 07/28/2022

[Details](#) [Deliverables](#) [Payments](#) [Documents](#)

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MORE	<u>LINE ITEM NUMBER</u>	<u>COMMODITY TYPE</u>	<u>STATE TERM CONTRACT ID</u>	<u>AGENCY SOLICITATION NUMBER</u>	QUANTITY	UNIT PRICE	TOTAL UNIT PRICE
	1	Expert witness service			69.0000	\$500.0000	\$34,500.00

This OCA will be used to capture expenditures for Consultant services: Technical assistance in the form of research, interpretation, and consultation to staff members of the Agency for the purpose of ...

Line Item Description: This OCA will be used to capture expenditures for Consultant services: Technical assistance in the form of research, interpretation, and consultation to staff members of the Agency for the purpose of assisting in the identification, analysis, and summarization of the relevant published reports and articles in the authoritative medical and scientific literature (published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations) related to health services being considered for coverage under the Florida Medicaid Program. State share only. FAST Cash See attached scope for more details. Term: PO issuance - June 30, 2022

Method of Procurement: Exempt, Health services, including examination, diagnosis, treatment, prevention, medical consultation or administration. [s. 287.057 (3) (e) 5, FS & Rule 60A-1002 (4) (k), FAC]

Line Split Details:

Split Accounting Line Number: 1
FLAIR Contract ID:
Org. Code and Description: 68406000000 -
Object Code and Description: 131800 -
Account Code: 68-20-2-474001-68500200-00-100777-00
Split Amount: \$34,500.00

Displaying 1 to 1 of 1

Agency Name	Purchase Order Number	Line Item Number	Line Item Description	Commodity Type Description	State Contract Term ID	Agency Solicitation Number	Quantity	Unit Price	Total Unit Price	Method of Procurement	Split Accounting Line Number	Split Amount	Account Code	Org. Code and Description	Object Code and Description	FLAIR Contract ID
AGENCY FOR HEALTH CARE ADMINISTRATION	C0550C	1	attached scope for more details. Term: PO issuance - June 30, 2022	Expert witness service			69	500	34500	Exempt, Health services, including examination, diagnosis, treatment, prevention, medical consultation or administration . [s. 287.057 (3) (e) 5, FS & Rule 60A-1002 (4) (k),FAC]		1	34500 00	68-20-2-474001-68500200-00-100777-	68406000000 - 131800 -	

From: miriam grossman
Subject: Re: AAP-FCAAP Comment Letter: Medicaid Coverage for Gender Affirming Care (Privileged & Confidential)
To: Andre Van Mol; Jason.Weida@ahca.myflorida.com; Andrew.Sheeran@ahca.myflorida.com
Cc: Weida, Jason; kidendo@comcast.net; Sheeran, Andrew
Sent: July 7, 2022 8:53 PM (UTC-04:00)
Attached: image001 (1).png, image002 (1).png, image003 (1).png, image004 (1).png, image005 (1).png, image006 (1).png, image007 (1).png, AAP-FCAAP Comment Letter_Medicaid Coverage for Gender-Affirming Care (FINAL).pdf

Can't wait to watch you take them apart Andre. Sorry I'm not there in person.

Sent from my iPhone

On Jul 7, 2022, at 8:46 PM, Andre Van Mol <95andrev@gmail.com> wrote:

Amazing. They don't make it out of the first paragraph without misrepresentation. They say "widely accepted standard of care" with reference to "the Endocrine Society ." Page 3895 of side guidelines state specifically these do not establish the standard of care. Furthermore, the first paragraph is already defeated by James Cantor's attachment, which speaks specifically about this kind of misrepresentation of organizational statements. OK, I will keep reading and save my comments for tomorrow.

Andre

Sent from my iPhone

On Jul 7, 2022, at 7:40 PM, Andre Van Mol <95andrev@gmail.com> wrote:

Just now seeing this at Atlanta airport.

Andre

Sent from my iPhone

On Jul 7, 2022, at 5:25 PM, Weida, Jason
<Jason.Weida@ahca.myflorida.com> wrote:

**PRIVILEGED & CONFIDENTIAL
ATTORNEY WORK PRODUCT PROTECTED**

Andre, Quentin, and Miriam,

Please see the below and attached. Today, the American Academy of Pediatrics and its Florida Chapter have submitted this white paper responding to the GAPMS report and the proposal rule. I encourage you to read it.

Thanks,
Jason

From: MEDICAID RULE COMMENTS
<MEDICAIDRULECOMMENTS@ahca.myflorida.com>
Sent: Thursday, July 7, 2022 5:11 PM
To: Weida, Jason <Jason.Weida@ahca.myflorida.com>
Subject: FW: AAP-FCAAP Comment Letter: Medicaid Coverage for Gender Affirming Care

From: Scott Van Deman <communications@fcaap.org>
Sent: Thursday, July 7, 2022 1:59 PM
To: MEDICAID RULE COMMENTS
<MEDICAIDRULECOMMENTS@ahca.myflorida.com>
Cc: Hudson, Jeff <Hudson@aap.org>; Alicia E. Adams, Esq.
<master@fcaap.org>
Subject: AAP-FCAAP Comment Letter: Medicaid Coverage for Gender Affirming Care

To whom it may concern:

Thank you for the opportunity to provide commentary to the Agency for Healthcare Administration on Medicaid rules currently being considered.

Attached is a joint letter from The American Academy of Pediatrics and the Florida Chapter of the American Academy of Pediatrics pertaining to the proposed rule concerning Medicaid's coverage of gender affirming care. This letter also has been submitted electronically through the feedback form at the Florida Department of State public notice number 25979915.

I am requesting that you please acknowledge receipt of this communication via return email.

Thank you once again, and please let me know if you have any questions.

Sincerely,

Scott VanDeman

Communications Coordinator

Florida Chapter of American Academy of Pediatrics, Inc.

Call: 850-224-3939, ext. 1005 | Text: 850-772-0654 | Fax: 912-452-9050

Email: svandeman@fcaap.org | Website: fcaap.org

Mail: 1400 Village Square Blvd., #3-87786, Tallahassee, FL 32312

From: miriam grossman
Subject: Medicaid Coverage for Gender Affirming Care (Privileged & Confidential)
To: Andre Van Mol; Andrew.Sheeran@ahca.myflorida.com
Cc: Weida Jason; Van Meter Quentin; Sheeran, Andrew
Sent: July 9, 2022 11:08 PM (UTC-04:00)

Hi everyone,

I just wanted to say how much I enjoyed the two hours. I was so pleased to hear a huge majority speaking in favor. They were such salt of the earth, patriotic, common sense people, I loved it and loved how they cheered each time de Santis was mentioned. I did not hear most of what you guys on the panel said due to a hitch with the audio. I was prepared to be challenged and put on the spot but the clock ticked and ticked and...nothing. Where did all the opposition go? Weren't you expecting a bigger turnout? That one church really brought a lot of people! I was smiling ear to ear by the end.

