

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

JANE DOE et al.,

Plaintiffs,

v.

JOSEPH A. LADAPO et al.,

Defendants.

Civil No. 4:23-cv-00114-RH-MAF

**NOTICE OF FILING DEPOSITION TRANSCRIPT**

Consistent with this Court's instructions, Tr. 476:10-477:10, Plaintiffs file the full and complete transcript of Dr. Monica Mortensen's September 28, 2023 deposition.

Respectfully submitted this 28th day of December, 2023.

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**LOCAL RULES CERTIFICATION**

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

*/s/ Simone Chriss*  
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**CERTIFICATE OF SERVICE**

I hereby certify that, on December 28, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system.

*/s/ Simone Chriss*  
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Counsel for Plaintiffs

Jane Doe

vs.

Joseph Ladapo

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Deposition of:

Monica Mortensen, D.O

September 28, 2023

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*Vol 1*



Monica Mortensen, D.O  
September 28, 2023

IN THE UNITED STATES DISTRICT COURT  
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DEPOSITION OF

MONICA MORTENSEN, D.O.

VOLUME 1 (Pages 1 - 181)

Thursday, September 28, 2023

10:00 a.m. - 3:22 p.m.

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Stenographically reported by:

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September 28, 2023

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2 Proceedings began at 10:00 a.m.:

3 STENOGRAPHER: Do you swear or affirm that the  
4 testimony you're about to give will be the truth,  
5 the whole truth, and nothing but the truth?

6 THE WITNESS: I do.

7 Whereupon:

8 MONICA MORTENSEN, D.O.

9 having been first duly sworn, was examined and  
10 testified as follows:

11 DIRECT EXAMINATION

12 BY MS. CHRISS:

13 Q Dr. Mortensen, thank you for being with us  
14 today. My name's Simone Chriss and I represent the  
15 Plaintiffs in this matter. I'll be asking you some  
16 questions about your expert opinion in this case today.  
17 If we could first just go over some background rules for  
18 the deposition. Have you been deposed previously?

19 A No.

20 Q So you understand that you are under oath  
21 today?

22 A I do.

23 Q And that the oath you took is the same that you  
24 would take in a court of law and you're testifying under  
25 penalty of perjury?

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1 A Correct. Yes. I understand.

2 Q And this requires that you testify truthfully.

3 A Yes.

4 Q So I will do my best, because sometimes I'm  
5 eager, so we're going to try to not speak at the same  
6 time. If you'll let me finish my question, I will try  
7 to let you finish your answer, that way we'll make the  
8 court reporter's job easier for the transcribing. Does  
9 that make sense?

10 A Yes, it does.

11 Q Great. If you don't understand something that  
12 I ask, please ask for clarification and I'm happy to  
13 rephrase the question. But if you don't ask for  
14 clarification I'm gonna assume that you understood the  
15 question, okay?

16 A I understand.

17 Q If you could answer the questions audibly with  
18 words. The court reporter can't take down nods of the  
19 head or things, like, uh-huh or unh-unh.

20 A I understand, yes.

21 Q Great. Occasionally Mr. Perko may make an  
22 objection to a question that is asked. Objections are  
23 made for the record only, you must still answer the  
24 question unless you are instructed not to by Mr. Perko?

25 A I understand.

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1 Q If at any time you want to take a break, need  
2 to take a break, please just let me know, we're happy to  
3 accommodate. The only thing we ask is if there's a  
4 question pending, I've asked a question, that you answer  
5 that question prior to taking a break.

6 A I understand.

7 Q Great. Are you on any medications today that  
8 would prevent you from giving true, accurate, and  
9 complete testimony?

10 A No.

11 Q Is there any reason why you can't give true,  
12 accurate, and complete testimony today?

13 A No.

14 Q All right. Let's get started. You have been  
15 retained as an expert by the defendants in this case,  
16 correct?

17 A Correct.

18 Q And you are also a named defendant in this case  
19 as a member of the Board of Osteopathic Medicine?

20 A Correct.

21 Q Did you prepare an expert rebuttal report in  
22 connection with this case?

23 A Yes, I did.

24 Q And that was rebutting the report of Dr.  
25 Bruggeman?

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1 A And one of your other experts as well, I think.

2 Q Dr. Shumer?

3 A Yes.

4 Q Okay. I am going to show you what we are going  
5 to mark as Plaintiffs' Exhibit 1. Here's for the  
6 witness, for you Mr. Perko. Do you recognize this  
7 document?

8 (Plaintiffs' Exhibit Number 1 was marked for  
9 identification.)

10 A Can I flip through really quick?

11 BY MS. CHRISS:

12 Q Please.

13 A I recognize the first page.

14 Q Make sure you've seen it.

15 A If I can just...

16 Yes.

17 Q And what do you recognize it to be?

18 A This is the expert report that I had written.

19 Q Did you bring any documents with you today?

20 A No, I did not.

21 Q Without telling me about conversations that you  
22 had with counsel, what did you do to prepare for your  
23 deposition today?

24 A For my deposition today?

25 Q Yes.

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1           A       I reviewed my expert report. I reviewed the  
2 Endocrine Society Guidelines, and I reviewed the WPATH  
3 Guidelines.

4           **Q       Anything else?**

5           A       No.

6           **Q       Without telling me the substance of**  
7 **conversations, did you meet with counsel to prepare for**  
8 **this deposition?**

9           A       Yes, I did.

10          **Q       And how many times?**

11          A       I don't remember. I want to say maybe three  
12 times? We've had very brief conversations.

13          **Q       All right. Did you speak with anyone other**  
14 **than counsel for defendants in preparing for this**  
15 **deposition?**

16          A       No, I did not.

17          **Q       Was anyone else present when you met with**  
18 **counsel?**

19          A       No.

20          **Q       Were you provided with any of the other**  
21 **experts' reports or deposition transcripts?**

22          A       Yes.

23          **Q       Which were those?**

24          A       I don't have them in front of me, but the two  
25 pediatric endocrinologists, the surgeons. Then I

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1 believe a nurse practitioner, a psychiatrist, and maybe  
2 a psychologist? I want to say there were seven expert  
3 reports that were sent.

4 Q Okay. And did you review any transcripts of  
5 expert depositions?

6 A No, I did not.

7 Q Okay. Were you provided with any other  
8 materials from counsel?

9 A No, just the expert reports.

10 Q Okay. When you were preparing your expert  
11 report that we marked as Exhibit 1, who did you work  
12 with on that?

13 A Just myself.

14 Q Okay. Did counsel for defendant provide you  
15 with any information while in preparation of your  
16 report?

17 A Just the expert reports that your team  
18 submitted.

19 Q So they didn't provide you with any assumptions  
20 that you relied upon in writing your report?

21 A No.

22 Q What were you asked to opine on in your expert  
23 report?

24 A The concerns about the informed consents.

25 Q Did anyone else provide you with any

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1 information that you considered in writing your report?

2 A No.

3 Q Does the bibliography that you included in your  
4 report include the full scope of information that you  
5 considered while writing it?

6 A I'm going to say no, I think I didn't include  
7 everything because I didn't think it was relevant.

8 Q Can you tell me specifically what you didn't  
9 include?

10 A No, I've reviewed a lot of literature, and some  
11 of it was repetitive or same statements, so I just stuck  
12 with one.

13 Q Okay. Who asked to you be an expert witness in  
14 this case?

15 A Counsel did.

16 Q And when were you retained as an expert in this  
17 matter?

18 A I don't know the exact date, I'd have to check  
19 my e-mail that I received.

20 Q Do you have, like, an approximation? Maybe the  
21 month or month range?

22 A Let's see, it had to be submitted by Labor Day,  
23 so it was September, so it must have been August.

24 Q Do you know why you were asked to be an expert  
25 witness in this case?

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1           A       Because I played a role in helping form the  
2 consents, so since there were concerns about the  
3 consents.

4           Q       Okay. And you are being compensated at an  
5 hourly rate of \$450 an hour for your time?

6           A       That's correct.

7           Q       Dr. Mortensen, have you treated any of the  
8 plaintiffs in this case?

9           A       Not to my knowledge.

10          Q       Have you reviewed the medical records of any of  
11 the plaintiffs in this case?

12          A       To be honest, I don't even know the names of  
13 the plaintiffs of the case, so not to my knowledge.

14          Q       And have you spoken to the treating physicians  
15 of any of the plaintiffs in this case?

16          A       I don't believe so.

17          Q       Okay. So if we could turn to your CV, which is  
18 Exhibit 1 to Exhibit 1, or Attachment 1 to Exhibit 1,  
19 it's labeled at the bottom A1; do you see that?

20          A       I do.

21          Q       Have there been any updates to your CV since  
22 you submitted your expert report?

23          A       I don't think so.

24          Q       Okay. So we're going to go over your  
25 background a little bit. Where did you go to college?

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1 A Loyola University in Chicago.

2 Q What degree did you receive?

3 A A Bachelor's in Science.

4 Q And where did you attend medical school?

5 A Midwestern University, or Chicago college of  
6 Osteopathic Medicine.

7 Q And where did you do your residency?

8 A So I did an osteopathic internship, which is  
9 also considered the first year of residency, at  
10 By^County Hospital, Osteopathic Hospital at in Henry  
11 Ford, it was a joint program in Detroit. Then I  
12 completed the last two years of my pediatric residency  
13 at Lutheran General.

14 Q And your fellowship, where did you do your  
15 fellowship?

16 A I did three years at the University of Chicago.

17 Q And it looks like there was a gap between your  
18 University of Chicago residency ending in 2007, and then  
19 starting a fellowship at Nemours in 2014. What was the  
20 reason for that seven-year gap?

21 A So I had already completed the three years  
22 required, this was an advanced fellowship program that  
23 was for one-years in order to sit for the Pediatric  
24 Endocrinology Boards.

25 Q So what were you doing between 2007 and 2014?

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1           A       So I was working as a pediatrician and a  
2       pediatric endocrinologist.

3           **Q       Where are you currently working?**

4           A       I'm currently working at Nemours Childrens  
5       Health in Jacksonville, Florida.

6           **Q       And how long have you been there?**

7           A       Nine years.

8           **Q       You've had that same position, title,  
9       throughout?**

10          A       Titles have changed. So I started first as a  
11       pediatric endocrinologist, then I became the Associate  
12       Clinical Director for Pediatric Endocrinology, only in  
13       Jacksonville, not a director of all it of. And then  
14       last you I became the Assistant Medical Director of the  
15       Diabetes Center.

16          **Q       Do you have any other current professional  
17       affiliations?**

18          A       Can you clarify what you mean by that?

19          **Q       Any other positions other than that at Nemours?**

20          A       Like as source of income or?

21          **Q       Yes.**

22          A       No.

23          **Q       Okay. Are you employed with the University of  
24       Florida?**

25          A       So I'm not employed by them, but I have an

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1 adjunct position with them as a teaching -- for a  
2 teaching role.

3 Q Okay.

4 A So our -- the fellowship program at Nemours is  
5 sponsored by the University of Florida in Jacksonville,  
6 so I have an adjunct teaching position with the  
7 University of Florida, but I'm not employed or salaried  
8 by them.

9 Q Did you receive any training in medical school  
10 regarding the treatment of gender dysphoria  
11 specifically?

12 A In medical school? No.

13 Q Have you done any original research related to  
14 transgender people or gender dysphoria?

15 A No.

16 Q How about gender identity?

17 A No.

18 Q Let's turn to your presentations, which are on  
19 page A6 of your CV. It looks like you've done  
20 presentations on precocious puberty and Turner Syndrome  
21 and the functional significance of the various types of  
22 ovarian morphologies of polycystic ovarian syndrome, and  
23 the third one is thyroid disorders in children. Are  
24 these the extent of the presentations you've done?

25 A Correct.

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1 Q So no presentations regarding gender dysphoria?

2 A Correct.

3 Q Or transgender healthcare?

4 A Correct.

5 Q We can turn to the next page, page A7 -- well,  
6 I guess starting on A6, you list your clinical practice,  
7 interests, and accomplishments. In their I see general  
8 pediatric endocrinology, PCOS and menstrual disorders,  
9 precocious puberty and pubertal disorders, adrenal  
10 disorders, pediatric calcium and bone disorders, as well  
11 as T1DM and T2DM. Are these the types of care that you  
12 provide?

13 A Correct.

14 Q The conditions that you provide treatment for?

15 A Correct.

16 Q And gender dysphoria is not among those listed?

17 A That's correct.

18 Q What's a Densitometrist?

19 A So that is reading bone mineral density scans,  
20 commonly referred to as DEXA scans.

21 Q Under research interests, on page A7, you list  
22 use of technology to improve diabetes control,  
23 precocious puberty, PCOS, metabolic effects of human  
24 growth hormone, and bone disorders in pediatrics; is  
25 that accurate?

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1 A Yes.

2 Q Okay. So, again, gender dysphoria is not among  
3 the research interests?

4 A Correct.

5 Q If we can go to your -- it says bibliography  
6 for Number 15, are these your publications?

7 A That's correct.

8 Q So this isn't the bibliography associated with  
9 your report, but rather your list of publications?

10 A Correct.

11 Q Okay. All five of these are related to  
12 polycystic ovaries and polycystic ovary syndrome; is  
13 that correct?

14 A That is correct.

15 Q None are related to the treatment of gender  
16 dysphoria?

17 A Correct.

18 Q And these publications range from 2006 to 2012;  
19 is that correct?

20 A Yes.

21 Q Are there any additional publications outside  
22 of these?

23 A No.

24 Q And none of these are original peer-reviewed  
25 research; is that correct?

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1           A       That is incorrect. The Number 3 was  
2 individual, and they were all peer-reviewed, because  
3 they are all in major publications.

4           Q       Okay. So if we could -- we're going to talk a  
5 little bit about your clinical experience, so if we  
6 could turn to paragraph 6 of your expert report, which  
7 is page 2 of Exhibit 1, you state: Speaking on behalf  
8 of myself as a subject matter expert and not as a  
9 representative of Nemours Childrens Health or the  
10 University of Florida. What do you mean when you say  
11 subject matter expert?

12          A       In relation to the consents that were written.

13          Q       Okay. So you hold yourself out as a subject  
14 matter expert on informed consent generally or informed  
15 consent for the treatment of gender dysphoria?

16          A       I would say in relation to the consents that  
17 were written. So, I mean, I think it's very hubris for  
18 people to say that they are experts on things, but I  
19 have written many other informed consents before, and I  
20 was involved in this informed consent.

21          Q       What other types of informed consent forms have  
22 you written?

23          A       I've written the informed consent for the use  
24 of puberty blockers for our center, and I've  
25 also written some of the informed consents for the

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1 research that I had performed. I am not a PI for some  
2 of the research in our center, but I am a Sub-I, so I  
3 have reviewed and been involved in some of those  
4 consents as well.

5 Q And when you say research, what types of  
6 research?

7 A So as was listed in my statement, so we do  
8 research in devices for diabetes. We are doing research  
9 in central precocious puberty, research for various  
10 different medications for industry research.

11 Q Okay. No research on the treatment of gender  
12 dysphoria though?

13 A Correct.

14 Q Okay. In paragraph 7 -- actually, we discussed  
15 that, you said you didn't receive -- actually, no, we  
16 didn't. You said in your medical degree, in medical  
17 school you didn't receive treatment specific to gender  
18 dysphoria, but in getting your bachelor degree was there  
19 any training specific to gender dysphoria?

20 A No.

21 Q And you stated in your medical degree there  
22 wasn't training specific to treatment of gender  
23 dysphoria?

24 A Correct.

25 Q In paragraph 8 you state you completed an

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1 osteopathic internship in pediatrics at Bi-County Henry  
2 Ford Hospital. Did you receive any training on the  
3 treatment of gender dysphoria then?

4 A No.

5 Q How about at your residency at Advocate  
6 Lutheran General Hospital?

7 A No.

8 Q Did you spend any clinical hours treating  
9 patients with gender dysphoria?

10 A At what timeframe are you asking?

11 Q During your residency?

12 A No, I did not.

13 Q Is it accurate that Advocate Lutheran General  
14 Hospital is part of the Advocate Healthcare System?

15 A At that time, yes. I don't know if it still is  
16 currently.

17 Q And is it accurate that that's a faith-based  
18 nonprofit hospital in Illinois?

19 A It's quite possible, yes.

20 Q You are not certain?

21 A I'm not certain.

22 Q I'm going to show you what we'll mark as  
23 Exhibit 2. If you see here where it says: Our  
24 mission -- the one, two, fourth paragraph down, it says:  
25 Our mission is to serve the health needs of individuals,

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1 families, and communities through a holistic philosophy  
2 routed in our fundamental understanding as human beings  
3 as created in God's image. Is that accurate?

4 (Plaintiffs' Exhibit Number 2 was marked for  
5 identification.)

6 A If you are asking what I'm reading, that you  
7 read that correctly? Yes.

8 BY MS. CHRISS:

9 Q And is the Advocate Healthcare, is this -- is  
10 it your understanding that this is from the institution  
11 where you received -- where you did your fellowship?

12 A Looking at the logo correct, but I also  
13 graduated a long time ago so I'm not sure what the  
14 mission statement was at that time, and this is saying  
15 it's in 2022. So I'm not 100 percent certain as to what  
16 the mission statement was back then.

17 Q Okay. So Dr. Mortensen, your fellowship with  
18 the University of Chicago, did you receive any training  
19 on the treatment of gender dysphoria at that time?

20 A No.

21 Q So you did not have any clinical hours  
22 providing treatment for patients who had gender  
23 dysphoria?

24 A Correct.

25 Q During your -- the gap between 2007 and 2014,

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1 when you came to Nemours, did you provide any treatment  
2 for gender dysphoria during that time?

3 A No. Personally, no.

4 Q What do you mean by personally?

5 A There were some people in our center who were  
6 providing some transgender care for adults.

7 Q But you were not involved in that treatment?

8 A Correct.

9 Q And you didn't do any training or receive any  
10 specialized knowledge on the treatment of gender  
11 dysphoria?

12 A Correct.

13 Q If we can turn to page 3, look at paragraph 10  
14 of your expert report. This is back to Exhibit 1. You  
15 state in paragraph 10 that you have extensive experience  
16 in treating children, adolescents, and young adults with  
17 endocrine conditions, including differences in sex  
18 development, Turner Syndrome, gonadal failure, delayed  
19 or precocious puberty, as well as Type 1 diabetes,  
20 thyroid disorders, and growth problems.

21 What types of medications do you prescribe for  
22 children and adolescents with DSD?

23 A So if we are seeing more specifically for  
24 Turner Syndrome or gonadal failure I'll use  
25 testosterone, forms of estrogen.

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1 Q Anything else?

2 A I mean for growth hormone we use growth  
3 hormone, we use anastrozole.

4 Q What about for delayed for precocious puberty?

5 A Precocious puberty we've use pubertal blockers,  
6 such as Lupron, or various forms of Lupron. And for  
7 delayed puberty we've used testosterone or estrogen to  
8 start puberty.

9 Q What about for Type 1 diabetes?

10 A Various forms of insulin and medical devices to  
11 deliver insulin and continuos glucose monitors.

12 Q What about for thyroid disorders?

13 A Depending on the type of thyroid disorders we  
14 would use thyroid hormone replacement, whether that be  
15 T3 of T4, or for hyperthyroidism, methinozole,  
16 Tapazole. Sometimes a beta blocker for an accelerated  
17 heart rate.

18 Q Okay. And for growth problems?

19 A Typically growth hormone deficiency. We would  
20 use growth hormone.

21 Q Okay. Are there other medications that you  
22 use, prescribe, for patients who have -- you mention  
23 adrenal disorders, menstrual irregularities, polycystic  
24 ovarian syndrome?

25 A Sure. We have -- I have prescribed birth

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1 control pills, metformin for PCOS. For -- what was the  
2 other question? Oh, for adrenal disorders. If they  
3 have something like congenital adrenal hyperplasia they,  
4 basically, have a lack of hormone, you give them  
5 hydrocortisone, Solu-Cortef, or Florinef, depending on  
6 the underlying disorder.

7 Q Okay. You state in that same paragraph 10:  
8 For about two years I saw and treated adolescents  
9 diagnosed with gender dysphoria. What two years were  
10 those?

11 A I'd have to go back in my reports, but I would  
12 say it was about 2017, because that's when the consensus  
13 guidelines were released.

14 Q What do you mean by consensus guidelines?

15 A Or the policy statement, or statement from the  
16 Endocrine Society in regards to gender dysphoria.

17 Q So you provided -- that statement of: For  
18 about two years I saw and treated adolescents diagnosed  
19 with gender dysphoria was, you believe, starting in 2017  
20 after the release of --

21 A Probably around that time, yes.

22 Q So 2017 to 2019?

23 A Most likely, yes. I believe so.

24 Q Okay. How many adolescents did you see who  
25 were diagnosed with gender dysphoria?

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1           A       I couldn't say an exact number that I treated.  
2 I would say it was probably less than 10.

3           **Q       How many did you diagnose with gender**  
4 **dysphoria?**

5           A       They typically came in with the diagnosis, so  
6 they were typically seen by a psychologist or therapist  
7 and were diagnosed. We would further discuss that  
8 diagnosis to confirm whether or not it was a true  
9 diagnosis.

10          **Q       So would it be fair to say you didn't diagnosis**  
11 **any adolescents with gender dysphoria yourself?**

12          A       Correct.

13          **Q       And of the 10 that you mentioned, how many did**  
14 **you determine their diagnosis was correct?**

15          A       Out of the 10 I suspected that maybe two or  
16 three were correct.

17          **Q       What do you mean by correct?**

18          A       That they had a thorough, in-depth evaluation.  
19 That it had started well in childhood, or later in  
20 adolescence. And that they truly were having a lot of  
21 mental health issues related to the onset of puberty and  
22 going through puberty.

23          **Q       So for those two or three who were correctly**  
24 **diagnosed, did you prescribe them medication?**

25          A       They were already on medication, so I continued

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1 their care.

2 Q Okay. And does that mean prescribing --

3 A A puberty blocker.

4 Q Okay. So for those you thought two or three,  
5 did you prescribe puberty blockers, did you prescribe  
6 any hormones?

7 A No. At our center we didn't feel comfortable  
8 with the cross-hormones, so they were transitioned over  
9 to an another multidisciplinary center, because we were  
10 not set-up as a multidisciplinary center.

11 Q But you did feel comfortable prescribing the  
12 puberty blockers?

13 A At the time I did.

14 Q And for the remaining seven or eight that you  
15 suspected were not diagnosed correctly, what did you do  
16 for them?

17 A I told them that I didn't feel that they met  
18 the criteria, but I also stated that we weren't a  
19 multidisciplinary center and I referred them to other  
20 centers that were either in Florida, or at that time  
21 Duke and other centers were doing it as well, saying  
22 that I wasn't 100 percent sure, so it was best they went  
23 to a center that had more experience to determine if  
24 this was the actual diagnosis and the proper course of  
25 treatment.

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1 Q And when you say center, I presume you are  
2 saying about multidisciplinary treatment centers that  
3 provide treatment for gender dysphoria?

4 A That is correct.

5 Q And so when you say that you assessed them to  
6 determine whether their gender dysphoria diagnosis was  
7 correct or not, what training did you have in assessing  
8 folks for gender dysphoria?

9 A I didn't have any formal training. I mean,  
10 this -- at that time it was a very relative new  
11 specialty, so anyone stating in 2015 and '17 that they  
12 are leading experts is kind of loosely driven. This is,  
13 kind of, a new specialty area. But I met with several  
14 other endocrinologists, I spoke with other friends that  
15 were working in transgender care for their opinions,  
16 support, resources to read, et cetera.

17 So we wanted to be able to provide something,  
18 because there was such a backlog of patients at these  
19 centers, that we wanted to be able to try to provide  
20 some type of support until they could get into a more  
21 multidisciplinary center, but I had no formal training.  
22 You can ask a lot of physicians about psychology, we are  
23 trained in psychology, we do learn that in med school,  
24 we learn that in residency, we learn that in life of  
25 doing these kind of evaluations.

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1 Q But no training specific to the diagnosis of  
2 gender dysphoria, correct?

3 A Correct.

4 Q When you say you met with several other  
5 endocrinologists, who were those endocrinologists?

6 A They've asked not to have their names released.

7 Q What facility or what institutions did they  
8 work at?

9 A They've asked not to have their names released.

10 Q What's the basis for them --

11 A They are afraid of discrimination and  
12 retaliation.

13 Q When you say you spoke with friends who  
14 provided treatment for gender dysphoria, who were those  
15 friends?

16 A They asked not to have their names released.

17 Q Dr. Mortensen, I respect the concerns that your  
18 colleagues have raised, but given that you have put this  
19 at issue in your report and relied on the statements of  
20 what these folks have shared with you, I would ask that  
21 you answer the question as to who these folks are and  
22 where they work?

23 THE WITNESS: May I ask counsel a question?

24 MS. CHRISS: (Shakes head.)

25 MR. PERKO: You can answer the question.

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1           A     Okay. One of the people who had provided me  
2     some information and where to go with the consent was  
3     Sara DiVall, she's at Seattle Childrens.

4     BY MS. CHRISS:

5           Q     Okay.

6           A     Another one was Priti Patel.

7           Q     I'm sorry, can you say that again.

8           A     Priti, P-R-I-T-I, Patel. And at the time she  
9     was in San Antonio, Texas, I believe. She's now in  
10    Arizona. And I briefly spoke with Jennifer Robbins, and  
11    she is at Lurie Childrens in Chicago.

12          Q     Is that all?

13          A     Yes.

14          Q     So is it fair to say, if I got this correct,  
15    these were all folks outside of the state of Florida?

16          A     Correct.

17          Q     Did any of these folks provide treatment for  
18    gender dysphoria to adolescents at this time?

19          A     All of them did.

20          Q     So they were all providing treatment to  
21    adolescents with gender dysphoria and were advising you  
22    on you providing that care; is that correct?

23          A     Correct.

24          Q     Okay. So you prescribed puberty blocking  
25    medication for the two or three that you thought were

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1 correctly diagnosed?

2 A Correct.

3 Q And did you do that in accordance with the  
4 Endocrine Society Guidelines?

5 A Correct.

6 Q And you didn't prescribe hormones for any?

7 A Correct.

8 Q And in paragraph 13 of your expert report you  
9 state: We did not have a multidisciplinary youth gender  
10 program. What is your understanding of what a  
11 multidisciplinary youth gender program is?

12 A So I view it as, multidisciplinary, as people  
13 from different areas of medicine, so you would expect a  
14 physician, a psychologist, a social worker, possibly a  
15 surgeon at the very least, and any other kind of support  
16 staff that would be needed. Then all of them would be  
17 trained in that specific discipline.

18 Q And so Nemours does not have a  
19 multidisciplinary clinic, correct?

20 A Correct.

21 Q You say you sought to evaluate and assist these  
22 adolescents as they tried to establish care at UF  
23 Gainesville. By UF Gainesville I presume you mean the  
24 youth gender program?

25 A Correct.

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1           **Q     What did you do to assist the adolescents?**

2           A     So some was to make sure they had appropriate  
3 resources so they could speak with our social worker  
4 about social transitioning. We have a psychologist  
5 there who started, and mostly saw our kids with DSD, so  
6 that was a special interest for her. She actually went  
7 and got more specialized training in regards to  
8 transgender care and transgender therapy. So we would  
9 try to get her in -- try to get the patients in to see  
10 her because we could trust her judgement and know she  
11 had the training.

12                     Sometimes they would ask for, specifically, for  
13 someone trained like her, so we could get her in. And  
14 then they were asking for more resources out in the area  
15 or other specialty programs that they could go to.

16           **Q     What's the name of the psychologist you**  
17 **mentioned?**

18           A     Lisa Buckloh.

19           **Q     So you referred patients who needed medical**  
20 **treatment to the UF multidisciplinary clinic?**

21           A     That or there was one in Orlando, there was one  
22 in Tampa as well.

23           **Q     And there were folks at those centers that**  
24 **were -- that had the expertise in treatment of gender**  
25 **dysphoria?**

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1 A That they reported they had the expertise, yes.

2 Q And you have no reason to believe they didn't,  
3 right?

4 A Sure.

5 Q Have you monitored care, other than the two to  
6 three patients you mentioned, have you monitored care  
7 for any patients undergoing gender-affirming medical  
8 treatment?

9 A Could you explain more what you mean by monitor  
10 for care.

11 Q Yeah. Are there patients that you have  
12 provided care to in any capacity who were receiving  
13 puberty blocking medication or cross-sex hormones for  
14 the treatment of their gender dysphoria?

15 A So you mean they're being treated by another  
16 center, but I might be treating them for a different  
17 endocrinology reason or providing support during that  
18 care.

19 Q Yes.

20 A Just to clarify.

21 Q Yes. Thank you.

22 A Yes, I have.

23 Q Okay. How many adolescents would you say  
24 you've monitored?

25 A I would say there was probably about three or

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1 four adolescents that were being seen at other centers  
2 that needed -- because of their insurance, like, they  
3 might have been going out of state for care and so they  
4 needed lab work to be ordered in-state by a state  
5 physician so their insurance would cover it, or they  
6 needed blood pressure checks or height checks or puberty  
7 checks so that we could, kind of, help assist with that,  
8 we could send our note over.

9           The patient -- the parent could get their  
10 record and share it with their endocrinologist that was  
11 managing, so there was probably just a small handful of  
12 those kids, but I would say that I see probably at least  
13 100 kids who have stated that they are transgender that  
14 I follow for either CAH or polycystic ovarian syndrome  
15 or other disorders, thyroid disease, et cetera. So they  
16 are being treated elsewhere for their  
17 transgender-affirming care, but they are being followed  
18 from me for their other medical endocrine issues.

19           **Q     Okay. Sorry, tell me that number again?**

20           A     Probably close to 100 over the years. I  
21 couldn't say what I'm actively, because many times they  
22 age out.

23           **Q     Okay. All right. Dr. Mortensen, does your**  
24 **expert report contain all of the opinions that you**  
25 **intend to provide at trial in this case?**

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1 A To my knowledge, yes.

2 Q Does paragraph 2 of your expert report, going  
3 back to page 1, does that summary -- is that an accurate  
4 summary of the opinions you are offering in this case?

5 A Yes.

6 Q When you say the bans on access to medications  
7 and surgeries for transgender youth that was set forth  
8 by the Florida Boards of Medicine and Osteopathic  
9 Medicine, are you referring there to the rules that were  
10 implemented prior to SB 254?

11 A Could you clarify what you mean?

12 Q Yeah, so there were rules implemented by the  
13 Board of Medicine and Board of Osteopathic Medicine that  
14 went into effect in March of this year. Then in May of  
15 this year, SB 254 went into affect, then that led to the  
16 Board adopting emergency rules and informed consent  
17 rules. But are you referring here to the rules that the  
18 board you sit on promulgated predating SB 254?

19 A I'm trying to think how to answer that.  
20 Because I wasn't really -- I didn't join the board until  
21 December, so some of the rules were already in place,  
22 but my expert opinion is really more on the consents,  
23 which was driven more by the law. Because the board did  
24 not say the consents needed to happen, the law did.

25 Q Is it correct that you were appointed to the

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1 Board of Osteopathic Medicine in December of 2022?

2 A That's correct.

3 Q And the rules at issue that I mentioned weren't  
4 voted on until February of 2023, so is it fair to say  
5 you were on the board at that time?

6 A That is fair to say, yes.

7 Q They went into effect in March of 2023?

8 A Correct.

9 Q Okay. Great. Paragraph 16 of your expert  
10 report, which is on page 5, you list the additional  
11 sources documents that you reviewed in creating your  
12 expert report. This includes the two rules that I just  
13 mentioned that went into effect in March, as well as SB  
14 254 and it's implementing emergency rules. Is that  
15 accurate that those are what you relied upon writing  
16 this report?

17 A Yes.

18 Q And are you -- you are opining on the treatment  
19 for minors, correct?

20 A Correct.

21 Q You, as in your role, you treat minors, not  
22 adult; is that correct?

23 A Correct.

24 Q And you've never provided treatment for adults?

25 A Correct.

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1 Q Specifically, in paragraph 16, the rule  
2 promulgated by the Board of Osteopathic Medicine, Rule  
3 64B15-14.014, Standards of Practice For the Treatment of  
4 Gender Dysphoria in Minors. You voted in favor of that  
5 rule; is that correct?

6 A That is correct.

7 Q And you were also part of the body that, Board  
8 of Osteopathic Medicine, that created the emergency  
9 rules and informed consent forms related to SB 254?

10 A That is correct.

11 Q In paragraph 17 you state: I reviewed the  
12 materials that were provided to the Rules and Regulation  
13 Committee for the Florida Board of Medicine and the  
14 Florida Board of Osteopathic Medicine. What is the  
15 Rules and Regulation Committee?

16 A So there are different committees for the  
17 boards, whether there be a disciplinary or physician  
18 assistant or pharmacy. And so their are different  
19 committees that are set out for different roles. So  
20 they had a Rules and Regulations Committee set up for --  
21 pertaining to the consents, is my understanding.

22 Q And what materials were provided to that  
23 committee?

24 A So I don't have access to them in front of me,  
25 but, typically, they will provide anything that has been

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1 submitted to the Board. So the WPATH Guidelines were in  
2 there. The statement from the Endocrine Society.  
3 Various publications from various -- whether it be  
4 scientific journals or whether it be news reporting  
5 articles. Statements from the community as well,  
6 whether people sent in e-mails of concerns or people  
7 provided more information as well as to their opinion or  
8 data to support their opinion.

9 Q Are these what I think are referred to as  
10 public books?

11 A Uh-huh.

12 Q And those were published online on the Florida  
13 Board of Medicine and Osteopathic Medicine's web site  
14 prior to the meetings?

15 A I believe so. I mean, we have an i-Viewer, so  
16 I don't know the public has access to all of those? I  
17 would assume they do, but I'm not 100 percent sure, it's  
18 just what was provided by the Board for review prior to  
19 meeting.

20 Q If there's anything that was provided to you  
21 that wasn't a part of the public books that were  
22 produced to us by defendants, could we get a copy of  
23 those materials?

24 A Such as? I'm not quite sure what you are  
25 asking.

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1 Q I believe you stated you weren't sure if the  
2 public books available to public online are the full  
3 extent that were provided to the Rules and Regulations  
4 Committee.

5 A Okay.

6 Q To the extent there was anything that was  
7 provided to you-all that you relied upon that's not in  
8 the public books, could we have a copy of those?

9 A I would assume so.

10 MS. CHRISS: Mr. Perko, could we request to get  
11 a copy of that?

12 MR. PERKO: I have to confirm whether or not  
13 there were. My understanding is everything was  
14 provided already.

15 BY MS. CHRISS:

16 Q All right. Dr. Mortensen, you stated that you  
17 have not testified as an expert in the past four years;  
18 is that correct?

19 A Correct.

20 Q Have you ever testified as an expert?

21 A No, I have not.

22 Q Have you ever testified in any capacity?

23 A No, I have not.

24 Q Okay. All right. Dr. Mortensen, what's gender  
25 identity?

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1 A That's a very open question.

2 Q **What's your understanding of gender identity?**

3 A There's a lot of different phrases and words  
4 that people have used, and a lot of the terminology has  
5 changed a lot as well. So I guess the most simplest  
6 explanation is gender identity is the identity of which  
7 as person has as to what they believe their gender is.  
8 Whether it be the one they were born with or one that  
9 they were assigned or the one that they affirm to be.

10 Q **Do you believe a person's gender identity can**  
11 **differ from their sex assigned at birth?**

12 A I do.

13 Q **Do you believe that gender identity can be**  
14 **changed by external influences, such as social medial or**  
15 **peer pressure?**

16 A I believe there can be a temporary influence  
17 over it.

18 Q **Can you explain a little more about what you**  
19 **mean?**

20 A So in my experience, I've seen a lot of kids  
21 who may be more neurodivergent who have a hard time  
22 fitting in and that have gravitated towards that, that  
23 they temporarily feel that maybe they would be better,  
24 maybe they do identify, but over time they recognize  
25 that that was just more of an influence and not what

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1 their true gender identity is.

2 Q Are you familiar with the WPATH Standards of  
3 Care?

4 A Yes.

5 Q Do you agree that they should be used in  
6 treating people with gender dysphoria?

7 A I think if people actually follow them the way  
8 that they were suggested and proposed that it would be  
9 very reasonable.

10 Q Do you have any basis for believing people  
11 aren't following them the way they were suggested?

12 A I do. I feel that from my experience in seeing  
13 some of the patients in my clinic for other disorders  
14 that I -- I've had kids who have been victims of abuse  
15 and haven't really explored that, that's why they don't  
16 feel comfortable in their gender, because they were  
17 sexually assaulted or abused and so it would be better  
18 for them, in their mind, to protect themselves and their  
19 body and psyche to be a male instead of a female. And I  
20 have seen some of these patients be affirmed and  
21 transitioned. And I've also seen they are starting to  
22 do things much, much younger than what was ever proposed  
23 or what was ever previously studied.

24 Q How many adolescents would you say you've  
25 treated who you believe that entered the category of

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1 **experiencing sexual abuse and that being the basis for**  
2 **their transgender identity?**

3 A I wouldn't say that's a majority of them, I  
4 would say it's a smaller subset. I think there's a  
5 multitude of different reasons, but I think that's the  
6 importance of really having a good psychologist do the  
7 evaluation to see where is this really coming from. But  
8 there's, you know, been, you know, about a handful of  
9 kids that had some kind of assault.

10 There's been a good number that they just feel  
11 uncomfortable with the transition of going from being a  
12 child to an adult, especially for young girls becoming  
13 woman. The idea of menstrual cycles and their body  
14 changing and their breast developing and all the horrors  
15 that they hear about it, so there's all the fear and  
16 concern and hormones really can change your opinion and  
17 your views. So I've seen a lot more confused about  
18 their sexuality than their actual gender.

19 So I've had young adults tell me that they are  
20 transitioning because their parent won't accept them as  
21 being gay and would rather accept them as a different  
22 gender instead of being gay. I've had them say they  
23 want to be accepted by their partner's parents and that  
24 they don't accept them being gay, so they are  
25 transitioning to get the approval of somebody else.

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1           It's just, kind of, surprising that they were  
2 able to go through programs and not have that picked up  
3 and recognized, that there's nothing wrong with being  
4 gay, and you shouldn't have to transition because you  
5 are gay. So that's why there's been, kind of, a lot of  
6 question and concern on my half of what's really  
7 happening with these kids? Is there really an in-depth  
8 thorough evaluation?

9           **Q     Dr. Mortensen, when you say you've seen people**  
10 **fall into these various categories you just mentioned.**  
11 **In what capacity have you seen them? Are you treating**  
12 **them for other conditions?**

13           A     Correct, for other conditions.

14           **Q     Are you interacting with these folks or**  
15 **learning about them in any other capacity?**

16           A     Could you clarify what you mean by that?

17           **Q     Yeah. Are you anecdotally hearing these**  
18 **stories from others or are these all patients that you**  
19 **directly are treating?**

20           A     I'm only going to refer to the ones that I  
21 directly treat. I have heard stories from other  
22 colleagues of mine, but that's hearsay, so I'm just  
23 going to go based on my personal experience with my  
24 patients.

25           **Q     And where are these patients receiving their**

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1 **treatment for gender dysphoria?**

2 A At various centers, either in Florida or out of  
3 the state.

4 **Q Which centers?**

5 A So I've heard one of them was going to Tampa, I  
6 heard another was going to UF, and I know that one, I  
7 think, went to Duke. And one said she went out of state  
8 but she didn't clarify. And I try not to dive too deep  
9 into it, I mean, I'm thrilled they are sharing their  
10 experience with me, telling me things, I certainly don't  
11 want to overstep my bounds, I want it to be a safe  
12 space, so I'll often say I'm sorry they are experiencing  
13 this, maybe this is something they should address with  
14 their team to discuss. So I don't encourage or  
15 discourage it. I encourage that they have -- continue  
16 to have those courageous conversations with the people  
17 that are treating their gender dysphoria. For all I  
18 know, maybe they weren't as up front and honest with the  
19 treating team as well.

20 **Q So you have no basis for believing they aren't**  
21 **having these discussions with their mental health**  
22 **providers and treatment teams?**

23 MR. PERKO: Object to form. You can answer.

24 A Oh. I can say that some of them haven't had  
25 those courageous conversations, and that's the concern

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1 is when I did -- I don't dig deeper, but I ask, Oh, have  
2 you talked about this with your therapist or with the  
3 team? And they are like, No, not really. I say, Well,  
4 why? I think that's important to address. I mean, they  
5 might want to benefit from knowing all of this. So  
6 maybe at your next visit you should bring this up and  
7 talk with them about it.

8 Sometimes it's a shame they feel about being  
9 gay or their relationship with their family, so they  
10 don't want to bring it up, because their family is happy  
11 that they are transitioning and that they are not gay.