To which state do we go next? I'm ready.

Miriam

Sent from my iPad

On Jul 8, 2022, at 12:29 AM, Andre Van Mol <95andrev@gmail.com> wrote:

Late morning sounds good. BTW, I got from Paul Hruz his classic takedown of the p.10 AAP letter slogan that randomized controlled trials may be unethical in GAT.

"It is often argued that conducting randomized controlled trials in the field of gender medicine would be unethical. This is based upon the false premise that the control group would receive no specific therapy. However, in scientific investigation all variables except the independent variable being tested are kept constant in both experimental and control groups. Thus, although members of the control group do not receive the intervention being studied, they are provided with all other aspects of treatment indicated for the condition; that is, they receive standard care. There are numerous means of psychological support for anxiety, depression, and other comorbidities associated with gender dysphoria. Coping skills can be developed in both treatment arms."

Andre

On Jul 7, 2022, at 8:13 PM, Weida, Jason <Jason.Weida@ahca.myflorida.com> wrote:

Got it. Thanks. We can discuss tomorrow. I got a conference room at the Agency for us if you want to come over before we head out to the hearing. Come at your leisure. Perhaps mid to late morning? We'll be heading over the hearing in the same vehicle (rental van) around 2:20.

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From: Andre Van Mol <95andrev@gmail.com>
Sent: Thursday, July 7, 2022 10:23:28 PM
To: Weida, Jason <Jason.Weida@ahca.myflorida.com>; Van Meter Quentin <kidendo@comcast.net>; Grossman Miriam <miriamgrossmanmd@hotmail.com>; Sheeran, Andrew <Andrew.Sheeran@ahca.myflorida.com>

Subject: Re: AAP-FCAAP Comment Letter: Medicaid Coverage for Gender Affirming Care
(Privileged & Confidential)

Here is my rebuttal of the AAP statement. Yellow highlights and usually embedded comments. I'm doing this from inside a plane on the tarmac using my iPhone hot spot, so I hope it works. :)

Andre

On Jul 7, 2022, at 3:10 PM, miriam grossman
<miriamgrossmanmd@hotmail.com> wrote:

Hi Jason
Thanks for forwarding. I skimmed through and don't see any surprises.
Please refer audience questions about standards of care to the other docs
who are more articulate on this subject than I.
Miriam

Sent from my iPhone

On Jul 7, 2022, at 5:25 PM, Weida, Jason
<Jason.Weida@ahca.myflorida.com> wrote:

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Andre, Quentin, and Miriam,

Please see the below and attached. Today, the American Academy of Pediatrics and its Florida Chapter have submitted this white paper responding to the GAPMS report and the proposal rule. I encourage you to read it.

Thanks,
Jason

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To: MEDICAID RULE COMMENTS
<MEDICAIDRULECOMMENTS@ahca.myflorida.com>

Cc: Hudson, Jeff <JHudson@aap.org>; Alicia E. Adams, Esq. <master@fcaap.org>

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Thank you once again, and please let me know if you have any questions.

Sincerely,

Scott VanDeman
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Florida Chapter of American Academy of Pediatrics, Inc.

Call: 850-224-3939, ext. 1005 | Text: 850-772-0654 | Fax: 912-452-9050

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Affirming Care (FINAL).pdf>

From: miriam grossman
Subject: My question
To: Andre Van Mol; Andrew.Sheeran@ahca.myflorida.com
Cc: Weida Jason; Van Meter Quentin; Sheeran, Andrew
Sent: July 8, 2022 10:17 AM (UTC-04:00)

Good morning all,
I hope to hear from you about my concerns about what Cantor wrote
About successful adult transition. Thanks
Miriam

Sent from my iPad

On Jul 8, 2022, at 12:29 AM, Andre Van Mol <95andrev@gmail.com> wrote:

Late morning sounds good. BTW, I got from Paul Hruz his classic takedown of the p.10 AAP letter slogan that randomized controlled trials may be unethical in GAT.

"It is often argued that conducting randomized controlled trials in the field of gender medicine would be unethical. This is based upon the false premise that the control group would receive no specific therapy. However, in scientific investigation all variables except the independent variable being tested are kept constant in both experimental and control groups. Thus, although members of the control group do not receive the intervention being studied, they are provided with all other aspects of treatment indicated for the condition; that is, they receive standard care. There are numerous means of psychological support for anxiety, depression, and other comorbidities associated with gender dysphoria. Coping skills can be developed in both treatment arms."

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Subject: Re: AAP-FCAAP Comment Letter: Medicaid Coverage for Gender Affirming Care (Privileged & Confidential)

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From: Weida, Jason
Subject: Yale (Privileged & Confidential)
To: Andre Van Mol; Van Meter Quentin; miriam grossman
Cc: Tamayo, Josefina; mjazil@holtzmanvogel.com; gperko@holtzmanvogel.com
Sent: July 19, 2022 3:34 PM (UTC-04:00)
Attached: Alstott et al FULL comment proposed rule re gender dysphoria ACCESSIBLE.pdf

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ATTORNEY WORK PRODUCT PROTECTED

Andre, Quentin, and Miriam,

Please see the attached report from Yale. You may or may not have seen this one already. Would you be able to review it and give me your preliminary thoughts? Happy to set up a call if that's what you prefer. If I could get some high-level comments on Yale's report by 2:00 PM Eastern tomorrow I would be very grateful.

In addition, you will each be overnighted a binder that contain a handful of the substantive comments (e.g., Yale, APP, Endocrine Society) that will be appended to a 17-page document summarizing the Agency's responses/positions with respect to the points raised in those substantive comments. Please review those materials as well so we can discuss as soon as you are able this week.

Thanks,
Jason

Jason C. Weida
Assistant Deputy Secretary
for Medicaid Policy & Quality



2727 Mahan Drive
Bldg 3 Room 2413
+1 850-412-4118 (Office)
+1 850-228-1898 (Cell)



Jason.Weida@ahca.myflorida.com

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Child, Adolescent, and Adult
Psychiatrist, Author
& International Public Speaker

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Miriam Grossman MD



Miriam Grossman MD is a practicing psychiatrist, author, and public speaker. Before gender ideology was on anyone's radar, she warned parents about its falsehoods and dangers in the final chapter of her 2009 book about sexuality education, "You're Teaching My Child WHAT?"

Dr. Grossman's practice currently focuses on gender-confused young people and their parents. She believes that every child is born in the right body. Dr Grossman has been vocal about the capture of her profession by ideologues, leading to dangerous and experimental treatments on children and betrayal of parents.

The author of four books, Dr. Grossman has been on over 300 radio, news, and television shows, and her work exposing the origin and hazards of the Sexuality and Gender Industry has been translated into eleven languages. She has lectured at the British House of Lords and the United Nations.

Dr. Grossman is featured in Daily Wire's *What Is A Woman?* and Fox Nation's documentary *The Miseducation of America*. Her recent articles have been published in media outlets such as The Daily Wire, Breitbart News, The Federalist and City Journal. Dr. Grossman's expert psychiatric opinion is sought for witness testimony and court reports.

Dr. Grossman graduated with honors from Bryn Mawr College and from New York University Medical School. She completed an internship in pediatrics at Beth Israel Hospital in New York City, and a residency in psychiatry at North Shore University Hospital – Cornell University Medical College, followed by a fellowship in child and adolescent psychiatry. Dr Grossman is board certified in psychiatry and in the sub-specialty of child and adolescent psychiatry.

Contact Dr. Grossman

**Родители и наставници!
Ова е за ВАС!**

**ВИСТИНАТА ЗА РОДОТ · ДЕЛ 1
РАЗОТКРИВАЊЕ НА ССО АГЕНДАТА**

**24 јуни 2021 | 19:30
ЗУМ настан**

**ОД НАС
ЗА НАС**

IPEDM

Д-р МИРИАМ ГРОСМАН

Доктор, обучен за педијатрија и специјализиран за детска, адолесцентна и возрасна психијатрија и автор на две книги од областа. Ги изложува лагите позади сепопфатното сексуално образование (ССО) со посебен осврт на родово-сензитивното образование.

©2022 by Miriam Grossman MD

Dr. Grossman's work has been published in 11 languages

No. 18-13592

**UNITED STATES COURT OF APPEALS FOR THE
ELEVENTH CIRCUIT**

DREW ADAMS,

Plaintiff-Appellee,

v.

SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA,

Defendant-Appellant.

Appeal from the United States District Court for the Middle District
of Florida, Honorable Timothy J. Corrigan, Case No. 3:17-cv-00739-
TJC-JBT

**BRIEF OF *AMICI CURIAE* DRS. MIRIAM GROSSMAN,
MICHAEL LAIDLAW, QUENTIN VAN METER, AND ANDRE
VAN MOL IN SUPPORT OF DEFENDANT-APPELLANT
SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA**

Gary S. McCaleb*

James A. Campbell

Counsel of Record

ALLIANCE DEFENDING FREEDOM

15100 N. 90th Street

Scottsdale, AZ 85260

(480) 444-0020

jcampbell@adflegal.org

Counsel for Amici Curiae

*PHV Application submitted

CERTIFICATE OF INTERESTED PERSONS

Pursuant to Local Rules 26.1-1 through 26.1-3, the undersigned certifies that the name of each person, attorney, association of persons, firm, law firm, partnership, and corporation that has or may have an interest in the outcome of this action—including subsidiaries, conglomerates, affiliates, parent corporations, publicly-traded companies that own 10% or more of a party's stock, and all other identifiable legal entities related to any party in the case, in addition to those set forth in the Initial Brief of Appellant The School Board of St. Johns County, Florida, include:

1. Alliance Defending Freedom – Counsel for Amici Curiae
2. Campbell, James A. – Counsel for Amici Curiae
3. Grossman, Miriam – Amicus Curiae
4. Laidlaw, Michael K. – Amicus Curiae
5. McCaleb, Gary S. – Counsel for Amici Curiae
6. Van Meter, Quentin L. – Amicus Curiae
7. Van Mol, Andre – Amicus Curiae

The undersigned will enter this information in the Court's web-based CIP contemporaneously with filing this Certificate of Interested Persons. As the *Amici Curiae* appear as individuals, no corporate disclosure statement is required.

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TABLE OF CITATIONS

American College of Pediatricians, *Gender Ideology Harms Children*, Aug. 17, 2016 16, 19-20

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Henriette A. Delemarre-van de Waal & Peggy T. Cohen-Kettenis, <i>Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Pediatric Endocrinology Aspects</i> , 155 <i>European Journal of Endocrinology</i> (2006)	22
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Kelley D. Drummond et al., <i>A Follow-up Study of Girls with Gender Identity Disorder</i> , 44 <i>Developmental Psychology</i> (2008).....	15
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Kaltiala-R. Heino, et al., <i>Gender dysphoria in adolescence: current perspectives</i> , 9 <i>Adolescent Health, Medicine and Therapeutics</i> (2018)	26
Paul W. Hruz, Lawrence S. Mayer & Paul R. McHugh, <i>Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria</i> , <i>The New Atlantis</i> , Spring 2017	18, 20, 23, 30

Annette Kuhn et al., <i>Quality of Life 15 Years After Sex Reassignment Surgery for Transsexualism</i> , 92 <i>Fertility & Sterility</i> (2009)	28
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STATEMENT OF THE ISSUE

Whether the district court was authorized to interpret “sex” to mean “gender identity” under Title IX and the Equal Protection Clause?

INTEREST OF *AMICI CURIAE*¹

Amici curiae are individual medical professionals and scientists, well-versed in the issues surrounding gender identity ideology. The Appellants and Appellees have consented to the filing of this brief.

Amicus curiae Miriam Grossman holds an M.D. from New York University. She completed an internship in pediatrics, a residency in adult psychiatry, and a fellowship in child and adolescent psychiatry. Dr. Grossman worked at UCLA’s Student Psychological Services for twelve years. In that capacity she evaluated and treated students who were conflicted about their gender identity. Dr. Grossman subsequently provided mental health treatment for children and adolescents at the Vista Del Mar clinic in Los Angeles. In that position and in her private

¹ Pursuant to Fed. R. App. P. 29(a) *amici curiae* state that this brief was not authored in whole or in part by counsel for any party, and no person or entity other than *amici curiae* and their counsel made a monetary contribution to the preparation or submission of this brief.

practice, she cared for patients who struggled with their identity as male or female. Dr. Grossman is the author of two books about the dangers of social ideology in education and health care, and has lectured extensively on the topic.

Amicus curiae Michael K. Laidlaw, M.D. is board-certified in Endocrinology, Diabetes, and Metabolism. He works in private practice and is a contributing member of gdworkinggroup.org, which is the international, professional work group on childhood and adolescent gender dysphoria.