12 **Q How many youth have directly told you or shared**  
13 **with you that they are transitioning because they are**  
14 **not accepted as gay?**

15 A At least four that I can come to, that I can  
16 see their faces.

17 **Q Where were those four receiving treatment?**

18 A I didn't ask.

19 **Q Did you take any action to, you know, maybe**  
20 **reach out to their treating provider or seek for them to**  
21 **meet with your psychologist?**

22 A I always offer our psychologist, so, you know,  
23 seeing that some of them have to travel, I say if you  
24 are not comfortable, or you are not happy with the  
25 therapist that you are currently using, we have a

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1 wonderful person that works in this area and I could do  
2 a referral to them. Or, if you want, I can have a  
3 conversation. So I really leave it up to the patient  
4 and/or the parent, because sometimes these conversations  
5 are without the parent as well, that they don't feel  
6 comfortable in front of their parent.

7 Q Have you ever reached out to the treating  
8 provider if you felt like the treatment being provided  
9 to this individual was inappropriate?

10 A I haven't.

11 Q Do you agree that puberty blockers can be an  
12 effective treatment for gender dysphoria in adolescents?

13 A I think that's very unclear.

14 Q So are there any instances in which you believe  
15 puberty blockers can be an effective treatment for  
16 gender dysphoria in adolescents?

17 A I believe yes, there probably is a percentage  
18 that would benefit from it.

19 Q Is it safe to say it should be assessed on a  
20 case-by-case basis?

21 A Yes.

22 Q What about hormones, do you agree that  
23 cross-sex hormones can be effective treatment for gender  
24 dysphoria?

25 A I think the jury is still out on that as well,

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1 but I do think there's part of the population that, yes,  
2 they would benefit from it.

3 Q Do you think surgery can ever be an effective  
4 treatment for gender dysphoria in adults?

5 A I think that the technologies are certainly  
6 advancing, so there certainly have had some successful  
7 outcomes, especially with, like, feminizing surgery for  
8 the face and breast implants. I think that genital  
9 surgeries there's still a lot work to be done, but, yes,  
10 there's some role in that.

11 Q So you think it can be effective to alleviate  
12 gender dysphoria in some instances?

13 A Some instances yes.

14 Q Do you think hormones can be an effective  
15 treatment for gender dysphoria in adults?

16 A In some, yes.

17 Q Do you believe that medications can ever  
18 appropriately be prescribed for off-label use?

19 A Yes.

20 Q Do you think there are circumstances where it's  
21 appropriate to dissuade a transgender person from  
22 conforming to their identity?

23 A What do you mean by dissuade?

24 Q Do you think there's instances where it would  
25 be appropriate to dissuade, deter, encourage a person to

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1 **identify in accordance with their sex assigned at birth,**  
2 **as opposed to their gender identity?**

3 A I don't think it's a role for someone to tell  
4 someone what opinion they should have. I think that if  
5 that person is experiencing those feelings and thoughts  
6 that they should be explored as to why they are having  
7 those feelings and thoughts and how to best manage those  
8 feelings and thoughts.

9 Q Do you think that the state of Florida should  
10 bar gender transition treatment for adolescents because  
11 the WPATH and Endocrine Society Guidelines are supported  
12 by low quality or poor quality evidence?

13 A I do.

14 Q So not on a case-by-case basis?

15 A I lean more towards, because we couldn't -- we  
16 have no role in research, so initially there was talk of  
17 research, but I believe that the people in Europe who  
18 have for more expertise and experience in this field  
19 that have been the pioneers of this field, they have  
20 really restricted and doing it more by a case-by-case,  
21 but it's really limited to a research setting in some of  
22 the countries.

23 So I feel if the person who's the expert and  
24 has been the one proposing all of these guidelines and  
25 spreading the guidelines has put a pause or a stop on

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1 it, it makes me put a pause and a stop on it.

2 Q Isn't it true, though, that in these other  
3 countries they have restricted, as you mention,  
4 providing this care in the context of clinical trials,  
5 but they have not categorically banned the treatment?

6 A I think some have banned and some have  
7 restricted, I can't speak to which ones.

8 Q When you say we have no role in research, who's  
9 the we you are referring to?

10 A The Board. So at one point it was proposed  
11 that it could be still used for research, like in  
12 research projects that, you know, have regulation, but  
13 we were informed that the Board does not hold any  
14 authority over -- over research, and that's more of a  
15 national role and not a state role or a Board role.

16 Q Is it true that in February, on February 10th  
17 of 2023, yourself and the other members of the Joint  
18 Boards voted to -- or the Board of Osteopathic Medicine,  
19 voted to remove the Section 2 of the rule that would  
20 have allowed for the IRB approved clinical trials to --  
21 for the initiation of care?

22 A That is true, because if it wanted to be  
23 through research it's federal regulation, not state  
24 regulation. So that research could still happen.

25 Q But you have banned the treatment for minors

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1 that have not yet initiated care, so how could that  
2 research happen?

3 A Because it's more on a national level, it's  
4 through, like, the National Institute of Health and  
5 those, just like you can do other medications and  
6 studies as well.

7 Q But the providers in the state of Florida are  
8 banned under penalty of criminalization from providing  
9 this care to minors so they cannot participate in  
10 research, clinical research trials, correct?

11 A That's not my understanding. That if they had  
12 proposed research and it was approved from a federal  
13 standing that they could still do research.

14 Q And what is the basis for that understanding?

15 A I believe one of the -- one of the people at  
16 one of the meetings who was for -- represented the state  
17 had made comments about that, that we had no regulation,  
18 if people wanted to do it, that doesn't block them from  
19 doing it, provided it goes through an IRB, because it's  
20 more of a national regulation, not a state regulation,  
21 was my understanding.

22 Q Okay. We'll come back to that. Returning just  
23 for a moment to your discussion about other countries.  
24 What's the basis for your knowledge of what's happening  
25 in Europe?

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1           A       So there's been a lot of press and media  
2 released about that. So some of it is just, you know,  
3 things that I picked up from newspaper articles. I  
4 think I provided one in the bibliography as well. Then  
5 just, kind of, discussion amongst my peers about what's  
6 been going on.

7           **Q       So you think that some countries have banned,**  
8 **not just restricted, but banned this treatment for**  
9 **minors?**

10          A       I believe so.

11          **Q       But you can't name which countries?**

12          A       I'm not 100 percent certain which ones have  
13 completely banned, and I know that some have restricted  
14 and some have said under case-by-case, and I know some  
15 have said only under research purposes. I couldn't  
16 speak to which ones.

17          **Q       How important was your understanding of what**  
18 **was happening internationally in your decision to vote**  
19 **in support of Florida's ban?**

20                   MR. PERKO: Object to form. You can answer.

21          A       Okay. I think when we are taking a look at the  
22 WPATH and we are taking a look at the Endocrine  
23 Society's statements, a lot of it is based on expert  
24 opinion. And many of those experts come from Europe,  
25 because this is a relatively new field in the United

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1 States, but something that's been going on for quite  
2 some time over in Europe. So the fact that it's been  
3 publicized that they are slowing down on things, I  
4 haven't seen these countries come out and say, No, No,  
5 No, that's not true. We are not restricting. We are  
6 not reducing. We are open, free, still doing business  
7 as usual, makes me pause, because they have a lot more  
8 expertise in it than we do and they are not really  
9 forthcoming as to why they've slowed down.

10 So it makes me wonder what's really happening  
11 as to what outcomes are occurring. So it does make  
12 me -- when somebody developed a surgical procedure that  
13 was supposed to help with heart disease and all of a  
14 sudden they say, you know, I'm not really going to do  
15 this surgical procedure, I'm going to put a pause on it,  
16 it would make anybody else doing that procedure put a  
17 pause on it as well.

18 **Q Have you spoken to anyone who developed a**  
19 **particular procedure that has said I am not going to do**  
20 **this anymore?**

21 **A Directly, no.**

22 **Q Okay. Do you think the medical risks**  
23 **associated with the use of puberty blockers and hormones**  
24 **justify banning their use as treatment for gender**  
25 **dysphoria?**

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1           A       Sorry, could you repeat that?

2           Q       Do you think that the medical risks associated  
3 with the use of puberty blockers and hormones justify  
4 banning their use as a treatment for gender dysphoria in  
5 adolescents?

6           A       I'm just trying to -- so when we are looking at  
7 risk versus benefit, the benefit they are saying is the  
8 improved psychological outcome would outweigh the risk  
9 of any of the side effects you would have from the  
10 medication. That's the idea behind the informed  
11 consents, for the patient to determine whether they feel  
12 the risk or the benefit, you know, the risk outweighs --  
13 they benefit outweighs the risk.

14                   So looking at the risk, I think it's really up  
15 to the patient, and the parents in a child's case, to  
16 determine whether they feel it does. The problem is is  
17 the data that supports all of the benefit is very  
18 loosely based and a lot of opinion based and very low  
19 grade. So what I have issue with is telling somebody  
20 that their life is going to be 100 percent better and  
21 they are not going to have any problems and all their  
22 psychiatric issues are going to go away, when that's not  
23 100 percent the case. So I feel it's fraudulent to try  
24 to sell it as it's 100 percent lifesaving when it's not.  
25 It works for some, but it doesn't work for others.

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1 Q Are you aware of any particular providers that  
2 has said to any patient I'm -- it's 100 percent sure  
3 that it will solve all your problems?

4 A I haven't spoken to any providers that say  
5 that, but the public is often saying this is lifesaving,  
6 this is lifesaving.

7 Q But you are not aware of providers that are  
8 using that language?

9 A No.

10 Q Do medical risks of hormones justify  
11 restricting or limiting their use of gender dysphoria in  
12 adults?

13 A Sorry, can you repeat?

14 Q Yes. Do medical risks of hormones, associated  
15 with hormones, justify restricting or limiting their use  
16 for treatment of gender dysphoria in adults?

17 A I didn't think there was any restrictions for  
18 the adults.

19 Q So would that be a no?

20 A No. Again, it goes back to the informed  
21 consent. I think the other point of the informed  
22 consent of what you were saying with are you aware of  
23 any providers who are doing this? The consent helps  
24 protect the patient, but it helps protect the provider  
25 as well, that they documented the conversation that they

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1 had. So there have been many times when a patient might  
2 come and their perception wasn't exactly reality of the  
3 visit, so the consents are to help the patient go  
4 through that and help the provider document that as well  
5 so everybody is on the same page of risk versus benefit,  
6 your decision if you want to move forward with it,  
7 making an informed decision.

8 **Q Are you aware of any other countries that have**  
9 **tried to limit gender transition medications for adults?**

10 A No, I am not aware.

11 MS. CHRISS: It has been about an hour, maybe  
12 take a five-minute break. Does that work for  
13 everyone?

14 THE WITNESS: Sure.

15 (Break taken at 11:15 until 11:22 p.m.)

16 BY MS. CHRISS:

17 **Q Dr. Mortensen, all right. Returning to the**  
18 **substantive opinions provided in your expert report. If**  
19 **we could turn to paragraph number 22 of the Exhibit 1,**  
20 **which is on page 22.**

21 A Page 7.

22 **Q Yep. I went to page 22.**

23 A You said item 22. I was hearing you.

24 **Q Do you want to switch seats?**

25 A Sometimes, yes.

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1           Q     I don't know about that. Okay. So paragraph  
2 22 on page 7 you mentioned at one of Nemours Childrens  
3 Clinics, Division of Pediatric Endocrinology and  
4 Metabolism weekly educational conferences we reviewed  
5 the guidelines. What are these weekly educational  
6 conferences?

7           A     So every Tuesday we have case conference, which  
8 is an educational forum for our pediatric endocrinology  
9 group, which would consist of the physicians, nurse  
10 practitioners, fellows, medical students, residents,  
11 sometimes members of our diabetes team, or our social  
12 worker, or a psychologist will attend. Sometimes it's  
13 multidisciplinary as well, genetics, neurosurg,  
14 neurology, any of the -ologies would attend. So we do  
15 journal reviews, like, published journals. Journal Club  
16 is what we call it. We will present interesting and  
17 challenging cases. Sometimes if we want to get the  
18 opinions of others based on their experience, and we'll  
19 review any time consensus guidelines -- not all of them,  
20 but when they come out we'll review them as well.

21           Q     Can you just tell me what you mean by consensus  
22 guidelines?

23           A     Well, like, for the American Diabetes  
24 Association they have consensus guidelines for the  
25 management of Type 1 diabetes, Type 2 diabetes in

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1 adolescents. So they'll often publish those consensus  
2 guidelines as to the standard of care they are  
3 recommending based on their care and their research.

4 **Q Are there other consensus guidelines that you**  
5 **are aware of?**

6 A Oh, there's a lot of consensus guidelines. You  
7 go to Endocrine Society, you can click consensus  
8 guidelines and it will often have it. I believe the  
9 transgender one is under there, but pretty much every  
10 society their consensus guidelines, or their statements.  
11 Sometimes they are referred to as practice statements.

12 **Q So the purpose of these weekly conferences is**  
13 **to go over --**

14 A To review and discuss and see the validity of  
15 them, to see if it would change our practice, to educate  
16 ourselves, elevate ourselves.

17 **Q Okay. When did these weekly conferences begin?**

18 A It was happening long before I started at  
19 Nemours.

20 **Q Okay. And when you say you reviewed the**  
21 **guidelines, are you referring to the Endocrine Society**  
22 **Guidelines for the treatment of gender dysphoria?**

23 A That is correct, yes.

24 **Q Who decided to review those guidelines?**

25 A I'm not 100 percent sure who decided to do it.

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1 I know it wasn't me, that I can say for sure, it wasn't  
2 me, but I don't recall who brought it up.

3 Q Okay. And when was this?

4 A That was around the time they were released.

5 Q So around 2017?

6 A Around that time, yes.

7 Q Okay. And so I asked who, but just generally,  
8 what prompted the review of the endocrine study  
9 guidelines?

10 A I feel like there was a big -- I guess I  
11 shouldn't use the word transition, but it seemed like  
12 there was a much bigger need and influx of referrals.  
13 So we would randomly get a patient here or there, but it  
14 seemed like the number of referrals or the reasons  
15 coming in was for gender dysphoria, and since, again,  
16 this seems like a relatively new field, and that  
17 information was released, it seemed like a good idea  
18 that we all review and make ourselves aware of what's  
19 going on and try to determine what we would feel the  
20 best route would be for our patients.

21 Q Was Dr. Benson involved in that meeting?

22 A I don't believe he was at Nemours at that time  
23 in Jacksonville. He worked at Nemours Orlando prior to  
24 that, but I don't believe he was there at the time.

25 Q Okay. Was Dr. -- I believe you mentioned the

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1 **psychologist, Dr. Buckloh was she involved?**

2 A No. We later had a discussion with her as a  
3 separate meeting.

4 Q I'll come back to that. When you say we-all  
5 agreed that these guidelines came from low quality  
6 studies. Who was the we you are referring to?

7 A So it would be the physicians who attended the  
8 meeting, so it would be whoever was there at the time, I  
9 guess we'd have to go back in the records and see which  
10 one of us were actually in attendance. As much as we  
11 all try to attend, we don't attend every meeting.

12 Q So did you-all review the studies and evidence  
13 upon which the guidelines were based?

14 A Yes.

15 Q And did you review all of those during that  
16 meeting?

17 A I want to say we reviewed some of the them, so  
18 as we were looking through them we pulled up PubMed,  
19 started to pull up some of the articles it was referring  
20 or referencing to where they came up with things. I  
21 don't believe that we looked at every single item in the  
22 bibliography, but ones we thought maybe were more  
23 relevant or we thought might be interesting.

24 Q And how did you decide that the guidelines came  
25 from low quality studies?

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1           A       Pretty much the guidelines they you that  
2 themselves by using the grade system.

3           **Q       So you didn't do a separate, independent**  
4 **analysis?**

5           A       No, we did not.

6           **Q       And you reviewed the WPATH Guidelines as well?**

7           A       We did not at that meeting. That was something  
8 I did separately. We had two physicians who wanted  
9 to -- I don't want to say pursue this area, but thought  
10 that it was reasonable we could provide some sort of  
11 coverage to the population. So there were two that were  
12 more driven, and so they were, you know, doing more of  
13 the literature at that time. I was going to work with  
14 some of the ones that I had already inherited, so I know  
15 I reviewed them independently, but I don't think we sat  
16 down as a group to discuss the WPATH Guidelines.

17          **Q       You just mentioned two that were more driven,**  
18 **you mean two --**

19          A       Two pediatric endocrinologists.

20          **Q       And who were those?**

21          A       Dr. Reham Hasan and Dr. Lournaris  
22 Torres-Santiago. Sorry.

23          **Q       One more time.**

24          A       Exactly. I have to say it how she says it,  
25 it's L-O-U-R-N-I-S, I think, Torres, T-O-R-R-E-S hyphen

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1 Santiago. We call her Lou.

2 Q I am going to. Thank you.

3 A She won't mind.

4 Q Are Dr. Lou and Dr. Hasan pediatric  
5 endocrinologists?

6 A That is correct.

7 Q And what did you mean when you say they were  
8 more driven?

9 A They were more excited by the idea of going  
10 down this path, so they, you know, everybody has their  
11 own niche, so as much as we all do general  
12 endocrinology, there are some of us that focus more in  
13 DSD or Turner Syndrome, that happens to be the venue  
14 that Dr. Torres works, so she felt more comfortable  
15 because she works with DSD and Turner Syndrome. Her  
16 research was in Turner Syndrome.

17 So, you know, it was -- we didn't think all of  
18 us would be able to be on top of all of the information  
19 and all well-trained on it, so we said who would like to  
20 specialize in this and focus their energies into  
21 learning more and doing more? And those were the two  
22 that had elected to pursue that route.

23 Q Great. Are they providing treatment for gender  
24 dysphoria currently?

25 A One. Dr. Hasan no longer is. And Dr. Torres

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1 currently doesn't have any patients on medications  
2 anymore, so she currently does not have any patients  
3 she's treating.

4 Q You say on medications anymore. You mean  
5 treatments for gender dysphoria?

6 A Correct.

7 Q Does that mean she doesn't have any patients  
8 that have gender dysphoria or her patients have stopped  
9 taking medications?

10 A So at our center, because we don't do the  
11 cross, usually once they are at that age that they've  
12 been on a puberty blocker or they were on the waitlist  
13 and they got into another center, they would take over  
14 the care.

15 Q Okay. So when you reviewed the WPATH  
16 Guidelines, same questions as with the endocrine study  
17 guidelines, how did you, sort of, review the strength of  
18 the evidence and the recommendations?

19 A So I felt like a lot of what the Endocrine  
20 Society did was based on what came out of WPATH, so many  
21 of the references were the same. They were a little bit  
22 more vague on WPATH of, like, not really advising  
23 different doses and everything. I think that's also,  
24 kind of, the problem with the research, is each person  
25 or each group might have had a different pathway that

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1 they felt more comfortable with pubertal induction or  
2 with giving hormones. And there's different hormones  
3 that are available in Europe than in the United States,  
4 so some of the studies are on drugs that we don't have  
5 access to over here. So it's really, kind of, hard.  
6 It's like apples and oranges on some level to compare  
7 and contrast.

8 **Q Did you include anyone who had expertise in the**  
9 **treatment of gender dysphoria?**

10 A In the meeting?

11 **Q In your meetings, in your evaluations of these**  
12 **guidelines?**

13 A No.

14 **Q Why not?**

15 A Well, at the time when it came out we just  
16 started looking at it to see what it was, and then I  
17 don't know if Dr. Hasan and Dr. Torres had reached out,  
18 because that was really more the area they were going to  
19 go into.

20 **Q When you state also in paragraph 22: We**  
21 **invited one of the psychologists who specializes with**  
22 **our patients who have disorders of sexual development**  
23 **who also had an interest in this new area, who is that?**

24 A That's Dr. Buckloh.

25 **Q Dr. Buckloh, okay. And what was their -- her?**

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1 A Her.

2 Q Her interest in this area?

3 A As I previously stated that she's always had an  
4 interest in our DSD population, everyone just kind of  
5 has whatever their own special niche is. We have some  
6 of our psychologists who work more with our cancer kids,  
7 we have some of our psychologists who work more with our  
8 diabetes population. That was the area that interested  
9 her the most. I don't know if it was because they are  
10 related to hormonal issues, I never really asked her  
11 what was her drive, but she seemed very interested and  
12 did her research and, you know, went to forums and, you  
13 know, we relied heavily on her on some of the  
14 information that she would bring back from some of the  
15 meetings.

16 Q Are aware of her publication titled Best  
17 Practices in Working With Parents and Caregivers of  
18 Transgender and Gender Diverse Youth?

19 A I might have skimmed it back in the day, but I  
20 couldn't really quote from it.

21 Q But you are aware that she published literature  
22 on this topic?

23 A Yes.

24 Q And that she lists gender dysphoria among her  
25 areas of expertise?

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1 A Yes.