Amicus curiae Quentin L. Van Meter, M.D. is a board-certified Pediatric Endocrinologist in private practice in Atlanta, Georgia, with extensive training in issues of transgender health over the past 40 years. Dr. Van Meter is currently President of the American College of Pediatricians, fellow of the Endocrine Society, member of the Pediatric Endocrine Society, and of the Endocrine Society. He has held positions as Associate Clinical/Adjunct Professor of Pediatrics at Emory University School of Medicine and the Morehouse Medical College.

Amicus curiae Andre Van Mol, M.D., is a board-certified Family Physician and Co-chair of the Committee on Adolescent Sexuality for

the American College of Pediatricians. Prior to establishing his distinguished family practice in Northern California, he served as a U.S. Navy family practice doctor and carrier air wing flight surgeon.

Amici critically evaluate, based on their clinical and scientific expertise, a central question in this case: whether “gender-affirming” policies and treatments for students who identify with a gender discordant from their sex is beneficial to those students. By “gender,” *Amici* mean an individual’s self-perception as male or female, which may be known to others only by the individual’s statement. As medical professionals, *Amici* are profoundly concerned that youth are not being well-served by gender affirmation policies or treatments that are unmoored from sound science. *Amici* focus on the premise that students who are confused about their sex are necessarily best treated by gender-affirmation methods—a premise that has been broadly advanced by advocates of gender identity theory in recent years. But such gender-affirmation treatments have virtually no basis in science or fact, and are often harmful to the youth who are struggling with discordant perceptions of their sex.

SUMMARY OF THE ARGUMENT

Amici, as physician-scientists, observe that the legal issues in this lawsuit center upon the meaning of the term *sex*, and further observe that throughout their long professional careers, *sex* until very recently referred to a person being male or female in the objective, biological sense. *Amici* note too that the term *gender* came into use to indicate two things quite different from *sex*. One meaning is society's expectations for how males and females should behave—that is, sex stereotypes. The other meaning that is most pertinent to this case, is a person's inner experience of being male, female, or anywhere between those two “extremes” as they are called.

Thus, *sex* is innate, fixed, and binary; *gender* is a subjective, fluid continuum.

With that background in mind, *Amici* possess scientific expertise that may be of assistance to the Court in evaluating sex and gender.

Currently in the United States, *gender* is defined as a persistent identification with a set of norms promoted by society as the behaviors, attitudes, and preferences associated with each *sex*. The definition is grounded in culture and perceived identity, not biology. Choosing a

gender—i.e., deciding to live as one sex or the other—neither is caused by nor causes any biological changes. There is no credible scientific literature that suggests that a person’s gender affects the objective biological reality that one is male or female. Nor is there any objective indicia of a person’s gender: according to gender identity theory, a person’s gender is what they claim it to be.

There is no doubt that some humans, including some youth in this case, experience disquiet with their sex. They struggle to identify with their sex. Some feel a distressing and persisting incongruity between their sex and their sense of themselves as male or female. But no matter how disturbing this condition of gender dysphoria may be, nothing about it affects the objective reality that all persons, dysphoric or not, remain the male or female persons that they were at conception, at birth, and thereafter.

Amici leave aside the questions of how best to treat gender dysphoria in adults, focusing instead on how to treat adolescents who suffer from this psychological disorder. To say this is an open question in medicine and science is understatement writ large: gender-affirmation policies such as those sought by Appellee Adams are

unsupported by any scientific evidence that such policies help the youths they aim to help. To the contrary, there is abundant scientific reason to believe that gender-affirmation efforts do no lasting good; rather, they may cause harm in many circumstances and lead to catastrophic outcomes for some youths.

Amici conclude based upon decades of academic study and clinical experience in psychiatry, psychology, and the biological bases of both of those fields, that obligating the School Board to adopt policies that amount to scientifically unwarranted, dangerous experiments upon our nation's youth would not be in the interest of the students that the School Board serves. *Amici* therefore urge that the lower court's decision be reversed.

ARGUMENT

I. A child's gender identity has no bearing on his or her sex.

Sex and *gender* represent two very distinct features of our world. While *sex* is binary and objective, determined by one's chromosomal constitution, and ultimately by clearly defined reproductive capacities, *gender* is a subjective sense of identity; a social role generated by

cultural norms.² The central underlying basis for sex is the distinction between the reproductive roles of males and females. *See* Lawrence S. Mayer & Paul R. McHugh, *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, New Atlantis, Fall 2016 at 89-90. In biology, an organism is male or female if it is biologically and physiologically designed to perform one of the respective roles in sexual reproduction. This definition does not depend upon amorphous physical characteristics or behaviors; nor does it hinge upon what an organism considers its sex to be, as it simply requires and depends upon understanding the reproductive system and its processes.

Reproductive roles provide the conceptual basis for the differentiation of animals into the biological categories of male and female. There is no other widely accepted biological classification for the sexes. Sex is a physiological reality that permeates every cell of an organism containing a nucleus. Sex is thus innate and immutable; the

² Gender identity advocates may cloud the question of interpreting “sex” by pointing to intersex conditions. But such conditions are rare, objectively diagnosable disorders of sexual development and are quite unlike the theory of a subjectively perceived gender continuum proposed by gender identity advocates. These objectively diagnosable disorders are not at issue in this case and do not undermine the desirability of using objective criteria of sex, rather than subjective gender, to provide privacy to students in privacy facilities.

genetic information directing development of male or female gonads and other primary sexual traits, which normally are encoded on chromosome pairs “XY” and “XX,” are present immediately upon conception. As early as eight weeks’ gestation, endogenously produced sex hormones cause prenatal brain imprinting that ultimately influences postnatal behaviors. See Francisco I. Reyes et al., *Studies on Human Sexual Development*, 37 *J. of Clinical Endocrinology & Metabolism* 74-78 (1973); Michael Lombardo, *Fetal Testosterone Influences Sexually Dimorphic Gray Matter in the Human Brain*, 32 *J. of Neuroscience* 674-80 (2012); P.C. Sizonenko, *Human Sexual Differentiation*, Geneva Foundation for Medical Education and Research (2017).³ It is therefore not the reproductive system alone that carries one’s sexual identity. *Every cell in the body containing a nucleus is marked with a sexual identity by its chromosomal constitution, XX or XY.* Thus, sex is not “assigned” at birth; rather, it is established at conception, “declares itself anatomically in utero and is acknowledged

³ Available at <http://bit.ly/2CrBDWE>.

at birth.” Michelle A. Cretella, *Gender Dysphoria in Children and Suppression of Debate*, 21 J. of Am. Physicians & Surgeons 51 (2016).