2 Q This was published in a journal called Clinical  
3 Practice, and Pediatric Psychology, were you aware of  
4 that?

5 A Uh-huh.

6 Q And in addition to Dr. Buckloh, the article was  
7 authored by a Dr. Anthony Alioto of Nemours Clinic in  
8 Delaware. Are you familiar with that doctor?

9 A I know of him, but I don't -- I never met with  
10 him or spoke with him.

11 Q He is the Clinical Director of Pediatric  
12 Psychologist Specialty Care in the Wilmington, Delaware  
13 office?

14 A Sure.

15 Q And in addition to your colleagues at Nemours,  
16 the article is published by a Dr. Jonathan Poquiz, are  
17 you familiar with him?

18 A No, I am not.

19 Q So -- okay. You go on to state: We had several  
20 meetings about what we could do as a group, although we  
21 had concerns of no long-term data, the guidelines and  
22 statement, and promise of these guidelines that patients  
23 could be helped seemed reasonable. What do you mean by  
24 what we could do as a group?

25 A So we knew that we didn't have all of the

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1 resources to establish a true multidisciplinary center,  
2 but we knew that there was a need, we've had, you know,  
3 several patients ask, like, can we just start? Can we  
4 be evaluated? Can we see -- is this what we have? We  
5 don't know, can we get some help? So we thought at  
6 least if we could get the ball rolling and assist them  
7 in getting into a center or starting off with a puberty  
8 blocker or, you know, make sure that they had the  
9 appropriate diagnosis and psychologists or therapists to  
10 work with in the interim.

11 **Q And when were these meetings?**

12 A They were back in 2017.

13 **Q And for these meetings specifically, when you**  
14 **discussed what you could do as a group, is that the same**  
15 **people in attendance as the weekly education meetings**  
16 **you mentioned?**

17 A We started there and then we became our own  
18 little subgroup.

19 **Q Was Dr. Buckloh involved in that subgroup?**

20 A Uh-huh.

21 **Q What resolution did you reach in terms of**  
22 **whether to create a multidisciplinary clinic?**

23 A We felt that we didn't have enough resources.  
24 I mean, Lisa was our only person who was really  
25 specialized in that. We had limited resources in

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1 regards to social work as well, so we felt like we  
2 really couldn't provide the best care. So that was a  
3 concern for us. Was felt that this was a new area so  
4 there were a lot of unknowns and a lot of questions that  
5 could happen, but we also didn't want to feel people --  
6 feel people would be left out with nothing, so we felt  
7 we could at least start with something of an  
8 introduction.

9 Q Okay. Continuing in that paragraph, I  
10 apologize, it's a long paragraph.

11 A Sorry I wrote a long paragraph.

12 Q It's okay. Although we have vast experience in  
13 prescribing GnRH analogue, commonly referred to now as  
14 puberty blockers, we had never used them for this  
15 indication but felt if we explained the risks and  
16 uncertainty it would be up to the patients and the  
17 families to determine if they felt the benefit  
18 outweighed the risk. Do you see that statement?

19 A Yes.

20 Q When you say we had vast experience in  
21 prescribing GnRH analogues, who is the we?

22 A That would be Dr. Torres and Dr. Hasan, then at  
23 the time I didn't feel like that was the career path I  
24 was going to go down to but I just wanted to help until  
25 they could get transitioned into Dr. Torres and Dr.

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1 Hasan.

2 Q But you prescribed GhRH analogues for other  
3 conditions?

4 A Correct.

5 Q Okay. And you are among the folks, you  
6 mentioned, that have vast experience in prescribing of  
7 GnRH analogues?

8 A Correct.

9 Q But none of you had ever prescribed them for  
10 the treatment of gender dysphoria?

11 A At the time when we were forming some pathway,  
12 that is correct, we did not have any experience at that  
13 time.

14 Q Okay. And you believed that if you explained  
15 the risks and uncertainty that it would be up to the  
16 patients and families; is that your position on, sort  
17 of, how that process should go?

18 A That was our position, yes.

19 Q Okay. And what conditions were you-all  
20 prescribing GnRH analogues for at that time?

21 A The most common would be central precocious  
22 puberty.

23 Q And how many patients would you say you  
24 prescribed GnRH analogues to for central precocious  
25 puberty?

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1           A     I honestly couldn't calculate a number, I'd  
2 have to go back and run a report.

3           **Q     Any other prescriptions you prescribed the**  
4 **blockers for?**

5           A     I think even one of your expert witnesses had  
6 said sometimes if we have an issue with rapid onset of  
7 puberty at a normal age with compromise in growth that  
8 we've used puberty blocker with growth hormone in an  
9 effort to improve their adult height outcome.

10          **Q     Is it the case for generally medical care**  
11 **prescribed generally that you explain the risks and**  
12 **benefits to the patient, and patient to parent when they**  
13 **are a minor, and they assess the risks and benefits and**  
14 **make the decision?**

15          A     That is correct.

16          **Q     Is there any treatment that you can think of**  
17 **that has no risks associated?**

18          A     No, there is no treatment that I can think of  
19 that has no risk.

20          **Q     And in your practice do you provide the**  
21 **information about risks and benefits and allow the**  
22 **patient and family to make the decision for all types of**  
23 **treatment?**

24          A     Yes.

25          **Q     You state, continuing in that same paragraph,**

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1 but on the next page, page 8: We agreed that the  
2 patient would start with an evaluation with our  
3 psychologist first, and if she felt they met criteria  
4 they would meet with the endocrinologist. Is she  
5 Dr. Buckloh?

6 A Correct.

7 Q Just confirming. Okay. And what were the  
8 criteria?

9 A So if we go back to the Endocrine Society, they  
10 had criteria for treatment.

11 Q Okay. And that was what was --

12 A That was the basis of what we were doing.

13 Q And how many children did she assess for  
14 whether they met the criteria?

15 A I don't know, but she did tell me that the  
16 amount that actually sees us is really, really small  
17 compared to what she was actually seeing in the clinic.  
18 That although she had a lot of kids with gender  
19 dysphoria, there weren't many that she actually referred  
20 to us.

21 Q And do you know why that is?

22 A I believe she said was that it was more of  
23 the -- you know, many of the kids -- I don't know what  
24 the statistics is off the top of my head, I know I wrote  
25 it in here, something like 70 to 90 percent will -- they

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1 feel that way, but they desist, they no longer feel  
2 that, and so they usually don't get treatment.

3 Q So these are prepubertal minors?

4 A She she's prepubertal as well.

5 Q Did she state to you how many children had a  
6 diagnosis of gender dysphoria who then desisted and  
7 ceased in identifying?

8 A No, she did not.

9 Q How many did meet the criteria?

10 A I don't know the number off the top of my head,  
11 but I know it was a very small number.

12 Q And those folks were referred to you?

13 A To Dr. Hasan and Dr. Torres.

14 Q And for those that didn't meet the criteria,  
15 what was their pathway? What happened?

16 A She usually worked with them. So there was a  
17 good chunk that we never even saw. For sometimes we  
18 would get an evaluation come in and they didn't see her  
19 first, they saw us first, so they might have come in  
20 with a different diagnosis or a different, you know,  
21 indication, or whatever, and then when we would have the  
22 discussion that's what they were there for. So at that  
23 time they would evaluate and assess, then they would  
24 either see if they were already seen by somebody or if  
25 they weren't, we would get them in with Dr. Buckloh. Or

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1 if they were seen by somebody, they asked for a letter  
2 or supportive statement for the diagnosis or, you know,  
3 could we have the ability to talk to these people.

4 Q So for those who were assessed and deemed to  
5 meet the criteria under the Endocrine Society  
6 Guidelines, you stated the options were discussed. What  
7 were the options for those patients?

8 A So the options would be do you want to continue  
9 with psychotherapy or do you want to pursue a puberty  
10 blocker.

11 Q And how many pursued puberty blockers?

12 A I would have to ask Dr. Torres and Dr. Hasan,  
13 but they said that not a vast majority of them pursued  
14 it.

15 Q And do you have any understanding of how many  
16 of those were prepubescent and, therefore, it was not  
17 medically indicated for them?

18 A No, I don't.

19 Q Okay. You stated then if the endocrinologist  
20 felt they met the criteria. What were the criteria that  
21 the endocrinologists were applying?

22 A From the Endocrine Society.

23 Q So the same as Dr. Buckloh?

24 A Uh-huh.

25 Q You then said that the risks and benefits were

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1 discussed. What are the benefits associated with  
2 puberty blocking medication for the treatment of gender  
3 dysphoria?

4 A Well, according to the guidelines there can be  
5 some psychological improvement.

6 Q Anything else?

7 A That's all I think they said. I think some of  
8 them are saying since they are doing to puberty blockers  
9 younger and younger that they could have better outcomes  
10 physically, not require feminizing surgery, so a better  
11 cosmetic.

12 Q Are those the benefits that you shared with the  
13 patients when you discussed risks and benefits?

14 A Yes.

15 Q And what risks did you discuss with patients  
16 with regard to puberty blockers?

17 A So the consents that are from the Board is very  
18 similar to the consents that we used at Nemours.

19 Q So the risks indicated --

20 A So the risks, yeah, they are very similar.

21 Q If possible could we get a copy of the consent  
22 forms that you used at the Nemours?

23 A You probably already have them because it was  
24 submitted to the Board for review.

25 Q Are they labeled by your clinic name?

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1           A     Yes. They were supposed to redact it, but they  
2 did not.

3           Q     Interesting. Okay. We are going to look at  
4 some of the drafts that were in the public book later,  
5 maybe one of those is it, maybe they did redact it, if  
6 not we'd love to get a copy of that.

7           A     Yes.

8           Q     Okay. So what were the benefits discussed with  
9 regard to estrogen?

10          A     We didn't do the cross-sex, so at that point if  
11 they were ready to transition -- sometimes they would  
12 come in already at 16 or 17, so they just wanted to  
13 start estrogen or testosterone, and we would say that  
14 that isn't what we do, and we would refer them to  
15 another center. But we didn't do estrogen and  
16 testosterone, so we didn't really discuss the risks or  
17 the benefits. At the time we were not aware that the  
18 vast majority of people going on puberty blockers would  
19 automatically grow to cross-sex hormones, so that was  
20 something that I know I wasn't aware of at the time.

21                   The interpretation that I had was this was just  
22 going to be a pause on things as they were dealing with  
23 so much of, just, kind of, working through, then  
24 deciding which route they wanted to go. I wasn't aware  
25 that once they are on a puberty blocker the vast

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1 majority end up going on the cross. I know that we  
2 talked like that is a potential down the road, and, you  
3 know, that's something that you would want to consider  
4 as we do this, but, you know, sometimes they were  
5 started on the puberty blocker and they were ready to go  
6 over to another center.

7 **Q Okay. So you didn't discuss risks and benefits**  
8 **of estrogen and testosterone?**

9 A No, we did not.

10 **Q Did you discuss risks and benefits of surgery**  
11 **for gender dysphoria?**

12 A No, we did not.

13 **Q You mention that there would be involvement of**  
14 **a licensed social worker if warranted. What would**  
15 **warrant the involvement of the social worker?**

16 A So if they didn't have help, so if they didn't  
17 have a social worker that was already working with them.  
18 Sometimes many of the schools have a social worker that  
19 is working with kids during their social transition, so  
20 if they needed assistance, our social worker would try  
21 to help or get them into a social worker that could  
22 help, have more experience on it, but it's not like  
23 everybody needed one, because they had already had one.

24 **Q I was interrupting. So sorry. So social**  
25 **workers can be beneficial as part of the treatment team?**

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1 A As part of the treatment team? Yes.

2 Q And I believe you-all have APRNs that work with  
3 your clinic as well?

4 A That's true.

5 Q And do you think they can be a beneficial part  
6 of the team?

7 A As far as pediatric endocrinology?

8 Q Uh-huh.

9 A Yes, they have a role.

10 Q You state: Although we all have experience  
11 with prescribing estrogen and testosterone, none of the  
12 endocrinologists felt comfortable with proceeding with  
13 this treatment for gender dysphoria since we knew it  
14 would have permanent changes and unknown consequences.

15 Again, the we, are you referring to the same  
16 two doctors and yourself?

17 A Uh-huh.

18 Q And what -- what conditions did you-all  
19 prescribe estrogen and testosterone for at that time?

20 A So those who the ovarian failure or testicular  
21 failure or gonadotropin deficiency.

22 Q Anything else?

23 A Sometimes for delayed puberty. So part of  
24 our -- I mean, the Turner Syndrome and Klinefelter all  
25 fall under ovarian failure and testicular failure.

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1 Q So at this time you felt uncomfortable  
2 proceeding with this treatment for gender dysphoria.  
3 When -- what is the timeline here? You met initially to  
4 discuss the guidelines, you say in 2017. Just trying to  
5 establish the timeline here.

6 A Sure.

7 Q When did you decide that you were uncomfortable  
8 proceeding with hormones?

9 A At the same time. When we decided what we were  
10 going to do we, we -- the three, mostly the two, decided  
11 pubertal blockers, but nobody was comfortable with that,  
12 so we never started treatment, or continued treatment  
13 with cross-sex hormones.

14 Q So when you say that same time, like, within  
15 the same day you-all met? Within a week?

16 A I'd say within a week and a month, but I'd say  
17 initially everybody was, like, very uncertain and didn't  
18 think that they wanted to do it. Then they spent a  
19 little time and came back and said, no, we don't want to  
20 do it.

21 Q Did that include Dr. Buckloh?

22 A Well, Dr. Buckloh doesn't prescribe those, so  
23 she wasn't playing a role in what the physician could  
24 prescribe, but her role was to help assist with the  
25 diagnosis and also with psychotherapy as well.

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1           Q     Did she feel comfortable recommending folks to  
2 receive estrogen and testosterone treatment elsewhere?

3           A     Yes. To my knowledge. I never asked, but I  
4 guess I had just assumed so, because when we were  
5 talking about we would be transitioning them to other  
6 centers she never seemed opposed to the idea of them  
7 going to another center.

8           Q     What was the basis for the opinion you formed  
9 so quickly about being uncomfortable prescribing  
10 hormones?

11           MR. PERKO: Object to form.

12           THE WITNESS: I can answer?

13           MR. PERKO: Yes.

14           A     It's well demonstrated that estrogen can cause  
15 blood clots and that estrogen has cancer promoting  
16 agents. So even when we are using a birth control pills  
17 for someone with PCOS or for menstrual abnormalities we  
18 discuss at length, we get family history. We know that  
19 risk for breast cancer is early menstruation, so  
20 prolonged exposure to estrogen. Delayed menopause,  
21 prolonged exposure, high dose birth control pills, and  
22 obesity, because fatty tissue creates estrogen.

23                     So it's well documented that estrogens can  
24 create and perpetuate cancers. In fact, the pubertal  
25 blocker that's used for puberty blocking is also used

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1 for women with breast cancer and men with prostate  
2 cancer, and that's to reduce the amount of estrogens,  
3 because estrogens can be cancer -- can cause cancers and  
4 promote cancer. So from that standpoint we, especially  
5 I felt uncomfortable, I guess I shouldn't speak on  
6 behalf of my colleagues, but, like, knowing that, if  
7 that happens for just a biological woman, what happens  
8 to a biological man? Don't know. Not a lot of studies  
9 out there. Don't really know the long term  
10 consequences.

11 For testosterone I treat girls with polycystic  
12 ovarian syndrome, that's an excess of testosterone that  
13 their body is naturally making and we know that that  
14 leads to depression, anxiety, virilization, but it also  
15 leads to a very high risk of heart disease. Type 2  
16 diabetes, insulin resistance, hyperlipidemia, obesity.  
17 So a big part of cardiovascular side effects associated  
18 with testosterone in biological females. So I actually  
19 had a patient tell me, because she was on metformin for  
20 prediabetes say, well, what happens when I go on T? And  
21 I said, Oh, I didn't know. That's when she came out to  
22 me, to tell me what was going on. She said, If I'm  
23 trying to prevent diabetes and lower my testosterone  
24 because it creates insuline resistance, which can cause  
25 diabetes, what's going to happen when I go on much, much

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1 higher doses of testosterone? And I was, like, that is  
2 a very interesting point and made me want to do more  
3 research about it.

4 But knowing what we know in regards to estrogen  
5 therapy and testosterone therapy, that's what made me  
6 especially decide, I just don't know what the long-term  
7 risks are and I just don't feel comfortable.

8 Q And these risks you mentioned, you were  
9 speaking of as being risks associated with the  
10 prescription of these medications for the conditions you  
11 do prescribe them for?

12 A Correct.

13 Q When you say that you agreed to transfer care  
14 to the center at UF or Orlando, what Orlando facility  
15 are you talking about?

16 A So there's Nemours Orlando that was -- and I  
17 don't know if they still are -- that was doing  
18 transgender health, that was run by an adolescent  
19 medicine doctor. And Arnold Palmer at one time was also  
20 created a transgender center.

21 Q Forgive my lack of knowledge of how these  
22 things work, but are the Nemours connected? Are they  
23 run by the same --

24 A They are run by the hierarchy, but --

25 Q Right.

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1           A       -- each site, like, what happens in Delaware, I  
2 mean, there's also different Delaware laws and  
3 restrictions and everything, isn't the same thing that  
4 happens in Orlando or the same thing that happens in  
5 Jacksonville. So they are different sites. So Orlando  
6 has their own set of administrators that report to a  
7 higher up in our home office in Delaware and  
8 Jacksonville has their own as well. Then in Orlando  
9 there are three different children's hospitals, there's  
10 Arnold Palmer, Nemours, and Florida Children's Hospital.  
11 Arnold Palmer at one point was seeing patients, I don't  
12 know what happened over time, if they still exist or  
13 not. I couldn't speak to that.

14           **Q       But they did have a gender multidisciplinary --**

15           A       At one point they did, because we were  
16 referring down there.

17           **Q       Okay. So you, sort of, outlined in paragraph**  
18 **22 this, correct me if I am misstating, but sort of this**  
19 **multistage process of assessing, you know, youth for**  
20 **treatment of gender dysphoria. Why have that, sort of,**  
21 **process in place if you weren't going to prescribe the**  
22 **treatment that they would need for the treatment of**  
23 **gender dysphoria?**

24           A       Because there was a big outcry from the public  
25 and the population that they needed to get some help

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1 until they could get into another center.

2 Q Okay. And so when you stated earlier that you  
3 treated adolescents with gender dysphoria for two years,  
4 you-all continued, sort of, assessing folks even after  
5 you made that initial determination pretty quickly that  
6 were you not going to prescribe cross-sex hormones?

7 MR. PERKO: Object to form.

8 A I'm not quite sure what you are asking?

9 BY MS. CHRISS:

10 Q You had stated earlier in your report that you  
11 provided -- let me just quote it so I don't misstate.  
12 In paragraph 10 you stated that for about two years I  
13 saw and treated adolescents diagnosed with gender  
14 dysphoria. But at the beginning of that two years,  
15 which you stated began around 2017, you came to the  
16 decision, determination, that you didn't feel  
17 comfortable prescribing the treatments for gender  
18 dysphoria, correct?

19 A I'm not quite sure what you are asking. I'm  
20 sorry.

21 Q That's okay. I apologize for inartfully  
22 stating my question. You mentioned that pretty quickly  
23 after that initial 2017 meeting when you reviewed the  
24 guidelines, you-all, your team, decided that you did not  
25 feel comfortable describing cross-sex hormones.

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1 A Yes.

2 Q But then you stated for about two years I saw  
3 and treated adolescents diagnosed with gender dysphoria.  
4 So I'm just trying to clarify that that two years was  
5 mostly this assessment process of assessing --

6 A Mostly assessing, yes.

7 Q -- and not prescribing?

8 A Uh-huh.

9 Q Great. In paragraph 23 on page 8 you said: I  
10 have several friends that also started transgender care.  
11 Are you referring to friends who are transgender and  
12 initiated receiving care or initiated providing care?

13 A I apologize for it being poorly written. No,  
14 that is relating to my fellow endocrinologists that I  
15 reported earlier.

16 Q Okay.

17 A So providing transgender care.

18 Q And those were folks providing this care at the  
19 out of state places you mentioned?

20 A Correct.

21 Q You say you sought their advice on how to start  
22 this type of clinic. What type of issues we would face.  
23 The type of support we would need, et cetera. Was this  
24 before or after you-all had decided you were not going  
25 to prescribe cross-sex hormones?

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1           A       So we had our meeting, and then at the meeting  
2 people decided to move forward; Dr. Torres and Dr.  
3 Hasan. Since we were going to be moving forward, that's  
4 when I reached out to my friends.