In contrast, gender has come to refer to “the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women,” which “influence the ways that people act, interact, and feel about themselves.” Am. Psychol. Ass’n, *Answers to Your Questions About Transgender People, Gender Identity and Gender Expression* (2011).⁴ A child’s *gender* reflects the extent to which he or she conforms to or deviates from socially normative behavior for young males or females.

By this definition, gender is mercurial. There is no objective definition for what it means to behave like a boy or a girl. Moreover, what is considered gender-typical behavior for boys and girls changes over time within a given culture and varies between cultures.⁵ A girl who behaves like a “tomboy” may modify her behavior as she ages, and

⁴ Available at <http://www.apa.org/topics/lgbt/transgender.pdf>.

⁵ Just a few decades ago, in the United States it would have been atypical for women to attend law school or medical school. It was projected that women would outnumber men in law schools in 2017. Debra Cassens Weiss, *Women Could Be a Majority of Law Students in 2017; These Schools Have 100-Plus Female Majorities*, ABA Journal, Mar. 16, 2016. Available at: http://www.abajournal.com/news/article/women_could_be_majority_of_law_students_in_2017_these_schools_have_100_plus.

a boy who prefers quiet play imitating domestic life may eventually develop an interest in adventure sports or hunting. Consequently, gender is a fluid concept with no truly objective meaning. Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* 6-7 (1990) (stating that “gender is neither the causal result of sex nor as seemingly fixed as sex,” but rather “a free-floating artifice, with the consequence that *man* and *masculine* might just as easily signify a female body as a male one, and *woman* and *feminine* a male body as easily as a female one”). Thus, nouns possess a *gender*; people possess a given *sex*. *Id.* Gender is not simply a fluid perception; it also represents rules of grammar morphed onto false perceived categories of human beings. *See id.* And language may serve distinctly ideological purposes untethered from scientific empirical data, as described *infra* and *supra*.

II. *Gender Dysphoria* is a psychological disorder marked by confusion and distress about one’s sex.

A gender-dysphoric youth experiences a sense of incongruity between the gender expectations linked to her or his biological sex and her or his biological sex itself. Tomer Shechner, *Gender Identity Disorder: A Literature Review from a Developmental Perspective*, 47 *Isr.*

J. of Psychiatry & Related Sci. 132-38 (2010). Gender-dysphoric boys may subjectively feel as if they are girls, and gender-dysphoric girls may subjectively feel as if they are boys, according to their sense of what that feeling of being a member of the opposite sex must be like. See Am. Psychol. Ass'n, *Diagnostic & Statistical Manual of Mental Disorders* [hereinafter, "DSM-V"] 452 (5th ed. 2013). So, too, dysphoria may manifest with males or females claiming an array of non-binary genders or no gender at all. See Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression 2* (3rd ed. 2014) (explaining that some "[g]enderqueer" people "identify their gender as falling outside the binary constructs of 'male' and 'female,'" and indicating that other gender identities include "androgynous, multigendered, gender nonconforming, third gender, and two-spirit").⁶

Yet subjective feelings, strong as they may be, can neither constitute nor transform objective reality. Cretella, *supra*, at 51 ("[T]his 'alternate perspective' of an 'innate gender fluidity' arising from

⁶ Available at <http://bit.ly/1mZQCsh>.

prenatally ‘feminized’ or ‘masculinized’ brains trapped in the wrong body is an ideological belief that has no basis in rigorous science.”); J. Michael Bailey & Kiira Triea, *What Many Transsexual Activists Don’t Want You to Know and Why You Should Know It Anyway*, 50 *Perspectives in Biology & Med.* 521-34 (2007) (finding little scientific basis for the belief that male-to-female transsexuals are women trapped in men’s bodies). A gender-dysphoric girl is not a boy trapped in a girl’s body, and a gender-dysphoric boy is not a girl trapped in a boy’s body. Students in St. Johns County schools retain their sex irrespective of their beliefs about their gender.

Studies of brain structure and function have not demonstrated any conclusive biological basis for transgendered identity. *See* Giuseppina Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-sex Hormonal Treatment: A Diffusion Tensor Imaging Study*, 45 *J. of Psychiatric Res.* 199-204 (2011) (offering no evidence to support the hypothesis that transgenderism is caused by differences in the structure of the brain); Giuseppina Rametti et al., *The Microstructure of White Matter in Male to Female Transsexuals Before Cross-sex Hormonal Treatment: A DTI Study*, 45 *J. of Psychiatric Res.*

949-54 (2011) (same); Emiliano Santarnecchi et al., *Intrinsic Cerebral Connectivity Analysis in an Untreated Female-to-Male Transsexual Subject: A First Attempt Using Resting-State fMRI*, 96

Neuroendocrinology 188-93 (2012) (in a study of brain activity, finding that a transsexual's brain profile was more closely related to his

biological sex than his desired one); Hans Berglund et al., *Male-to-Female Transsexuals Show Sex-Atypical Hypothalamus Activation*

When Smelling Odorous Steroids, 18 Cerebral Cortex 1900-08 (2008) (in

a study of brain activity, finding no support for the hypothesis that

transgenderism is caused by some innate, biological condition of the

brain). Some researchers believe that transgenderism can be attributed

to other biological causes, such as hormone exposure in utero. *See, e.g.*,

Nancy Segal, *Two Monozygotic Twin Pairs Discordant for Female-to-Male Transsexualism*, 35 Archives of Sexual Behav. 347-58 (2006)

(examining two sets of twins and hypothesizing, without evidence, that

uneven prenatal androgen exposures led one twin in each set to be

transsexual). Presently, no scientific evidence supports that conclusion.

Medically speaking, "There are no laboratory, imaging, or other

objective tests to diagnose a 'true transgender' child." Michael K.

Laidlaw et al, *Letter to the Editor: Endocrine Treatment of Gender-Dysphoria/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline, JCEM*, Online, Nov. 23, 2018.

III. There is no scientific or medical support for treating gender dysphoric children in accordance with their gender identity rather than their sex.

In standard medical and psychological practice, a youth who has a persistent, mistaken belief that is inconsistent with reality is not encouraged in his or her belief. *See Cretella, supra*, at 51 (listing other similar such conditions); Anne Lawrence, *Clinical and Theoretical Parallels Between Desire for Limb Amputation and Gender Identity Disorder*, 35 *Archives of Sexual Behav.* 263-78 (2006) (finding similarities between body-integrity-identity disorder and gender dysphoria). For instance, an anorexic child who experiences herself as obese is *not* encouraged to lose weight. He or she is not treated with liposuction; nor would a school cafeteria be obligated to supply special weight-reduction meals to affirm the student's perception. Instead, he or she is encouraged to align his or her belief with reality—i.e., to see himself or herself as he or she really is. This approach is not just a good guide to sound medical practice. It is common sense.