5           **Q       And by moving forward you mean what?**

6           A       Providing some care for transgender patients.

7           **Q       So puberty blocking medication?**

8           A       Correct.

9           **Q       Okay. And did you establish a**  
10 **multidisciplinary clinic?**

11          A       No.

12          **Q       What types of issues did they share with you**  
13 **you would face?**

14          A       So they said resources is very challenging.  
15 Having people that have the appropriate training is very  
16 challenging. Insurance issues of coverage for  
17 medications. Then they said there were a lot of  
18 concerns about side effects, consequences, and legal  
19 complications down the road.

20          **Q       You said that they discussed the need**  
21 **for written informed consent. Why did you-all, or they,**  
22 **or you, feel that written consent was required?**

23          A       So I didn't speak to them as a group, I spoke  
24 to them individually. I found it interesting that both  
25 of them had said that, but their advice from their

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1 administrators and their lawyers was because this is a  
2 new field of medicine, because there so many unknowns,  
3 because some -- we weren't really sure where things were  
4 going to go, the best thing to do was to have it in  
5 writing in order to protect the patient and protect the  
6 physician, and protect the center.

7 **Q Do you require written consents for other**  
8 **medications you prescribe adolescents?**

9 A Outside of research? No.

10 **Q So when you prescribe Lupron, for example, you**  
11 **don't require written consent?**

12 A No, because it's FDA approved for that  
13 indication.

14 **Q What about when you prescribe the off-label --**  
15 **medications off-label?**

16 A I don't do a written consent, but I do have a  
17 thorough conversation and I document in my note that  
18 it's an off-label medication, I discuss it's off-label  
19 with the family, I discuss the risks and benefits, and  
20 the unknowns that could be there, and the family agreed  
21 to treatment.

22 **Q Okay. No written consent? How do you decide**  
23 **when to require written consent and when not to?**

24 A So from a research standpoint it's very common,  
25 even if you are doing -- we're currently doing one for

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1 diabetes that the devices are FDA approved, the insulin  
2 is FDA approved, the indication for Type 1 diabetes is  
3 approved, but it's using it in a different subset of  
4 population, so even within all of those, because it's  
5 research driven, you have to have a consent to inform  
6 the patient and ensure they want to participate in it.

7 **Q That's just in the context of research?**

8 A That's in the context of research.

9 **Q Does the prescription of puberty blockers for**  
10 **precocious puberty have any unknown risks?**

11 A Yes.

12 **Q Does the prescription of puberty blockers for**  
13 **precocious puberty have any permanent side effects?**

14 A I think that -- I tell families that I don't  
15 know that, I know what I usually say is this has been  
16 studied for 30 years, we have 30 years of data. I go  
17 over the list of the most common and least common and I  
18 always say with any medication there are always  
19 unknowns.

20 **Q Do you require written consent?**

21 A No, I do not.

22 **Q So you inform them of the risks and benefits,**  
23 **then you note that in your chart or their notes?**

24 A Correct.

25 **Q You stated in that same paragraph: At their**

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1 centers there was a great concern for the long-term  
2 outcomes and consequences. What's the basis of that  
3 statement, that there was great concern?

4 A More specifically, at Seattle Children's they  
5 had a big lawsuit back in the day for a patient with  
6 severe cerebral palsy who was neurologically devastated  
7 and the parents wanted to keep the child as small as  
8 possible, so they gave estrogen treatments to fuse the  
9 growth plates. They wanted the child to look infantile  
10 for the concern of once they die and they have to go to  
11 a long-term care facility they wanted to not have this  
12 adult there, they were concerned about abuse, they were  
13 concerned about periods, they were concerned about what  
14 if someone violated her and she got pregnant.

15 So they did high dose estrogens. They did  
16 bilateral mastectomies and they removed her uterus. And  
17 even though both parents consented and it went to court,  
18 Seattle Children's lost a lot of money because the ACLU  
19 came in and sued for the reproductive rights of the  
20 child. Subsequently, the pediatric endocrinologist who  
21 had prescribed, had subsequently committed suicide over  
22 it. So they had great concerns, I mean, in Seattle, so  
23 it's a very, you know, open community and they were  
24 getting the demands, but their administrators were  
25 concerned about if there's going to be some type of

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1 fertility consequence or some kind of consequence, they  
2 didn't want to go through kind of litigation again, so  
3 that's why they were very insistent on consents.

4 **Q So they didn't stop providing these treatments,**  
5 **they just --**

6 A They didn't start the treatments without having  
7 a consent in place.

8 **Q Okay. And do you have a copy of the consent**  
9 **that they used?**

10 A I don't anymore. I had it way back in 2017,  
11 because she had sent me a copy of her consent and then  
12 my friend gave me the other copy from Texas and I just,  
13 kind of, merged the information when that formed.

14 **Q Do you have a copy of the Texas one?**

15 A I have the Texas one. That was also submitted.  
16 It should be part of the documents as well, because I  
17 felt, and our team felt, that it was more thorough than  
18 the Seattle one.

19 **Q So you relied upon that in creating the**  
20 **informed consent forms at issue here?**

21 A I relied on that as a basis, but we still did  
22 our research and review to make sure the information was  
23 accurate and complete, to the best of our knowledge at  
24 the time of what we knew.

25 **Q When you said there were many unknowns, and**

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1 this is also a very vulnerable population, what do you  
2 mean by vulnerable?

3 A So children, in general, are vulnerable.  
4 Adolescents are especially vulnerable, especially when  
5 hormones are involved and decisionmaking. Then the  
6 LGBTQ-plus community is also very vulnerable too, they  
7 can be victimized, they can be discriminated against, so  
8 you got many hits against that. There's a lot  
9 vulnerable. So you want to make sure. And there's also  
10 a component of mental health. It's well-documented that  
11 the trans community have a lot of mental health issues.  
12 So that's also another vulnerability in there.

13 So you want to make sure in the midst of all  
14 that confusion that's going on, especially the teenaged  
15 hormone brain, it's well-documented -- I mean, that's  
16 why insurance is so expensive for driving a car. That's  
17 why the highest risk of suicide is in adolescents, is  
18 because of hormones impacting the brain. So it's a  
19 very, very vulnerable population. So you want to make  
20 sure that they can give consent, because that's also a  
21 question of are they even in a state where they can give  
22 consent? You want to try protect them. Even though  
23 they are very in the moment now, they might not be  
24 thinking about fertility in 10, 20 years down the line,  
25 they are thinking about in the moment.

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1           So that's, kind of, the idea of consents, is  
2 these are things that can happen down the road. I need  
3 to, know you, make sure you understand these are  
4 potential risks that can happen and do you understand  
5 that and is everybody okay with what can happen down the  
6 road? And we also don't know what can happen down the  
7 road.

8           **Q     But, again, you don't require written consents**  
9 **for the prescription of these medications for the other**  
10 **conditions you prescribe them for?**

11          A     Because they are FDA approved for that  
12 indication, so that would mean you'd have to have a  
13 written consent for every medication you prescribe.

14          **Q     Is every medication you prescribe FDA-approved**  
15 **for the indication you prescribe it for?**

16          A     Most are.

17          **Q     In the pediatric population?**

18          A     In the pediatric population, yes. But I if do  
19 something that's off-label, I explain it's off-label.  
20 Oftentimes there's research I can refer to, and if it's  
21 a limited study, I say it's a limited study, a limited  
22 outcome data, I'm not 100 percent sure if, A, this is  
23 going to work for what we are trying to do. I'm also  
24 not sure what the long-term consequence is. How  
25 important is it for you, as a family, to treat what

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1 we've got going on?

2 Q And you provide that verbally though?

3 A Correct.

4 Q Not through a written consent?

5 A Correct.

6 Q Okay. You stated your friends provided you  
7 copies with their consent, but you also found consents  
8 online. Do you remember what consents you found online?

9 A I don't remember, no.

10 Q Were you looking at consent forms for treatment  
11 of adolescents generally or specific to the treatment of  
12 gender dysphoria?

13 A Adolescents more specifically. There was --  
14 anytime you put transgender you are going to get some  
15 adult stuff too, so I might have glanced at it, but I  
16 was focused more on the adolescent.

17 Q And just confirming again, the friends you  
18 referred to several times throughout these paragraphs,  
19 are the same people you mentioned in the beginning?

20 A Correct.

21 Q Okay. You stated that among the concerns by  
22 their administrators at the places where your friends  
23 work, included regret. Did they discuss any particular  
24 patients who experienced regret?

25 A No. At the time at Seattle Children's they

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1 created their consents before they even started the  
2 program. But I think, based on the case, and I'm  
3 speculating, but based on the case they had, some people  
4 must have had regrets. So I think that's, kind of, the  
5 big thing of detransitioners, their complaint is that  
6 they weren't informed. Well, if you have it all written  
7 out and you are signing off, initialling it, you can't  
8 come back and say you weren't informed. You initialed  
9 that you did, we had a conversation.

10 It also gives them pause to really think about  
11 what they want and if this is the right thing for them.  
12 So it helps protect them, but it also helps protect the  
13 provider as well. It's very open and a transparent, you  
14 know, forum for them to have the conversation of the  
15 risks versus the benefits and that everybody is on the  
16 same page.

17 **Q Is it true that folks have regret about other**  
18 **medical interventions they may receive?**

19 A I'm sure that's true, yeah.

20 **Q Have you had any patient specifically come to**  
21 **you and say that they detransitioned?**

22 A No.

23 **Q Have you had a patient come to you and say they**  
24 **regretted treatment for gender dysphoria?**

25 A No.

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1           **Q**     You say you met with your team and reviewed the  
2 consents and that we created our own consent. It was  
3 also sent to our attorneys for review and approval.

4                   Was this consent -- was it one consent form or  
5 multiple consent forms?

6           A     We only did one consent form and that was for  
7 the puberty blockers, because we weren't doing the  
8 cross-sex hormones.

9           **Q**     Did you involve anyone in the process of  
10 creating that informed consent form who had expertise in  
11 the treatment of gender dysphoria?

12          A     No.

13          **Q**     Do all consent forms get sent to the attorney  
14 for review and approval?

15          A     Well, I know for the consents for all of the  
16 research stuff it goes to an IRB, and Internal Board  
17 Review, and there's usually someone in legal there who  
18 reviews them as well.

19          **Q**     But for non-research?

20          A     For non-research, I don't know. I really did  
21 this through the advice of my friends. So I felt that  
22 anytime you had something that's a contract it's best to  
23 have it approved by a lawyer, and they had their  
24 administrators and lawyers look at it, so I followed  
25 their advice and submitted it to our lawyers.

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1 Q Had you created consent forms outside of the  
2 research context for any other medications you  
3 prescribed?

4 A No.

5 Q When you discuss in paragraph 24, which is on  
6 page 9 of your report, the number of referrals started  
7 to increase. Most of these adolescents did not meet  
8 criteria, but the families were very aggressive in  
9 demanding treatment. What do you mean by very  
10 aggressive?

11 A So there were threats, you know, you need to do  
12 this, you have to do this. I'm going to file a  
13 complaint against you. I'm going to report you. I'm  
14 going to sue you. That's what I mean by aggressive and  
15 demanding.

16 Q So these were parents who felt their child  
17 needed treatment and you were unwilling to provide that  
18 treatment?

19 A Yes. We would state that we wouldn't feel  
20 comfortable, but we'd happily referred them to places  
21 that would provide that treatment.

22 Q How many families would you say were  
23 aggressive?

24 A Oh, a small handful.

25 Q And how many would you say demanded treatment?

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1           A       I mean, I stopped, but I can say that's one of  
2 the reasons Dr. Hasan stepped out, because of the  
3 demands.

4           Q       So just trying to get this timeline, when did  
5 you stop?

6           A       By 2019, I wasn't really in it, maybe a year, a  
7 year and a half, not very long.

8           Q       So you no longer treated or assessed children  
9 for gender dysphoria?

10          A       Correct.

11          Q       Well, you-all were -- when you stated the  
12 number of referrals started to increase. Were you  
13 getting kids referred from other providers?

14          A       Yeah, from pediatrician's office, or there's a  
15 lot of self-referrals.

16          Q       And the ones from the pediatrician offices, who  
17 was referring?

18          A       Oh, I couldn't tell you.

19          Q       And were they referring to you specifically for  
20 the treatment of gender dysphoria?

21          A       Yes.

22          Q       When you say when they were denied treatment  
23 they sought treatment elsewhere. You mentioned  
24 previously referring them to UF and Orlando and Tampa.  
25 Did you follow-up with these patients to see if they

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1 were prescribed the treatments for gender dysphoria?

2 A No, I did not.

3 Q Did you follow-up to see how they were doing?

4 A No. As a treating provider I'm not allowed to  
5 do that. Like, if I'm not treating their gender  
6 dysphoria and they're not my patient, because they're  
7 not coming for another endocrinopathy, it's not related  
8 to what I'm doing, you are not allowed to do that.  
9 That's a compliance issue. A legality issue. So I  
10 can't call and say, Hey, did you -- I didn't think they  
11 should get treatment. Did you give them treatment?  
12 That's not appropriate. That's...

13 Q Okay. So you don't know how those patients did  
14 after you referred them to the centers?

15 A For the vast majority, no. I would say I had  
16 maybe one or two patients that I would follow for  
17 something else, whether it be PCOS or Hashimoto  
18 thyroiditis, or another thing that were -- that they  
19 sought treatment elsewhere for their transgender but  
20 still required to get their endocrine care from me, and  
21 for that they would admit, or disclose, because when we  
22 ask what medications they were on, whether or not they  
23 were receiving testosterone or estrogen or Lupron at the  
24 time.

25 Q You say that was one or two patients?

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1           A       Uh-huh.

2           Q       So are those the patients you are referring to  
3 in the next sentence when you say: Those that were on  
4 treatment did not seem to have much improvement with  
5 their depression and anxiety?

6           A       That's some of them. But that was also my  
7 personal experience for the few kids that I had worked  
8 with, they still seemed to have a lot of issues with  
9 depression and anxiety. They still had  
10 hospital admissions to the behavioral health unit, that  
11 was, kind of, the perception that Dr. Hasan was also  
12 seeing as well, which is one of the reasons why she  
13 elected to not want to pursue doing transgender  
14 medicine.

15                    It didn't seem to be as successful as they were  
16 reporting that it was. So our perception didn't seem to  
17 be that this was really having these great outcomes that  
18 was proposed to us.

19           Q       You mentioned earlier you treated maybe 10  
20 patients that were -- you were -- that were being  
21 prescribed some treatment for gender dysphoria?

22           A       Uh-huh.

23           Q       So the patients that you were able to follow  
24 and continue seeing, like the one or two you mentioned,  
25 they were coming to you for treatment of other

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1 **conditions?**

2 A Uh-huh.

3 Q **And can you cite the depression and anxiety**  
4 **scores that you gathered on these patients to say that**  
5 **their anxiety and depression didn't seem to improve?**

6 A No, I didn't do a PHQ9 or, you know, I would  
7 usually do a suicide risk assessment to make sure  
8 everything was okay, as we do with many of our  
9 population. But, no, I didn't assess any scores to  
10 them.

11 Q **Did any of these handful of kids have suicide**  
12 **risks or suicide attempts?**

13 A I believe one of them had a suicide attempt.  
14 Some of them had suicidal thoughts, though.

15 Q **And what was the sample size? I know we**  
16 **discussed the numbers. Did you observe whether the**  
17 **treatment they were receiving alleviated their gender**  
18 **dysphoria?**

19 A I mean, I think that in order to clarify the  
20 question, alleviating gender dysphoria sounds like you  
21 are, like, curing them of gender dysphoria, which they  
22 have gender dysphoria, it's their feelings and their  
23 anxiety and their stress over their gender, it's, kind  
24 of, a different view. That's why I'm being clear with  
25 what you are asking me.

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1 Q Okay.

2 A So do I think they are cured of their gender  
3 dysphoria? No. Do I think that it improved their  
4 mental health? I didn't -- from my perspective I didn't  
5 see a vast improvement of mental health, which was the  
6 whole purpose of prescribing these medicines.

7 Q Did you see a negative impact on their mental  
8 health after they --

9 A I saw some have a negative impact. Some were  
10 neutral. And some had mild temporary improvement, and I  
11 don't know where they went from there after they  
12 graduated out.

13 Q This was the one to two you saw for other  
14 prescriptions that had been prescribed elsewhere?

15 A Those specific ones, yes.

16 Q You stated that I began to feel uncomfortable  
17 that this therapy was not as successful as they stated.  
18 Who is they?

19 A Basically, the guidelines. So the experts that  
20 are telling us this from the Endocrine Society.

21 Q But you weren't able to, sort of, assess the  
22 outcomes for any of the patients who you referred to  
23 other treating centers and weren't able to follow,  
24 correct?

25 A Not all of them, no.

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1           Q       How many of the patients that you state didn't  
2 seem to have much improvement with their depression and  
3 anxiety were on puberty blockers?

4           A       Well, the handful that I had of, like, less  
5 than 10, or about 10. I would say at least two that I  
6 know of things got worse. Four they were stable. And  
7 the rest still had some issues.

8           Q       How many of the patients when you state didn't  
9 seem to have much improvement with their depression and  
10 anxiety were on testosterone?

11          A       None, because I didn't prescribe testosterone.

12          Q       And how many were on estrogen?

13          A       None, because I don't prescribe estrogen.

14          Q       How did distinguish their experiences of  
15 depression and anxiety that may be separate from their  
16 gender dysphoria from their -- their experiences of  
17 gender dysphoria?

18          A       Well, that's the idea of having a psychologist  
19 involved who's actively treating, then we could have our  
20 meetings to discuss how things were going from their  
21 side and what they were seeing. So a lot of it would be  
22 based on what I was getting feedback from Dr. Buck^low.  
23 Sometimes a therapist might be able, if the family  
24 agreed, we could reach out to their therapist to see how  
25 things were going. Then I would, you know, ask them how

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1 things were going. Did they think things were -- how  
2 are things going in your life? Do you think things are  
3 getting better? Do you have any concerns? Do you have  
4 anything we need to discuss today? Do you feel like  
5 things are getting better? Or is this helping? Is this  
6 harming? Do you have any concerns you want to address?

7 **Q Did any of them elect to stop the treatment?**

8 A For the puberty blockers, no.

9 **Q How many of them were seeing Dr. Buckloh?**

10 A I would say for the ones that I saw, at least  
11 50 percent with were Dr. Buckloh.

12 **Q And for the other 50 percent who were their --**

13 A They were, like, with a therapist out in the  
14 community.

15 **Q Do you know who?**

16 A No.

17 **Q You stated: I elected to stop treating**  
18 **patients for gender dysphoria. Last year another one of**  
19 **my colleagues also elected to stop seeing transgender**  
20 **adolescents for the same concerns. Is that Dr. --**

21 A Hasan.

22 **Q Hasan and when you say elected to stop seeing**  
23 **transgender adolescents, do you mean for the treatment**  
24 **of gender dysphoria or --**

25 A For the treatment of gender dysphoria.

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1 Q Okay. Who did you communicate it to, that you  
2 elected to stop seeing patients for gender dysphoria?

3 A At the time it was my section head, Dr. Ross.  
4 And I said I don't feel comfortable, we have two other  
5 providers who, you know, wish to pursue this and do  
6 this. I would like take my name off the referral list.

7 Q So is Dr. Lou?

8 A Dr. Lou is fine.

9 Q Is Dr. Lou still treating patients for gender  
10 dysphoria?

11 A She was still taking, except now she doesn't  
12 have anyone currently on Lupron, and with the law you  
13 can't start, so she currently does not have any patients  
14 she's treating for gender dysphoria.

15 Q Could she treat patients under the auspices of  
16 an IRB trial, as you mentioned earlier?

17 A Provided that we went through the appropriate  
18 channels to make sure it's correct, yes.

19 Q But you-all have not -- have not done that?

20 A No.

21 Q Do you know if your colleagues on the boards  
22 share your understanding of what you stated is, sort of,  
23 an exception that would allow patients to initiate  
24 treatment in Florida?

25 A I mean, we don't have conversations outside the

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1 board meetings, so other than what was stated in the  
2 meetings I don't know 100 percent what they understand  
3 and don't understand.

4 Q Do you think just your colleagues in the  
5 medical profession, pediatric endocrinologists in the  
6 state of Florida, share your understanding?

7 A Could you repeat that or rephrase it?

8 Q Do you think there are pediatric  
9 endocrinologists in the state of Florida that provide  
10 treatment for gender dysphoria who share your  
11 understanding that they could, in fact, initiate  
12 treatment for minors if it were under the auspices of an  
13 IRB-approved clinical trial?