Until quite recently, these considerations predominated in how gender-dysphoric children were treated. Dr. Kenneth Zucker, long acknowledged as one of the foremost authorities on gender dysphoria in children, spent years helping his patients align their subjective gender identity with their objective biological sex. He used psychosocial treatments (talk therapy, family counseling, etc.) to treat gender dysphoria and had much success. *See Cretella, supra*, at 50 (describing Zucker's work); Kenneth J. Zucker et al., *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*, 59 *J. of Homosexuality* 369-97 (2012). And a systematic follow-up study by Dr. Zucker and his colleagues regarding the children they treated found that gender dysphoria persisted in only three of the twenty-five female patients. Kelley D. Drummond et al., *A Follow-up Study of Girls with Gender Identity Disorder*, 44 *Developmental Psychology* 34-45 (2008).

Dr. Zucker's eminently sound practice is anchored in recognizing the ineradicable reality that each child is immutably either male or female. It is also influenced by the universally recognized fact that gender dysphoria in children is almost always transient: the vast

majority of gender-dysphoric youth naturally reconcile their gender identity with their biological sex. Overwhelmingly, competent authorities agree that between 80 and 95 percent of children who say that they are transgender naturally come to accept their sex and enjoy emotional health by late adolescence. *See, e.g.,* Peggy Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. of Sexual Med. 1892, 1893 (2008). The American College of Pediatricians, for example, recently concluded that as many as 98 percent of gender-confused boys, and 88 percent of gender-confused girls, naturally resolve their dysphoria. Am. C. of Pediatricians, *Gender Ideology Harms Children*, Sept. 2016;⁷ *see also* DSM-V, *supra*, at 455.

Traditional psychosocial treatments for gender dysphoria, such as those used by Dr. Zucker, are prudent; they work with and not against the facts of science and the predictable rhythms of children's psychosexual development. They allow gender-dysphoric children to reconcile their subjective gender identity with their objective biological sex without irreversible effects or using harmful medical treatments.

⁷ Available at <http://bit.ly/2QJ6hTR>.

Although some researchers report that they have identified certain factors associated with the persistence of gender dysphoria into adulthood, there is *no* evidence that *any* clinician can identify with any certainty the perhaps one-in-twenty children for whom gender dysphoria will to some extent persist. *See, e.g.,* Thomas D. Steensma et al., *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-up Study*, 52 *J. of the Am. Acad. of Child & Adolescent Psychiatry* 582-90 (2013). Because such a large majority of these children will naturally resolve their confusion, proper medical practice calls for a cautious “wait-and-see” approach for all gender-dysphoric children. This approach can be and often is rightly supplemented by family or individual psychotherapy to identify and treat the underlying problems that present as the belief that one belongs to the opposite sex.

Policies and protocols that treat children who experience gender-atypical thoughts or behavior as if they belong to the opposite sex, on the contrary, interfere with the natural progress of psycho-sexual development. Such treatments encourage a gender-dysphoric youth to adhere to his or her false belief that he or she is the opposite sex. These

treatments would help the child to maintain his or her dysphoria but with less distress by, among other things, obligating (sometimes by the force of law) others in the child's life to go along with it. Importantly, there are *no* long-term, longitudinal, controlled studies that support the use of gender-affirming policies and treatments for gender dysphoria. Cretella, *supra*, at 52. Not one.

This is particularly concerning as the treatment course moves from social and verbal affirmation to intrusive medical interventions. See Paul W. Hruz, Lawrence S. Mayer & Paul R. McHugh, *Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria*, *The New Atlantis*, Spring 2017 at 6 (discussing the plasticity of youth gender identity and postulating that “[i]f the increasing use of gender-affirming care does cause children to persist with their identification as the opposite sex, then many children who would otherwise not need ongoing medical treatment would be exposed to hormonal and surgical interventions”).

Thus, for schools to adopt gender-affirmation policies is a novel—and dangerous—experiment with no objective scientific basis to support such decisions. Considering all the existing scientific evidence—some

more of which we shall explore—it amounts to bad medicine based upon ideology rather than good medicine grounded in sound scientific evidence.

IV. Gender-affirming policies generally harm, rather than help, gender-dysphoric children.

When schools begin using their privacy facilities to affirm individual student's psychological perceptions, some may say that it is at most a harmless expedient, a bit of play-acting to help children to feel better about themselves during a difficult time in their lives.

There is substantial evidence, however, that this approach is harmful—even when it is viewed on its own terms as a way to help the afflicted youth get through a tough time. The American College of Pediatricians recently declared:

There is an obvious self-fulfilling nature to encouraging young [gender-dysphoric] children to impersonate the opposite sex and then institute pubertal suppression. If a boy who questions whether or not he is a boy (who is meant to grow into a man) is treated as a girl, then has his natural pubertal progression to manhood suppressed, have we not set in motion an inevitable outcome? All of his same sex peers develop into young men, his opposite sex friends develop into young women, but he remains a pre-pubertal boy. He will be left psycho-socially isolated and alone.

Am. C. of Pediatricians, *supra*; cf. Hruz, *Growing Pains, supra*, at 23, 25 (noting that when puberty-suppressing hormones are withdrawn in girls who have been treated for a condition that causes the early onset of puberty, menstruation began at “essentially the average age as the general population”—age 13—but beginning to suppress puberty at age 12 for gender-dysphoric children may create physical or psychological challenges to “simply resum[ing] normal pubertal development down the road”). Indeed, the American Psychological Association Handbook on Sexuality and Psychology cautions against a rush to affirm that “runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist.” W. Bockting, *Ch. 24: Transgender Identity Development*, in 1 American Psychological Association Handbook on Sexuality and Psychology 744, 750 (D. Tolman & L. Diamond eds., 2014).

It is well-recognized, too, that repetition has some effect on the structure and function of a person’s brain. This phenomenon, known as *neuroplasticity*, means that a child who is encouraged to impersonate the opposite sex may be less likely to reverse course later in life. One

study showed that the white matter microstructure of specific brain areas in female-to-male transsexuals was more similar to that of heterosexual males than to that of heterosexual females. *See* Giuseppina Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-sex Hormonal Treatment: A Diffusion Tensor Imaging Study*, 45 *J. of Psychiatric Res.* 199-204 (2011).