14 A I believe, yes, because I thought that the  
15 representative from the state said he reached out to UF  
16 and Tampa and also, I think, Miami to see if they had  
17 interest in research, so.

18 Q So who's that individual?

19 A I don't know, I would have to check the minutes  
20 from the meeting.

21 Q Do you know meeting that was?

22 A It had to be the February meeting.

23 Q February 2023, obviously?

24 A Yes.

25 Q Okay.

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1 A Well, obviously.

2 Q Are you able to elect to stop treating patients  
3 for any condition that you disagree with?

4 A Yes.

5 Q And have you ever done so previously?

6 A I don't think that I've ever been asked, I  
7 mean, there's this issue, but I don't believe I've ever  
8 been asked to do something that was outside what I  
9 perceived to be my comfort zone.

10 Q Does Dr. Benson provide treatment for gender  
11 dysphoria?

12 A Not to my knowledge.

13 Q Dr. Mortensen, I want to establish a timeline  
14 here for the development of the Boards of Medicine rules  
15 that ban treatment for minors, SB 254, and the  
16 implementing rules -- emergency rules and informed  
17 consent forms. So are you familiar with the process  
18 that the Boards of Medicine and Osteopathic Medicine  
19 followed in promulgating the standard of practice for  
20 the treatment of gender dysphoria in minors?

21 A Yes.

22 Q Are you familiar with the April 20, 2022,  
23 guidance from the Florida Department of Health that  
24 initiated the state's actions regarding this issue?

25 A Yes.

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1 Q And that guidance recommended that social  
2 gender transition should not be a treatment option for  
3 children or adolescents. Anyone under 18 should not be  
4 prescribed puberty blockers or hormone therapy, and  
5 gender reassignment surgery should not be an option for  
6 children or adolescents, correct?

7 A Correct.

8 Q Do you agree with those recommendations?

9 A Yes.

10 Q You agree that social gender transition should  
11 not be a treatment option?

12 A The data that was presented in the Endocrine  
13 Society is based on the Dutch. And the Dutch didn't do  
14 social transition. The Dutch did a lot of mental health  
15 and counseling, not conversion therapy. So if you are  
16 going on the basis of this is going to improve, you  
17 should follow the way that -- it's like an experiment,  
18 you have to have reproducibility. So if this is how the  
19 Dutch did it, and this is how we're going to do it, then  
20 we should do it the way that they did it, but they have  
21 really changed the guidelines not to reflect what the  
22 research was. So they don't have a lot of research  
23 saying with social transition is there improvement or  
24 not improvement? The data that the Dutch presented was  
25 based on not socially transitioning, not starting

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1 puberty blockers until they were almost mid-puberty, not  
2 early puberty, and not starting cross-sex hormones until  
3 over 16, and surgeries not until over 18.

4 Q Are you aware of data and evidence that has  
5 emerged since the Dutch study that indicates there are  
6 improvements in gender dysphoria when youth are allowed  
7 to socially transition?

8 MR. PERKO: Object to form.

9 A It's very mixed. The one that was published  
10 by -- the NIH study that was done, I'd have to look to  
11 see which one. If you break it out and look at the  
12 transgender female, there really wasn't an improvement,  
13 was not an improvement. When they do it collectively as  
14 a whole it seems like there's an improvement. But they  
15 still had people who had depression, anxiety, and two  
16 suicides, also suicide ideations. So you could have  
17 easily changed that topic, or the title, to say that  
18 there really wasn't a great improvement.

19 Q Okay. What specific study are you referring  
20 to?

21 A Go to my bibliography. Let's see. The New  
22 England Journal of Medicine from Chen as the main  
23 author: Psychosocial Functioning in Transgender Youth  
24 After Two Years of Hormones.

25 Q Dr. Mortensen, are you familiar with the letter

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1 that was written by the 300 healthcare practitioners in  
2 the state of Florida urging the state not to proceed  
3 with these rules?

4 A Yes.

5 Q Are you familiar with any of the providers that  
6 signed onto that letter?

7 A I didn't look into their CVs, no.

8 Q If I told you the lead author was a pediatric  
9 endocrinologist that provides treatment for gender  
10 dysphoria at the UF Health multidisciplinary treatment  
11 clinic that you referred patients to, would that sound  
12 accurate to you?

13 A It would not be a surprise.

14 Q Are you familiar with the process that the  
15 Agency For Health Care Administration, AHCA, took based  
16 on the Florida Department of Health's guidance?

17 A Yes.

18 MR. PERKO: Object to form.

19 BY MS. CHRISS:

20 Q And you are familiar with what they call the  
21 ^Gap Bones Report?

22 A Somewhat.

23 Q And the Gap Bones^ report was part of what was  
24 presented to the Florida Boards of Medicine and  
25 Osteopathic Medicine in requesting that you-all go

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1 through the rulemaking process?

2 A Correct.

3 Q Are you familiar with -- strike that.

4 Are aware that on June 2nd, 2022, Surgeon

5 General Ladapo sent a letter to the Boards of Medicine

6 sharing that guidance in the GAPMS Report from the

7 Agency for Healthcare Administration?

8 A Yes.

9 Q And requesting that you take action on that  
10 matter?

11 A Yes.

12 Q And you are familiar with the July 8th, 2022,  
13 petition to initiate rulemaking that the Boards were  
14 presented with?

15 A Yes.

16 Q If I could share with you what we'll mark as  
17 Exhibit 3. This is the petition that you stated you  
18 were familiar with. On page 3 do you see where it  
19 discusses in paragraph 12 the April 20th, 2022, advisory  
20 recommending against blockers, hormone therapy, and sex  
21 reassignment surgery?

22 (Plaintiffs' Exhibit Number 3 was marked for  
23 identification.)

24 A Yes.

25 BY MS. CHRISS:

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1 Q Okay. And you see that on pages 4 and 5 it  
2 discusses the Agency Report, and that was attached as  
3 Exhibit B? I apologize, in paragraph 13 it states:  
4 Based on the Department's advisory, the Agency for  
5 Healthcare Administration conducted a study to determine  
6 whether such procedures are consistent with generally  
7 accepted professional medical standards. The Agency  
8 published it's findings on June 2nd, 2022, a copy of  
9 which is attach as Exhibit B.

10 A Yes, I read that.

11 Q Okay. Do you see that on page six it states in  
12 paragraph 22: Even an adult who possessed the capacity  
13 to consent to experimental treatment, research  
14 supporting chemical and surgical interventions for  
15 treatment of gender dysphoria is insufficient to  
16 demonstrate long-term efficacy and safety and there's a  
17 risk of irreversible physical changes, including  
18 infertility or sterility, therefore, robust informed  
19 consent requirements are necessary.

20 A Yes.

21 Q Are you aware of whether the Boards adopted any  
22 informed consent forms at this time?

23 A Well, the emergency consents.

24 Q Right. So that was after SB 254?

25 A Yes.

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1 Q But in terms of this rulemaking process, the  
2 initial rulemaking process, did the Boards adopt any  
3 informed consent forms?

4 A Other than the emergency consent forms, no.

5 Q Okay. So no. And on pages 6 and 7 you see a  
6 proposed standard of care, correct?

7 A Yes.

8 Q And this was the Florida Department of Health's  
9 proposal to the Boards?

10 A Yes.

11 Q Do you see where it says on page 7 in paragraph  
12 C: When any of the experimental treatments referenced  
13 above are used to treat gender dysphoria in adults  
14 informed consents shall be in writing by forms approved  
15 by the Board at least 24 hours before treatment is  
16 provided. Proposed forms are attached as Exhibit C and  
17 D.

18 A Yes.

19 Q If we can turn to Exhibit C and D, which is the  
20 last page of this exhibit. Are these the informed  
21 consent forms that the Department proposed?

22 A I believe so.

23 MR. PERKO: Object to form.

24 A I believe so.

25 BY MS. CHRISS:

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1 Q And to your understanding did the Board of  
2 Medicine and Board of Osteopathic Medicine, adopt these  
3 informed consent forms?

4 A I believe that -- I'm not -- I mean, I believe  
5 that we did, and that -- but we were advised to do the  
6 emergency consent.

7 Q So just to, sort of, get a timeline, Dr.  
8 Mortensen, there was a petition to initiate rulemaking  
9 that resulted in the two rules that banned care for  
10 minors that you voted on on February 10th, 2023. And  
11 when you voted on that day to adopt those rules, there  
12 was no informed consent form as part of that, correct?

13 A I believe so.

14 Q And the informed consent forms you were a part  
15 of the process of creating were done after SB 254  
16 required the Boards to create those informed consent  
17 forms?

18 A I believe so.

19 Q Okay. So for purposes of the initial  
20 rulemaking process, there were no informed consent forms  
21 adopted?

22 A I believe so.

23 Q Okay. And do you know why the Boards decided  
24 not to adopt these recommended forms?

25 MR. PERKO: Object to form.

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1 A I'm not really sure.

2 BY MS. CHRISS:

3 Q Okay. And just looking at these informed  
4 consent forms again, is it correct they require only one  
5 signature at the bottom?

6 A That is correct.

7 Q And that they have one, two, three, four, five,  
8 six, seven bullet points?

9 A Yes.

10 Q And to the best of your knowledge do they  
11 require a witness to sign?

12 A To the best of my knowledge, no.

13 Q And do they require any initials?

14 A No, they do not.

15 Q Paragraph 6 on page 2 states: Section  
16 458.3311(b) Florida Statutes, grants the Board authority  
17 to establish standards of care for particular practice  
18 settings, including, but not limited to, the performance  
19 of complex or multiple procedures and informed consent.  
20 What does complex or multiple procedures mean?

21 MR. PERKO: Object to form.

22 A It could mean a number of things.

23 BY MS. CHRISS:

24 Q What do you understand it to mean?

25 A I think if we are talking more specifically for

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1 the treatment for gender dysphoria or transitional care  
2 it would be medications or surgical procedures.

3 **Q Are you aware of other standards of care for**  
4 **particular practice settings, including the performance**  
5 **of complex or multiple procedures, that the Board has**  
6 **adopted?**

7 A I'm not 100 percent sure, as being new to the  
8 Board.

9 **Q Okay.**

10 A But it's not outside of other boards to do  
11 regulatory things, such as the opioid epidemic. I mean,  
12 that's why there are opioid contracts and pain management  
13 contracts and rules and regulation in regards to that  
14 because of the use and misuse.

15 **Q Do you have any evidence of use or misuse of**  
16 **treatments for gender dysphoria?**

17 A I feel that with some of the things that have  
18 been reported that kids are starting much younger than  
19 what was initially advised and also what the Dutch had  
20 proposed. It seems we have a higher number of  
21 detransitioners was because there was a misuse or abuse.  
22 I do feel it has been -- there have been things that  
23 have been over-prescribed and over-diagnosed.

24 **Q Are there patients in your clinical experience**  
25 **for whom you can attest to misdiagnosis, misprescribing?**

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1 A Yes.

2 Q And who was the provider that prescribed that  
3 care?

4 A I do not recall off the top of my head.

5 Q At what institution did they work?

6 A I do not know, sometimes I didn't really get  
7 into it with the families or the patients.

8 Q Did you ever file any sort of complaint with  
9 the Board or ethical violation anything of that sort?

10 A No, but sometimes I wish I did.

11 Q But you don't remember who the prescriber was?

12 A No.

13 Q Are you aware -- we are done with that exhibit.  
14 Are you aware that the Board of Medicine and Osteopathic  
15 Medicine met on August 5th, 2022, to discuss this  
16 petition to initiate rulemaking?

17 A Yes.

18 Q Are you aware that Surgeon General Ladapo was  
19 invited to speak?

20 A Yes.

21 Q And I should ask, this is all part of the  
22 rulemaking record in the public books, I assume you are  
23 familiar with those?

24 A Yes.

25 Q And I presume that you got up to speed, having

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1 been appointed after this time, you got up to speed on  
2 what had happened prior?

3 A Oh, yes.

4 Q And Dr. Ladapo discussed the -- what ACHA had  
5 done with the GAPMS Report and urged the Board to move  
6 forward with rulemaking?

7 A Yes.

8 Q Do you know if Dr. Ladapo has provided  
9 treatment for gender dysphoria?

10 A I am unaware.

11 Q Also the Boards heard from a Mr. John Wilson  
12 from the Florida Department of Health?

13 A Yes.

14 Q Is that the individual you were mentioning  
15 earlier?

16 A Maybe, I don't know.

17 Q And he presented the petition to initiate  
18 rulemaking?

19 A Yes.

20 Q And do you recall that the Boards heard from  
21 Dr. Michael Howler, the Chief of Pediatric Endocrinology  
22 at UF?

23 A Yes.

24 Q And he urged the Boards to reject the petition  
25 and cited his extensive knowledge of working with

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1 transgender youth?

2 MR. PERKO: Object to form.

3 A Yes.

4 BY MS. CHRISS:

5 Q And the Boards also heard from a Dr. Van Meter  
6 are you familiar with him?

7 A Not really.

8 Q Are you familiar that he presented to the  
9 Boards?

10 A Yes.

11 Q Are you aware that he was an expert witness  
12 retained by the state in the lawsuit against the Agency  
13 For Healthcare Administration?

14 A I'm sorry, repeat that?

15 MR. PERKO: I'll object to the form.

16 BY MS. CHRISS:

17 Q Are you aware that he was an expert witness who  
18 was retained by the state in the other litigation  
19 against the Medicaid rule banning gender-affirming care?

20 MR. PERKO: Object to form.

21 A No, I don't. I don't know anything about that.

22 BY MS. CHRISS:

23 Q Are you aware that Dr. Van Meter was paid by  
24 the Florida Agency of Healthcare Administration to  
25 attend the board meeting at issue?

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1 MR. PERKO: Object to form.

2 A No, not aware of that.

3 BY MS. CHRISS:

4 Q You are familiar with the GAPMS report?

5 A Yes.

6 Q And Dr. Van Meter was one of the consultants

7 that created that report?

8 MR. PERKO: Object to form; relevance.

9 A Yeah, I'm not sure.

10 BY MS. CHRISS:

11 Q That report was presented to the Boards as a

12 part of what you were to rely upon in the decisionmaking

13 process in deciding whether to pursue these rules; is

14 that correct?

15 MR. PERKO: Object to form.

16 A I'm not sure what you are asking me? So I

17 didn't really answer.

18 BY MS. CHRISS:

19 Q Oh, are you -- let me break this up to separate

20 questions, apologies. So you're aware of the GAPMS

21 report that found treatment for gender dysphoria to be

22 experimental?

23 A Yes.

24 Q And that was what we discussed was the Agency's

25 findings in the petition to initiate rulemaking that we

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1 just looked at?

2 A Yes.

3 Q Okay. And are you aware that Dr. Van Meter was  
4 one of the consultants who helped with the creation of  
5 the GAPMS report?

6 MR. PERKO: Object to form.

7 A I wasn't aware who was involved in that  
8 process.

9 BY MS. CHRISS:

10 Q But you were aware that Dr. Van Meter presented  
11 to the Board?

12 A Yes.

13 Q On these findings?

14 A Yes.

15 Q In your experience, have you seen other  
16 instances where an outside person was paid to come speak  
17 to the Board about an issue like this?

18 A I wouldn't know anything about that.

19 Q During your time on the Board has that  
20 happened?

21 A I have no knowledge of that.

22 Q Okay. So the Board of Osteopathic Medicine  
23 then met on August 12th to discuss the joint -- let me  
24 back up. There was a joint committee formed with  
25 certain members from the Board of Medicine and certain

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1 members from the Board of Osteopathic Medicine; is that  
2 correct?

3 A That is correct.

4 Q You would later be a part of that committee?

5 A That is correct.

6 Q So the initial August 5th meeting was the Board  
7 of Medicine meeting to discuss the petition to initiate  
8 rulemaking, and the August 12th meeting was the Board of  
9 Osteopathic Medicine meeting to discussion the petition  
10 to initiate rulemaking; is that correct?

11 A I would have to check dates, but that seems  
12 accurate.

13 Q And, again, Surgeon General Ladapo spoke and --  
14 is that correct?

15 A Yes.

16 Q Okay. And it states that in the meeting  
17 minutes for that meeting, it states that only one public  
18 comment was given by an individual named Dr. Tom Benton;  
19 do you know who that is?

20 A Not personally, no.

21 Q Are you aware of him?

22 A No.

23 Q The meeting minutes reflected --

24 MR. PERKO: Counsel, I'm going to -- we had a  
25 stipulation that there would be no factual discovery

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1 about the rulemaking, and that's exactly what you  
2 are doing here, violating the stipulation. This has  
3 nothing to do with Dr. Mortensen's expert opinions.

4 MR. REDBURN: Sure it does.

5 MS. CHRISS: Dr. Mortensen provides expert  
6 opinions on, as we established earlier, the Board of  
7 Medicine rules banning treatment for minors, SB 254,  
8 and the emergency rules, and informed consent forms.

9 MR. PERKO: What does that have to do with the  
10 rulemaking here?

11 MS. CHRISS: I'm asking her about the Board of  
12 Medicine rules that ban treatment for gender --

13 MR. PERKO: You are asking about the process  
14 and what was done during that. That's factual  
15 discovery into the rulemaking process --

16 MR. REDBURN: She's testified at the beginning  
17 of this deposition that the reason she was asked to  
18 be an expert was because of her involvement in the  
19 administration process that led to the development  
20 of these forms. She drew the connection --

21 MR. PERKO: These forms. You are not talking  
22 about the forms.

23 MR. REDBURN: It's all part of same rulemaking.

24 MS. CHRISS: Mr. Perko, if I may, paragraph 2  
25 of page 1 of her report says: In summary, there's a

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1 medical basis for the bans on access to medications  
2 and surgeries for transgender youth diagnosed with  
3 gender dysphoria that was set forth by the Florida  
4 Boards of Medicine and Osteopathic Medicine, and by  
5 the Florida Legislature through SB 254 and is  
6 implementing rules.

7 She has provided an expert opinion that there  
8 is a medical basis for these bans and I'm simply  
9 asking for her understanding of the medical basis  
10 for those bans.

11 MR. PERKO: You are not asking her about the  
12 medical basis of the bans, you are asking her what  
13 happened during the rulemaking process where she  
14 wasn't even involved.

15 MS. CHRISS: I asked Mr. Mortensen if she had  
16 familiarized herself with the process, because she  
17 took a vote on February 10th, 2023, in favor of  
18 banning this care and we need to understand what  
19 that vote was based upon.

20 MR. PERKO: All right. I'll see where you go  
21 with this, but I think we're wasting a lot of time  
22 and I think you are violating the stipulation.

23 MR. REDBURN: Go ahead.

24 THE WITNESS: Can I take a bathroom break?

25 MS. CHRISS: Absolutely.

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1 MR. REDBURN: Should we break for lunch?

2 MR. PERKO: That's probably a good idea.

3 MS. CHRISS: Yeah. I think that makes sense.

4 Come back at 2:00.

5 (Break taken at 12:52 until 2:02 p.m.)

6 BY MS. CHRISS:

7 Q Dr. Mortensen, here we are again. I am going

8 to show you -- hand you what we'll mark as Exhibit 4.

9 If you don't mind taking a moment to look at this

10 document. The first page is an e-mail from Matthew

11 Benson, then the pages that follow are an open letter to

12 the Florida Board of Medicine. Oh, actually, sorry,

13 could I have these exhibits back for a moment. Sorry

14 about that.

15 Do you recall writing an open letter to the

16 Board of Medicine with Dr. Benson and several other

17 physicians?

18 (Plaintiffs' Exhibit Number 4 was marked for

19 identification.)

20 A Yes, I do.

21 BY MS. CHRISS:

22 Q Was that on or about September 26, 2022?

23 A I believe I just saw that date, yes.

24 Q And apologies for that.

25 A No, it helped jog the memory.

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1 Q Great. What was the open letter submitted --  
2 what was the purpose?

3 A The purpose was to give our opinion, as people  
4 who practice pediatric endocrinology, our view of the  
5 low-grade research and affirmative medications and care  
6 of people with transgender in adolescence.

7 Q And you signed onto this letter, correct?

8 A Correct.

9 Q And who were the other -- Matthew Benson I  
10 understand also works at Nemours?

11 A That is correct.

12 Q He is now a member of the Board of Medicine?

13 A That is correct.

14 Q Who is Larry Fox?

15 A Larry Fox is currently our Division Chief of  
16 Pediatric Endocrinology.

17 Q Dr. Hasan is the one you mentioned stopped  
18 providing this treatment?

19 A Correct.

20 Q Dr. Mauras?

21 A Dr. Mauras.

22 Q Mauras.

23 A Formerly the division chief, but she's our  
24 vice-chair of clinical research for Nemours for the  
25 state of Florida.

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1 Q Does she provide any treatment for gender  
2 dysphoria?

3 A No.

4 Q Monica Mortensen, that's you.

5 A That's me. That's Lou.

6 Q Lou -- here we go. Now seeing it helps.

7 A Sure.

8 Q I mean, it doesn't help. It makes it harder.

9 A It really doesn't, yeah.

10 Q Now I get what you meant. Dr. Lou is the other  
11 individual who had some experience in prescribing  
12 blockers but currently is not providing treatment for  
13 gender dysphoria?

14 A That's correct.

15 Q Dr. Snyder?

16 A Correct. She's another pediatric  
17 endocrinologist in our group at Nemours.

18 Q Does she provide treatment for gender  
19 dysphoria?

20 A No, she does not.

21 Q There's an APRN Joe Permuy?

22 A Uh-huh.

23 Q Who's he?

24 A He's one of the nurse practitioners who worked  
25 with us at pediatric endocrinology.

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1 Q Does he provide treatment for gender dysphoria?

2 A No, he does not.

3 Q Same question Kaley Carroll?

4 A Also one of our nurse practitioners.

5 Q And does she provide treatment for gender  
6 dysphoria?

7 A No, she does not.

8 Q And you stated earlier that Dr. Benson, to your  
9 knowledge, does not?

10 A Not to my knowledge.

11 Q So you submitted this letter to the Boards of  
12 Medicine, this was prior to being appointed to the Board  
13 of Osteopathic Medicine?

14 A That's correct.

15 Q Okay. What, sort of, compelled you and the  
16 other doctors to provide this testimony?

17 A Well, it's just something that we've been  
18 seeing in some of our patients, just as I had said, some  
19 of my patients that I treat for other endocrinopathies,  
20 they have also transgender dysphoria, and many of them  
21 also have other patients they may be treated for another  
22 endocrinopathy but who are also treating as well at  
23 another center for transgender.

24 Q You were appointed to the Board of Osteopathic  
25 Medicine in December of 2022; is that correct?

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1 A That's correct.

2 Q When were you first contacted about the  
3 appointment to the Board?

4 A Shortly before that.

5 Q Okay. Who were you contacted by?

6 A I honestly don't recall the name, I'm terrible  
7 with names.

8 Q What was the process that led to you becoming a  
9 board member?

10 A Dr. Benson actually applied for the Allopathic  
11 Board, so he said why don't you apply for the  
12 Osteopathic Board. I didn't even know if there were any  
13 openings or not, but I thought it might be something to  
14 try and see a different side and view of medicine. So I  
15 just applied online.

16 Q Okay. When did you apply?

17 A I want to say either end of October or  
18 November.

19 Q Okay. How long was the process of being  
20 selected and appointed?

21 A I mean, probably several weeks, or a month,  
22 after the application was submitted.

23 Q And who had to provide input on that process?

24 A No one. He just told me go online, go online  
25 and you can apply for the position.

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1           Q     I apologize. The process of you being -- I  
2     assume there are more candidates, that everybody who  
3     applies doesn't get appointed to the Board?

4           A     I would assume as well.

5           Q     What goes into how they decide who will be  
6     appointed to the Board?

7           A     You have to ask them, I'm not part of the  
8     decisionmaking process of who gets to be on the Board.

9           Q     Okay. Do you have any idea why you were  
10    selected?

11          A     I believe because there's no one doing  
12    pediatrics on the Board. I also had worked at a  
13    federally qualified health center that worked with  
14    family practice, we did funding, we did a lot of QI, so  
15    I have a QI background. I did pediatrics, as well as  
16    pediatric endocrinology also, and as part of doing that  
17    job we looked at standards of care for screening for  
18    breast cancer, heart disease, vaccinations, and I've  
19    also, as you had mentioned earlier, that I'm, you know,  
20    certified to read densitometry, so that's also big for  
21    women's health, a women's health issue as well. So I  
22    have a pretty vast background, so I've been doing it for  
23    a while, so I would assume that would have played a role  
24    in it.

25          Q     Did anyone other than Dr. Benson encourage you

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1 to apply?

2 A No.

3 Q And this is a -- this is an appointment that is  
4 made by the Governor; is that correct?

5 A That's my understanding.

6 Q Did you speak to anyone else, other than Dr.  
7 Benson, in the application or selection process?

8 A Not to my knowledge, no.

9 Q Like, who informed you you had been appointed?

10 A Actually, I think Dr. Benson saw the notice,  
11 because he got -- he was looking for his and he said,  
12 You've been appointed. So it was posted, so I could see  
13 that I got the position.

14 Q And how did you become a member of the Florida  
15 Boards of Medicine and Osteopathic Medicine's Joint  
16 Rules and Legislative Committee?

17 A Initially when you join they give a you list of  
18 committees to join, so everybody has some roles that  
19 they have to play. So I had signed up for various  
20 committees, and I believe that was one of them. Then  
21 when it came time for drafting the consents, because I  
22 have experience in pediatric endocrinology it seemed  
23 like a good idea for me to sit on that Rules Committee.

24 Q You were on that Rules Committee, though, prior  
25 to the informed consent process?

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1 A Yes.

2 Q You were on that committee during the voting on  
3 rule -- the rules at issue that you and Dr. Benson  
4 submitted this letter about?

5 A Can you clarify? It sounds like you are saying  
6 I was on the committee when that letter was submitted --

7 Q No. No.

8 A -- and that's not true.

9 Q I apologize. So September you submit a letter  
10 to the Boards of Medicine encouraging their adoption of  
11 the two rules that we discussed previously that banned  
12 the treatment for minors. You then were appointed in  
13 December. And then you voted on that, those rules, you  
14 voted on the Osteopathic Medicine version, in February  
15 of 2023, correct?

16 A Correct.

17 Q Okay. And did anyone ask you to join the Rules  
18 and Legislative Committee or --

19 A No. We were given -- here's a list, I mean,  
20 there's also, like, the Medical Marijuana Board, but  
21 what does a pediatric endocrinologist know about that,  
22 and for rules I feel like I'm, kind of, well-rounded and  
23 I can investigate, talk with experts, so I felt more  
24 comfortable going that route than the marijuana. I  
25 don't have any physician assistants in my practice, so I

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1 didn't want to join that committee, so.

2 Q Okay. And were any of the other members of the  
3 Joint Rules and Legislative Committee pediatric  
4 endocrinologists?

5 A Dr. Benson.

6 Q Just you and Dr. Benson?

7 A Are pediatric endocrinologists, yes.

8 Q Are you aware that Dr. Benson also spoke in  
9 favor of the rule banning Medicare coverage of  
10 gender-affirming care?

11 A No.

12 Q He didn't talk to you about that?

13 A No.

14 Q Did you provide any testimony or written  
15 comments?

16 A No. The only written comment is that open  
17 letter.

18 Q Okay. So did you and Dr. Benson and the other  
19 doctors that signed onto this, kind of, collaborate on  
20 this letter?

21 A He had informed us that he was going to send a  
22 letter and he asked us to review and see if it seemed  
23 factual or if anything seemed wrong or inappropriate,  
24 then if any of us wanted to sign the letter we could.

25 Q So you reviewed it, I assume agreed with it,

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1 and signed on?

2 A Yes.

3 Q Were there discussions between the authors --  
4 or the signatories?

5 A Not in regards to, like, the huge content, I  
6 mean, we all knew who was signing, because our names  
7 were on there. Dr. Benson I think spent a good time  
8 with Dr. Mauras in making some of the edits to the  
9 letter.

10 Q When you were working on this letter did you  
11 discuss -- there's a part of the letter that discusses  
12 youth and young adults that are openly expressing regret  
13 and de-transitioning. Did you guys talk about  
14 detransitioners and that experience?

15 A I know that with Dr. Hasan and Dr. Torres,  
16 because that's, kind of, their area that they were going  
17 into, they mentioned that they had heard, and I believe  
18 that they might have had a patient or two, I don't know,  
19 it's all hearsay, about detransitioners. But there's  
20 been a lot of stuff in the news about detransitioners.  
21 So it's not that it's an unheard of topic.

22 Q But you haven't -- I think you mentioned early  
23 you hadn't had any patients report to you that they had  
24 de-transitioned or regretted --

25 A Correct.

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1 Q -- treatment? Are you aware that Dr. Benson  
2 participated in a round table discussion with Surgeon  
3 General Ladapo and detransitioners?

4 A No, I didn't.

5 Q He didn't share anything about that with you?

6 A No. We have to be careful with the whole Board  
7 thing because of the Sunshine State Law. There's a lot  
8 of things, especially since we know that transgender is  
9 a topic for the Board, that we just kind of shut and  
10 don't discuss that. He might discuss it with other  
11 colleagues, I might discussion it with other colleagues,  
12 but I didn't know that he did that, or if he did I don't  
13 recall it.

14 Q I apologize. So I should have specified the  
15 timeline. So prior to you-all being appointed to the  
16 Board, so no issues with communications there, the round  
17 table that he participated in was on July 8th of 2022.  
18 So I was wondering if his experience hearing from  
19 detransitioners was at all discussed in you-all writing  
20 about that topic in this letter in September?

21 A I don't recall discussing that.

22 Q Okay. Would you -- you mentioned earlier to  
23 the best of your knowledge Dr. Benson has not provided  
24 treatment for gender dysphoria, correct?

25 A Correct.

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1 Q Would you describe him as an expert in gender  
2 dysphoria?

3 A I -- I mean, I would say he's well-read on it.  
4 I wouldn't say he's an expert on it.

5 Q I'm going to show you what we'll mark, I  
6 apologize I had to take this last one back, so actual  
7 Number 4. There's two copies there. Dr. Mortensen,  
8 this is the -- what appears to be the agenda from that  
9 round table. I just want to ask if you are familiar  
10 with some of these names, if you look under intro you'll  
11 see, you know, expert Matthew Benson. Are you familiar  
12 with a Stella O'Malley?

13 (Plaintiffs' Exhibit Number 4 was marked for  
14 identification.)

15 A No.

16 BY MS. CHRISS:

17 Q Or a Joseph Burgo?

18 A No.

19 Q Do you recall during several of the Board of  
20 Medicine meetings that you state you reviewed the public  
21 book and the testimony of from the meeting minutes, do  
22 you recall hearing from a detransitioner Chloe Cole?

23 A Yes.

24 Q And a detransitioner Sophia Galvin?

25 A Yes.

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1 Q And a parent named Amy Atterberry?

2 A Yes.

3 Q Okay. So those were folks that also testified  
4 at the Board of Medicine meetings?

5 A Correct.

6 Q Have you had any other experiences with those  
7 individuals?

8 A Like, personal experience?

9 Q Through your role on the Board or elsewhere?

10 A Oh, no. No. I think Chloe is quite an  
11 advocate, so I've seen some interviews.

12 Q Yes, so if you look below of run of show where  
13 you see Dr. Benson spoke after it says Amy, Billy  
14 Burleigh, Erin Brewer, and Richie. Do you recall in the  
15 public book that you reviewed seeing written comments  
16 from these individuals?

17 A I don't recall.

18 Q Okay. And then if we could -- sorry, below  
19 where it says: Experts and the evolution of  
20 gender-affirming care, you see it says Dr. Benson is  
21 listed as one of the experts, and discuss the knowns and  
22 unknowns of medical intervention with puberty blockers  
23 and cross-sex hormone treatment models in children.

24 Did Dr. Benson participate in any of the  
25 meetings you discussed earlier at Nemours where the

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1 provision of this care was discussed?

2 A No, I don't think he was there at the time.

3 Q Do you know if prior to his joining Nemours he  
4 was providing treatment for gender dysphoria?

5 A I'm not sure.

6 Q Okay. Thank you. If you could just flip to  
7 the back briefly, the last bullet point says: Let them  
8 know their stories will be provided to the Board of  
9 Medicine and we will follow-up to make sure their  
10 stories are told. You see that?

11 A Uh-huh. Yes.

12 Q Is that consistent with your experience of  
13 these folks stories being told?

14 A Yes, a lot of stories were told.

15 Q All right. Thank you. Dr. Mortensen.

16 A Yes, that's me.

17 Q My apologies. Do you know how comments --  
18 public comments are submitted to the Board?

19 A You mean for the actual meeting or do you mean  
20 via the ones that come in through the iViewer?

21 Q Excellent question. Let's first do the ones  
22 that come in like the one you submitted to the Boards.

23 A So you just -- you can e-mail the Board of  
24 Medicine.

25 Q Okay. And what about in-person testimony at

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1 **the hearings, how does that happen?**

2 A So typically they would -- in the meetings I've  
3 been at they would pass around cards and people would  
4 sign up. There are certain circumstances I think where  
5 people were on the agenda, but they would have cards to  
6 put their name on and then there was just a stack and  
7 they were shuffled and they were put in front of the  
8 moderator and the moderator would just draw from the  
9 pile.

10 Q Okay. If we can just -- turning back to your  
11 letter for one moment. You discuss in the letter that  
12 you submitted to the Board that this is -- that your  
13 deeply concerned about the off-label use of puberty  
14 blockers and cross-sex hormones; do you remember saying  
15 that?

16 A Yes.

17 Q What does the phrase off-label mean?

18 A It means that it's not FDA approved for that  
19 indication.

20 Q Are you aware that off-label does not mean  
21 experimental?

22 MR. PERKO: Object to form.

23 A Depends on, I guess, your interpretation of it.  
24 Sometimes when it's off-label there are -- when you get  
25 an FDA approval there are people that use it off-label

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1 but still do research studies for it, so there's  
2 literature data to support the use of it even though  
3 they hadn't applied for through indication through the  
4 FDA. There are many meds that are used off-label, but  
5 sometimes it could be considered experimental if there  
6 really isn't a lot of data to support the use of it or  
7 the long-term outcomes.

8 BY MS. CHRISS:

9 Q So it can be experimental?

10 A Experimental.

11 Q But off-label doesn't have anything to do with  
12 whether a medication is safe and effective for a  
13 particular use?

14 A By saying that something is FDA approved it's  
15 saying the Food and Drug Administration has reviewed and  
16 they support the data for the indication of the use and  
17 the side effects or the risks. When it's off-label it  
18 means that it hasn't been reviewed by the FDA for that  
19 indication.

20 Q Is it true that medications are often used  
21 off-label, particularly in pediatrics?

22 A I would say that's fair.

23 Q Are you aware of a study that looked at  
24 off-label use using a very restrictive definition of  
25 off-label for pediatrics and found that approximately

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1 30 percent of encounters in children's hospitals  
2 involved off-label use?

3 A That wouldn't be surprising.

4 Q Are you -- I apologize, I should have touched  
5 on this during when we were going over the CV. Are you  
6 a member of the American Academy of Pediatrics?

7 A Not anymore.

8 Q When did you stop being a member?

9 A I don't know, probably more than five years  
10 ago. It became too expensive with all the dues that we  
11 have to do, with all the Endocrine Society, the ADA, and  
12 the Pediatric Endocrine Society, and I only have so much  
13 money, I had to chose which was going to be the best  
14 bang for my buck.

15 Q Understood. Are you aware that the AAP  
16 Committee on Drugs has a statement saying in no way does  
17 a lack of labeling signify therapy is unsupported by  
18 clinical experience or data in children?

19 MR. PERKO: Object to form.

20 A I mean, it's very possible that that's what  
21 they said, but I couldn't quote you on it.

22 BY MS. CHRISS:

23 Q And would you agree that among the reasons for  
24 off-label use being common in pediatrics is that often  
25 sponsors don't seek FDA approval after it's been

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1 approved for one use because they don't expect that the  
2 future revenue will offset the cost of obtaining  
3 approval?

4 A It's very fair to say yes.

5 Q Dr. Mortensen, earlier you mentioned that you  
6 had extensive experience treating growth problems; is  
7 that correct?

8 A That is correct.

9 Q And have you prescribed aromatase inhibitors  
10 for short stature?

11 A I have.

12 Q Are you aware that medication is not FDA  
13 approved for that medication?

14 A I'm very aware, which is why I tell my patients  
15 that and I also document in my notes that it's off-label  
16 use and the risk and the benefits.

17 Q But you don't require written consent, right?

18 A No, I don't.

19 Q And you know there's no randomized control  
20 trials supporting the use of that medication?

21 A Dr. Mauras had a randomized control trials in  
22 using it with (indiscernible) and she's well-published,  
23 and has traveled the world showing her data.

24 Q Is that a study you would be able to share with  
25 us?

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1           A       Sure.

2           **Q       Thank you. Why is it important to prescribe**  
3 **these types of medications, like aromatase inhibitors,**  
4 **to youth with growth issues?**

5           A       So part of growth hormone deficiency and growth  
6 disorders is trying to achieve a functional adult height  
7 that someone would not be considered disabled or have  
8 difficulty driving a car or all those other things. So  
9 we use growth hormone for the approval or the FDA  
10 indications of whether the growth hormone deficiency,  
11 idiopathic short stature, there's, you know, SGA,  
12 there's a list of reasons it has been FDA approved for.  
13 But sometimes when a child goes through puberty at a  
14 normal age, but rather quickly, it confuses their growth  
15 plates and compromise their adult height. So the use of  
16 the medication helps prevent the premature fusion of a  
17 growth plate, because a growth plate should take several  
18 years to fuse. So they're undergoing a medical  
19 condition that's causing fast fusion of the growth  
20 plates, and this is to help slow down that fast  
21 premature fusion to allow them more time grow to grow to  
22 achieve a functional adult height.

23           **Q       And do you -- scratch that.**

24                   **Do you describe -- will you prescribe Lupron**  
25 **for kids with short statute or growth issues?**

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1 A I have.

2 Q And is it FDA approved for that condition?

3 A No, it is not.

4 Q Do you prescribe metformin for patients with  
5 Type 2 diabetes?

6 A I do.

7 Q Is it FDA approved for that indication?

8 A For children over the age of 10 it is.

9 Q Have you prescribed it for children under the  
10 age of 10?

11 A No, I have not.

12 Q You state in your open letter that there's  
13 limited data from prospective controlled trials which  
14 are the gold standard by which we judge any therapeutic  
15 intervention; is that correct?

16 A That is correct.

17 Q Do you only prescribe medications that have  
18 data from prospective controlled trials?

19 A No.

20 Q Are you aware that medical research on children  
21 is less likely to use randomized trials than is medical  
22 research for adults?

23 A I am not aware, I know it's more challenging,  
24 but that seems to be the studies that we do at our  
25 centers.

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1 Q Do you believe there are times when it would be  
2 unethical to conduct randomized trials?

3 A Yes.

4 Q Can you give me an example?

5 A Sometimes when it's a life-threatening  
6 situation, so there have been times, like, cancer agents  
7 or things like that, that they have to get an approval  
8 for.

9 Q Would it be unethical to expose -- knowingly  
10 expose a participant to an inferior intervention?

11 MR. PERKO: Object to form.

12 A I think that's one of the pitfalls of research  
13 is when you do have placebo arms that is part of the  
14 risk that happens with research. So you could be giving  
15 a med that one is a placebo and one is the med and you  
16 don't know which one you are giving.

17 BY MS. CHRISS:

18 Q If you understood that the benefits of the  
19 treatment were demonstrated as alleviating the condition  
20 at issue, would you find it unethical to withhold that  
21 treatment from members of the control group?

22 A I'm not sure what you are asking?

23 Q Is it ethical to withhold treatment that you  
24 know is effective in alleviating the condition at issue?

25 A Could you rephrase that?

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1           Q       In your opinion, would it be ethical to  
2 withhold medical care for a person with a condition that  
3 the medical care has been shown to improve that  
4 condition?

5           MR. PERKO: Object to form.

6           A       So I think -- are you asking me, like, in a  
7 research setting? Or, I mean, that's kind of the  
8 problem that happens with research is, what you do is  
9 you file for an exemption saying that we believe the  
10 benefit outweighs the risk, and that's what we are going  
11 to do, so.

12 BY MS. CHRISS:

13           Q       Okay. So in your letter you state: Rapid  
14 proliferation of a myriad of clinics and programs where  
15 many of these children are prescribed these therapies on  
16 demand with little to no in depth assessment of the  
17 psychological needs of these youngsters. Do you recall  
18 that?

19           A       I do.

20           Q       What are the myriad of clinics you-all are  
21 referring to?

22           A       I mean, there's been clinics outside of Florida  
23 as well. I mean, I can't list them verbatim, but I just  
24 remember that we were -- from my experience of -- there  
25 are actually some pediatricians that are doing this and

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1 there are people across state lines that are doing it,  
2 it just seems like anybody -- anybody who wants to can  
3 provided this medicine.