The results of that study may be explained by neuroplasticity. For instance, if a boy repeatedly behaves as a girl, his brain is likely to develop in such a way that eventual alignment with his biological sex is less likely to occur. Cretella, *supra*, at 53. Under this logic, then, some number of gender-dysphoric children who would naturally come to peacefully accept their sex are prevented from doing so when gender-affirming policies are imposed upon them by adults in their orbit who have bought into gender identity ideology.

Indeed, policies that compel social affirmation of gender-dysphoric children do not exist in an ideological vacuum. Gender-affirmation policies are typically nested within a larger ideology about how to help children who believe that they are trapped in the wrong bodies.

Although school gender-affirming policies do not themselves require

medical procedures, puberty suppression, hormone therapy, and surgical interventions are almost invariably in the picture. The more that gender identity ideology is promoted to children, the more that children can be expected to accept, and even to pursue, drastic medical courses.

The gender-dysphoric youth surrounded by adults and peers who encourage his or her self-perception is likely to perceive his natural biological development as a source of distress. Puberty-suppressing hormones are often used as early as age eleven to prevent the natural development of unwanted sex characteristics. Henriette A. Delemarre-van de Waal & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Pediatric Endocrinology Aspects*, 155 Eur. J. of Endocrinology S131, S132 (2006). Then, starting at age sixteen, a *faux* puberty akin to that which would normally occur for the opposite sex is induced via a regimen of cross-sex hormones. *Id.* at S133.

Indeed, trans puberty is a misnomer, and “the abnormal, pathologic state of hypogonadotropic hypogonadism is induced by puberty blocking medications. Then dangerous high dose hormones of the opposite sex

are given to cause hirsutism (hair growth of the face, chest, back and abdomen) in females and gynecomastia (abnormal breast tissue growth) in males. The medications also atrophy and chemically degrade the sex organs.” Michael K. Laidlaw, *The Gender Identity Phantom*, gdworkinggroup.org, Oct. 24, 2018 (footnotes omitted).

Importantly, these medical treatments are “neither fully reversible nor harmless.” Cretella, *supra*, at 53; *see also* Hruz, *supra*, at 21-26 (analyzing claims of reversibility). And per Laidlaw, the “consequences of this gender affirmative therapy (GAT) are not trivial and include potential sterility, sexual dysfunction, thromboembolic and cardiovascular disease, and malignancy.” Laidlaw, *Letter, supra* (footnotes omitted). Puberty suppression hormones prevent the development of secondary sex characteristics, arrest bone growth, prevent full organization and maturation of the brain, and inhibit fertility. Cretella, *supra*, at 53. Cross-sex hormones increase a child’s risk for coronary disease and sterility. *Id.* at 50, 53. Oral estrogen, which is administered to gender-dysphoric boys, may cause thrombosis, cardiovascular disease, weight gain, hypertriglyceridemia, elevated blood pressure, decreased glucose tolerance, gallbladder disease,

prolactinoma, and breast cancer. *Id.* at 53 (citing Eva Moore et al., *Endocrine Treatment of Transsexual People: A Review of Treatment Regimens, Outcomes, and Adverse Effects*, 88 J. of Clinical Endocrinology & Metabolism 3467-73 (2003)).

Similarly, testosterone administered to gender-dysphoric girls may negatively affect their cholesterol; increase their homocysteine levels (a risk factor for heart disease); cause hepatotoxicity and polycythemia (an excess of red blood cells); increase their risk of sleep apnea; cause insulin resistance; and have unknown effects on breast, endometrial, and ovarian tissues. *Id.* (citing Moore, *supra*, at 3467-73). “The Endocrine Society’s guidelines recommend elevating females’ testosterone levels from a normal of 10 to 50 ng/dL to 300 to 1000 ng/dL, values typically found with androgen secreting tumors.” Laidlaw, *Letter, supra*. Finally, girls may legally obtain a mastectomy at sixteen, which carries with it its own unique set of future problems, especially because it is irreversible. Should a change of mind later occur, no future procedure can replace functioning mammary glands, so lactation and breast feeding are rendered impossible. *Id.* (citing Lauren Schmidt, *Psychological Outcomes and Reproductive Issues Among Gender*

Dysphoric Individuals, 44 *Endocrinology Metabolism Clinics of N. Am.* 773-85 (2015)).

The Hayes Directory reviewed all relevant literature on these treatments in 2014 and gave it the lowest possible rating: the research findings were “too sparse” and “too limited” even to *suggest* conclusions. Hayes, Inc., *Hormone Therapy for the Treatment of Gender Dysphoria*, Hayes Medical Technology Directory (2014). Unsurprisingly, the FDA does not approve using cross-sex hormones and blocking agents for gender-affirmation treatments.

But such sparse, limited evidence has not inhibited gender identity advocates from proposing aggressive, risky, and, in some respects, irreversible treatments to affirm children in their perceptions about their gender. One of those advocates is Dr. Jason Rafferty. See Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* 142(4) *Pediatrics* (Oct. 2018).⁸ He takes his position despite “almost all clinics and professional organizations in the world us[ing] ... the watchful

⁸ Available at <http://bit.ly/2Ab8n4E>.

waiting approach.” James Cantor, *American Academy of Pediatrics Policy and Trans-kids: Fact-checking*, Sexology Today, Oct. 17, 2018.⁹ Cantor—who is among Rafferty’s critics—further explains: “Not only did [Dr. Rafferty’s article] fail to provide *extraordinary* evidence, it failed to provide the evidence at all” for requiring the affirmative-therapy approach to the exclusion of all others. *Id.*

A recent Finnish study cautioned: “In such situations [of adolescent gender incongruence] appropriate treatment for psychiatric comorbidity may be warranted before conclusions regarding gender identity can be drawn.” Kaltiala-R. Heino et al., *Gender dysphoria in adolescence: current perspectives*, 9 *Adolescent Health, Med. and Therapeutics* 31-41 (2018). Again, the American Psychological Association Handbook on Sexuality and Psychology also cautions against a rush to affirm that “runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist.” Bockting, *supra*, at 750. Indeed, children

⁹ Available at <https://bit.ly/2rT7RDR>.

are not legally capable of assessing the severity of these risks or weighing the perceived benefits of gender affirmance (if any) against its many harms. Amanda C. Pustilnika & Leslie Meltzer Henry, *Adolescent Medical Decision Making and the Law of the Horse*. 15 J. Health Care L. & Pol’y 1 (2012). Neurologically, the adolescent brain is immature and lacks an adult capacity for risk assessment prior to the early to mid-20s. Cretella, *supra*, at 53.

Yet gender-affirming policies urge gender-dysphoric children to forgo their fertility and jeopardize their physical health.

Finally, gender-affirming policies aggressively promote the false notion that gender-dysphoria youths are “trapped in the wrong body.” Consequently, many gender-dysphoric youths will seek at the earliest legal age to obtain the closest thing to their desired body that modern medicine can offer. Simply put: policies such as those at issue in this case will lead some young adults who would have realigned their perceptions with their sex to instead pursue surgery to transform their physical features to approximate the sex that they imagine.

Importantly, there is no sound evidence that such dramatic surgery produces lasting benefits in treating gender dysphoria.¹⁰ Upon reviewing the evidence regarding sex-reassignment surgery, the Hayes Directory stated that “only weak conclusions” were possible due to “serious limitations” in the research to date. Hayes, Inc., *Sex Reassignment Surgery for the Treatment of Gender Dysphoria*, Hayes Medical Technology Directory (2014); Annette Kuhn et al., *Quality of Life 15 Years After Sex Reassignment Surgery for Transsexualism*, 92 *Fertility & Sterility* 1685-89 (2009) (finding considerably lower general life satisfaction in post-surgical transsexuals as compared with females who had at least one pelvic surgery in the past).

Equally telling is Cecilia Dhejne et al., *Long-Term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE, Feb. 22, 2011, which supplied some of the most worrisome data, derived from a survey of the entire population of Sweden. Despite the patients living within a sexually liberal, trans-

¹⁰ One study (Annelou L.C. de Vries et al., *Young Adult Psychological Outcomes After Puberty Suppression and Gender Reassignment*, 134 *Pediatrics* 696-704 (2014)) reported some short-term benefits. But the authors made no effort to assess long-term effects, and their study was, in any event, not properly controlled.

affirming society, the study found that “[p]ersons with transsexualism, *after sex reassignment*, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population.” This include a startling 1,900% increase in death from suicide, a 490% increase in attempted suicide, and a 280% increase in psychiatric inpatient care compared to the general population of Sweden.

It appears that the most radical of treatments with exceedingly powerful hormones and permanently disfiguring and risky surgeries are done because of the child’s self-identification—effectively a self-diagnosis. See David Batty, *Mistaken Identity*, The Guardian, July 30, 2004 (in an assessment of more than 100 follow-up studies on post-operative transsexuals, concluding that none of the studies proved that sex reassignment is beneficial for patients and that none of those studies thoroughly investigated “[t]he potential complications of hormones and genital surgery, which include deep vein thrombosis and incontinence”).¹¹ “The health consequences of [gender affirming

¹¹ Available at <http://bit.ly/2EGBEYO>.

therapy] are highly detrimental, the stated quality of evidence in the guidelines is low, and diagnostic certainty is poor. Furthermore, limited longterm outcome data fail to demonstrate longterm success in suicide prevention.” Laidlaw, *Letter, supra* (footnotes omitted). One outcome is certain: anyone who goes through with “sex-change” surgery will never be able to engage in a reproductive sexual act. *See Hruz, supra*, at 25 (“[M]edical technology does not make it possible for a patient to actually grow the sex organs of the opposite sex . . . Infertility is therefore one of the major side effects of the course of treatment”). “Those started on PB [puberty blockade] at Tanner stage II, as recommended by current guidelines, will be blocked prior to sperm maturation and ovum release. They will have no prospect of biological offspring while on HDCS hormones and continuing on to gonadectomy.” Laidlaw, *Letter, supra*.

What begins in school with a gender-affirmation policy is not likely to stay in school, but rather will bend the normative course of sexual and psychological development in ways that science does not support, and a young student cannot accurately evaluate. Courts and policy are roving far afield from sound science on this issue, and

reversing the lower court in this case is one way to allow science and medicine the time to progress and offer better solutions.

CONCLUSION

Gender-affirmation treatments and the related school policies such as those demanded here assume that treating gender-dysphoric children to affirm their self-proclaimed gender identity rather than their sex is ultimately beneficial to them. But there is no scientific evidence to support that assumption; on the contrary, the evidence shows that affirming the mistaken belief that a child is a prisoner of the wrong body is ultimately harmful to that child.

Amici agree with the American College of Pediatricians' conclusion that conditioning children to believe that a lifetime of impersonating someone of the opposite sex, achievable only through chemical and surgical interventions, is harmful to youths. This Court should reverse the lower court decision that gave legal weight to unfounded scientific conclusions. No judicial imprimatur ought to be given to such a harmful and scientifically unfounded policy.

Respectfully submitted this 27th day of December, 2018.

/s/ James A. Campbell

Gary S. McCaleb

James A. Campbell

Counsel of Record

ALLIANCE DEFENDING

FREEDOM

15100 N. 90th Street

Scottsdale, AZ 85260

(480) 444-0020

jcampbell@adflegal.org

Counsel for *Amici Curiae*

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), the undersigned certifies that this brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B). Exclusive of the sections exempted by Fed. R. App. P. 32(f), the brief contains 5,732 words, according to the word count feature of the software (Microsoft Word 2013) used to prepare the brief. The brief has been prepared in proportionately spaced typeface using Century Schoolbook 14 point.

/s/ James A. Campbell
James A. Campbell
Counsel for *Amici Curiae*

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was filed electronically with the Court's CM-ECF system on this 27th day of December, 2018. Service will be effectuated by the Court's electronic notification system upon all parties and counsel of record.

/s/ James A. Campbell
James A. Campbell
Counsel for *Amici Curiae*

Gov. DeSantis appoints ADF Senior Counsel Denise Harle to Florida Faith-Based and Community-Based Advisory Council

Published December 23, 2021



The following quote may be attributed to **Alliance Defending Freedom Senior Counsel Denise Harle, director of the ADF Center for Life** regarding her appointment by Gov. Ron DeSantis to the Florida Faith-Based and Community-Based Advisory Council:

“Churches and faith-based organizations contribute significantly to any flourishing community through their compassion and care for people, especially to society’s most vulnerable citizens. Recognizing this, Gov. Ron DeSantis established a Faith and Community-Based Initiative to support Florida churches and nonprofits and maximize their invaluable contribution. I am honored and excited to partner with Gov. DeSantis in this mission as I join the initiative’s Advisory Council. Through this partnership, we will serve more churches and ministries, advance important policies that protect life and support adoption and foster agencies, and continue to ensure Floridians—and Americans across the country—can freely live out their faith.”

- Pronunciation guide: Harle (HAR’-lee)

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