4 Q So you state there's a myriad of clinics where  
5 they are prescribing these therapies on demand with  
6 little to no in-depth assessment. Analysis did you-all  
7 do to come to that conclusion? That there's little or  
8 no in-depth assessment?

9 A I think that's the basis of our experience that  
10 we've witnessed in the clinic, as I stated earlier, I  
11 had many people that would tell me they went and they  
12 saw a therapist and they got a letter saying, yes, this  
13 is what I have, and they got one hour. Just one hour  
14 and you have the diagnosis and they want to start  
15 medications today.

16 And the guidelines actually propose that you do  
17 more in-depth, you have more conversation. Even the  
18 Dutch waiting a long time before they started  
19 medications. So that's why we are saying this rapid  
20 pace it seems. I had patients who have gone and on  
21 their first visit I think were prescribed testosterone.  
22 I know that happened at Duke, because I had two patients  
23 who went to Duke for that.

24 Q So other than two patients at Duke, what other  
25 patients do you have personal knowledge of that

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1 happening?

2 A That's only the personal knowledge. The rest  
3 is what I've heard from friends and colleagues.

4 Q Okay. So -- okay. Are you aware of whether  
5 Dr. Benson did any analysis of the clinics, or had any  
6 personal experience with patients having that experience  
7 in order to come to this conclusion?

8 A I don't know.

9 Q When a patient is assessed for gender dysphoria  
10 outside of your clinic, or even, I guess, in your  
11 clinic, I presume you don't sit in with the  
12 psychologist?

13 A Correct.

14 Q How are you able to decide how in-depth of an  
15 assessment was done for that patient?

16 A A lot of times it's the notes that they forward  
17 or the letter that they submit. So sometimes it's  
18 saying, you know, I've worked with this patient for two  
19 years, this has been the history, this is why they meet  
20 the criteria, so on and so forth. If I know it's a  
21 reputable source and it's confirmed by the conversation  
22 I'm having, it's a far more comfortable situation than  
23 receiving a letter that's just very generic and blank  
24 and saying, I assessed the patient, this is what they  
25 have, then asking the patient how many -- you know, how

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1 many sessions did you have? What did you discover under  
2 the sessions? What do you know about it? Finding they  
3 were very limited evaluations.

4 Q How many of the letters that were sent to you  
5 were those, sort of, blank this is the patient, this is  
6 what they have?

7 A I can -- remember, I only have a small handful,  
8 so it was only about two.

9 Q And you don't remember who the therapist was  
10 that wrote that letter?

11 A No.

12 Q Okay. You state in the open letter: We  
13 commend the largest longitudinal intervention trial  
14 funded by the NIH in 2015 in US transgender youth, et  
15 cetera, et cetera. Are you familiar with that statement  
16 made? You talk about how it's critically important to  
17 do these clinical trials, right?

18 A (Shakes head.)

19 Q Do you believe that clinical trials should be  
20 occurring in Florida to study the impacts on transgender  
21 youth?

22 A I think there's enough people in the world and  
23 the United States doing it that we really don't have to  
24 do it here.

25 Q You say -- I think you've addressed it, just

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1 want to make sure. You say: We have witnessed children  
2 being prescribed cross-sex hormones after a single brief  
3 visit to clinics. When you say witnessed, what do you  
4 mean there?

5 A As I said earlier, I witnessed it from two  
6 patients from Duke that they left to go there and on  
7 their first visit they were taught how to give  
8 testosterone and they had the injections on that first  
9 visit. Then Dr. Mouras and some other colleagues had  
10 shared their experience of similar situations happening  
11 at other places.

12 Q Of patients relaying to them --

13 A Relaying to them.

14 Q Something happened elsewhere?

15 A Uh-huh.

16 Q And how many patients would you say they  
17 experienced that with?

18 A I couldn't quantify.

19 Q Do you know what -- other than Duke, what  
20 clinics this occurred at?

21 A I don't recall.

22 Q You didn't reach out to anyone at Duke to share  
23 your concerns?

24 A No, instead at that time I think UF came into  
25 play and other centers in Florida came into play, so

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1 people weren't really going to go up to Duke. We took  
2 them off our list of referring places.

3 Q Is -- so UF is not among the clinics that you  
4 are referring to that, are in your-all's opinion,  
5 providing this care incorrectly?

6 A Again, I haven't had a lot recently, but I  
7 don't -- I, myself, don't recall my patients. I believe  
8 I heard from someone else they did, there was issue, but  
9 I, myself, personally, no.

10 Q Okay. And you-all still refer patients there?

11 A Yes.

12 Q Okay. Similar question, you say prescribed.

13 These folks were prescribed by physicians, and  
14 non-physician providers with limited experience and  
15 minimal to no involvement by well-trained psychologists.  
16 How did you come to know what experience the provider at  
17 the Duke clinic had for the two patients you were  
18 referring to?

19 A Well, when I asked the patient they weren't  
20 even seen by a psychologist or anyone up there, they  
21 were only seen by the endocrinologist. And they used  
22 the exact same generic letter that I had, and just  
23 presented it to them, took it as factual, and started  
24 medication.

25 Q But you don't know what experience and training

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1 that endocrinologist had?

2 A No.

3 Q Or how many patients they had treated for  
4 gender dysphoria?

5 A No. As I said earlier, it's a relatively new  
6 field, so when you are defining an expert, two years,  
7 three years, five years, I mean. Ten or plus more years  
8 of direct patient care would be an expert. So seeing  
9 that this is a relative new field, there's not a lot of  
10 experts in the United States.

11 Q You state in your open letter: The Florida  
12 Department of Health commissioned two researchers from  
13 McMaster University. What are you referring to there?

14 A I don't remember.

15 Q It says: To understand the state of the  
16 evidence the Florida Department of Health commissioned  
17 two researchers from McMaster University where the term  
18 evidence-based medicine was coined for a systematic  
19 review of the available evidence. Then there's a link  
20 to [ACHA.myflorida.com/letkidsbekids](https://acha.myflorida.com/letkidsbekids). What is the  
21 McMaster University report you are talking about?

22 A I don't remember all the details, I have to  
23 refresh myself on that.

24 Q Are you familiar with what let kids be kids is  
25 referring to?

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1 A Vaguely, but I don't remember all of the  
2 details.

3 Q Okay. And in the end of your letter you state:

4 A group of physicians, psychologists, risk management  
5 experts, ethicists, and lay people on a medical board  
6 should be able to assess the evidence while also  
7 advising on a proper standard of care as opposed to  
8 legislative and political bodies. Do you recall that?

9 A Yes.

10 Q So you agree that legislative and political  
11 bodies shouldn't be making these decisions?

12 MR. PERKO: Object to form.

13 A I think that it would be great if physicians  
14 could monitor physicians, but, unfortunately, sometimes  
15 it goes beyond that and government regulation needs to  
16 come into play. The opioid epidemic is the biggest  
17 example of that over the years.

18 Q When it comes to the treatment of gender  
19 dysphoria are you aware of any complaints that were  
20 filed against providers from misprescribing or  
21 misdiagnosing?

22 A You just had a list of people that testified  
23 saying that they did have complaints.

24 Q Those individuals, or is it your understanding  
25 that any of those individuals are Florida residents or

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1 received medical care in Florida?

2 A I don't know, but --

3 Q So --

4 A -- I'd like to make sure they received  
5 healthcare here.

6 Q Are you aware of any complaints filed against  
7 providers for providing this care inappropriately?

8 A Not yet.

9 Q And when you say -- you said: A group of  
10 physicians, psychologists, risk management experts,  
11 ethicists, and lay people on a medical board should make  
12 these decisions. What psychologists were involved in  
13 the Board of Medicine and Osteopathic Medicine's  
14 rulemaking to ban gender dysphoria care for minors?

15 A I don't remember.

16 Q What about risk management experts?

17 A I don't recall if they were involved.

18 Q What about ethicists?

19 A I'm not sure.

20 Q Okay. As I mentioned earlier, there was an --  
21 I don't know if I mentioned it earlier. Are you aware  
22 there was a public workshop on the Board of Medicine and  
23 Osteopathic Medicine's rules that were promulgated in  
24 this case that we discussed earlier?

25 A Sorry, I should vocalized and not make a face,

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1 but, I'm sorry --

2 Q I got what you meant. It was clear.

3 A But for the record, I have to say, I'm sorry,  
4 what?

5 Q Yep, I bet that's what she's already written.  
6 What is a public workshop, in terms of the rulemaking  
7 process?

8 A My understanding is that it is an open forum of  
9 people, either scheduled to speak or allowed to speak,  
10 in regards to certain topics.

11 Q Okay. Are you aware there was a public  
12 workshop for the development of the Board of Medicine  
13 and Osteopathic Medicine's rules creating a standard of  
14 care for gender dysphoria treatment in minors?

15 A Yes.

16 Q And have you reviewed the public book that was  
17 associated with that, that workshop?

18 A I went through some of it, yes. Most.

19 Q And --

20 A It was a lot.

21 Q It was a lot. And you are aware that the  
22 Boards invited expert -- subject matter experts to speak  
23 at that meeting?

24 A Yes.

25 Q What is the purpose of a rulemaking workshop?

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1           A       I would believe it's to make rules in regards  
2 to certain issues for the public safety and health.

3           Q       Are you aware of how the subject matter experts  
4 were selected?

5           A       No, I am not.

6           Q       Are you familiar with Dr. Patrick Hunter?

7           A       Yes, I am.

8           Q       And how?

9           A       He's on the Board.

10          Q       And what is his profession?

11          A       I believe he's a pediatrician, and I think he  
12 has a background in ethics, but I'm not 100 percent  
13 sure.

14          Q       Was he a member of the joint committee that you  
15 sat on?

16          A       Yes.

17          Q       Are you aware that he invited Dr. Michael Biggs  
18 to be a subject matter expert?

19          A       No, not aware of who he invited.

20          Q       Are you aware that he invited Dr. Kaltiala to  
21 be a subject matter expert?

22          A       No. Again, this was before my time, so I don't  
23 know who invited or who was in charge of inviting or who  
24 chose who got to speak.

25          Q       Okay. Are you aware that Dr. Michael Laidlaw

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1 was one of the subject matter experts?

2 A I believe so, yes.

3 Q Are you aware he -- actually, we'll come back

4 to that in a moment. I apologize. Who is Danielle

5 Terrell?

6 A Oh, she's one of the administrators for the

7 Osteopathic Board.

8 Q Would you agree that she's the executive

9 director?

10 A Yes, that's her actual title, thank you.

11 Q Great. Have you -- strike that.

12 What is your understanding of Ms. Terrell's

13 role?

14 A That she's one of the administrators, so she

15 takes in a lot of the paperwork and sorts through it,

16 works with the lawyers, works with us, works with a team

17 of people to help with all the business that happens

18 with the Board.

19 Q Is she a part of the public hearings and

20 workshops and things like that?

21 A I believe she was -- had to be present.

22 Q What is your understanding of -- I know you

23 touched on this earlier, but when folks show up to

24 testify or provide public comment, what's your

25 understanding of the process by which they are able to

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1 do so?

2 A So you are meaning at the meetings?

3 Q Uh-huh.

4 A So it kind of depends on the type of meeting.

5 I believe that on the February meeting there were people

6 who submitted complaints that wanted to speak and so

7 they were granted to speak, then it was open forum with

8 the cards that we previously discussed.

9 Q So there's cards that you fill out when you get  
10 there and then if they choose you you get to speak; is  
11 that correct?

12 A Uh-huh.

13 Q Is it your understanding that this is random?

14 A Yes.

15 Q I'm going to show you what I'm going to  
16 actually mark this time as Exhibit 5. This is an e-mail  
17 exchange. Do you see the name where it says from up  
18 top?

19 (Plaintiffs' Exhibit Number 5 was marked for  
20 identification.)

21 A Yes.

22 BY MS. CHRISS:

23 Q And is that the Danielle Terrell who's the  
24 executive director of the board that you sit on?

25 A Yes.

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1 Q It states, if you will turn to page 2 for me,  
2 down at the bottom where it starts: October 25th, 2022,  
3 Danielle, I work with Vernadette Broyles and she asked  
4 me to send you the list of testifiers for Friday.

5 Do you see that?

6 A Yes.

7 Q And Dr. Laidlaw, above that from Vernadette  
8 Broyles it says: To be clear, the expert is Dr. Michael  
9 Laidlaw, endocrinologist.

10 Do you see that?

11 A Yes.

12 Q If you turn to page 4 for me. For the record  
13 this is Bates stamp FDOH000042405. If you see where at  
14 the top it says: Danielle Terrell said thank you.  
15 Below that, someone named Bettye Strickland, do you know  
16 who that is?

17 A I think I'm on the wrong page.

18 Q Oh, I apologize. The fourth page. The back of  
19 the second page.

20 A Are we counting --

21 MR. PERKO: The bottom it is 4205.

22 A 4205. Okay.

23 BY MS. CHRISS:

24 Q Yeah. Are you there?

25 A Front and back. Page 4 you mean the back?

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1 Q Yes, I apologize.

2 A That's okay. The other one is one-sided. I'm  
3 on the right page. Hurray.

4 Q Thank you. If you go to the middle where that  
5 e-mail from Danielle Terrell on Wednesday, October 26,  
6 2022, it states: Please see the list of people below  
7 that will be the first to make public comment. We need  
8 to ensure that cards are filled out for all  
9 detransitioners and the parent.

10 Do you see that?

11 A Uh-huh.

12 Q Do you know who Vernadette Broyles is, the  
13 individual who sent this em-mail to Danielle Terrell?

14 A No.

15 Q Are you familiar with the Child and Parental  
16 Rights Campaign?

17 A Not really.

18 Q What do you know?

19 A They do child and parental rights. I mean, I'm  
20 sure they submitted things to the Board to read, but, I  
21 mean, we get, like, 6,000 pages of documents for things  
22 for and against, so I don't really associate the name  
23 for or against, so.

24 Q Understood.

25 A This is also well before my time.

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1 Q Right. Right. I'm just trying to get an  
2 understanding of whether it is typical for the board to  
3 pre-fill out speaker cards and ensure certain people  
4 will be able to speak first. Is that your experience or  
5 understanding of how that process works?

6 A I'm not really sure of what the process was.  
7 All I can say is the meetings I was at they were handing  
8 out cards for people.

9 Q Okay. If you could turn to page 9, which at  
10 the bottom states -- or the Bates number is 000044022.

11 A Yes.

12 Q Okay. In the middle you will see where  
13 Danielle Terrell says on Thursday, October 27, 2022:  
14 Jennifer, the list contains a total of 20 people not  
15 including the SME, I believe that's meaning subject  
16 matter expert.

17 A Okay.

18 Q This would total one hour of our public comment  
19 time. How would you like me to respond to this?

20 Do you see that?

21 A Yes, I do.

22 Q Do you know how much time was allotted for  
23 public comment?

24 A I wasn't there at the meeting, so I don't know.

25 Q Would it be reasonable if I told you the

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1 meeting minutes reflected two hours?

2 MR. PERKO: Object to form.

3 BY MS. CHRISS:

4 Q Strike that question. You are right.

5 So looking back, briefly, at the list I

6 directed you to at first on page 3, starts on the bottom

7 of page 2 and goes on to page 3. Again,

8 detransitioners, do you recognize the names as folks who

9 testified at the Board meeting?

10 A I mean, all I recognize is Chloe Cole, but

11 she's a very prominent figure. I don't --

12 Q Have you -- I apologize.

13 A I mean, I'm terrible with names. Faces I'm  
14 better with, but I'm not really sure who they are.

15 Q Have you had any interaction or any involvement  
16 with Ms. Cole outside of her testifying at these  
17 hearings?

18 A No. And I wasn't even at that hearing.

19 Q Okay. Okay. Thank you. Is it your  
20 understanding that the public comments that folks  
21 submit, there's a deadline by which they are provided?

22 A I think you mean the time that they are allowed  
23 to fill out the card --

24 Q No, I'm sorry --

25 A -- or do you mean the time --

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1 Q -- the one you send via e-mail.

2 A I'm sorry?

3 Q The ones you mentioned previously are submitted  
4 by e-mail?

5 A No, I don't even know what the timeframe is,  
6 because we get updated once all the times are -- so I'm  
7 not 100 percent sure what timeframe before the meeting  
8 people have to submit their comments. I don't know.

9 Q Okay. Turning back to this October 28th public  
10 workshop where -- my understanding is it was a rule  
11 development workshop; is that correct?

12 A That's your understanding. I think that's my  
13 understanding too. I wasn't there.

14 Q Are you familiar with the -- again, with the  
15 public book that was part of the administrative record  
16 in this process?

17 A Sure.

18 Q Did you review the presentation provided by Dr.  
19 Laidlaw?

20 A Yes.

21 Q I'm going to mark this as Plaintiffs'  
22 Exhibit 6, and, unfortunately, I only have one copy of  
23 the presentation, so I'll give that to Dr. Mortensen, if  
24 that's okay.

25 MR. PERKO: Is this marked separately?

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1 MS. CHRISS: It is supposed to be part of this,  
2 but I accidentally only printed the one copy. It is  
3 part of the same public book this was extracted  
4 from. December 28th -- sorry, October 28th, 2022,  
5 public book produced by defendants in this case.

6 (Plaintiffs' Exhibit Number 6 was marked for  
7 identification.)

8 BY MS. CHRISS:

9 Q So first looking at the agenda, do you see  
10 where it says: Subject matter experts?

11 A Going to this one first?

12 Q Yeah. My apologies.

13 A That's okay. First page.

14 Q Okay. Earlier I asked you if this was fair to  
15 characterize this as a rule development workshop, I  
16 apologize, it says rule workshop. Is that your  
17 understanding of what this was?

18 A Yes.

19 Q The agenda states: Development of rule  
20 language. So that's what was happening at the meeting?

21 A My understanding, yes.

22 Q Is 64B15-14.014, is that the rule that you  
23 voted on as a member of the Board of Osteopathic  
24 Medicine on the first page of the agenda?

25 A I believe so, I didn't memorize the numbers,

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1 but I believe so.

2 Q Okay.

3 A There's a lot of letters and numbers.

4 Q I know.

5 A It seems like -- those look accurate.

6 Q Perfect. So you'll see there's the subject  
7 matter experts we discussed previously. Discussion and  
8 development of rule language. Public comments, et  
9 cetera. Is this what a typical agenda looks like?

10 A Yes.

11 Q Great. If you can just go to the fourth page,  
12 which is really the back of the second page. Do you see  
13 the CV of Michael Biggs?

14 A I do.

15 Q Okay. Great. So if you could turn to Dr.  
16 Laidlaw's presentation, which is the PowerPoint you have  
17 in front of you.

18 A Okay.

19 Q Does this appear to be an accurate copy of the  
20 presentation that Dr. Laidlaw submitted to the Board?

21 A It does.

22 Q And this was included in the public book for  
23 this meeting?

24 A It was.

25 Q Great. We can move on.

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1 A Please.

2 Q You are not enjoying this?

3 A I had better days.

4 MR. PERKO: So Laidlaw presentation should go  
5 with the --

6 MS. CHRISS: Yes. I apologize.

7 THE WITNESS: With 6.

8 BY MS. CHRISS:

9 Q I'm going to mark this as Plaintiffs'  
10 Exhibit 7. This is one last -- I think last excerpt  
11 from that same public book. If you could just take a  
12 quick look. Are you familiar with a Dr. Gregory  
13 Coffman?

14 (Plaintiffs' Exhibit Number 7 was marked for  
15 identification.)

16 A Not personally.

17 BY MS. CHRISS:

18 Q Are you aware that he was appointed to the  
19 Board of Medicine?

20 A Oh, okay. Yeah. I'm not great with names. I  
21 said that earlier.

22 Q That's okay. Are you aware that he was a  
23 member of the Rules Committee as well?

24 A The Rules Committee? I'm really trying to  
25 remember what his face looks like right now.

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1 Q I won't tell him.

2 A Now that you are telling me he's a member of  
3 the Board, how embarrassing. I didn't memorize their  
4 names.

5 Q That's okay.

6 A I must have talked to him. Okay.

7 Q Dr. Coffman was appointed at the same time as  
8 Dr. Benson to the Board of Medicine. Just, if you are  
9 not familiar with him, no trouble, this is just a  
10 statement that he submitted to the Boards prior to being  
11 appointed to the Board of Medicine. But we can move on.

12 So, Dr. Mortensen, earlier we discussed a  
13 little bit about the vote, sort of, decision to remove  
14 the IRB-approved clinical trial exception to this rule,  
15 but what is your understanding of the basis for the  
16 original inclusion of that exception in the rule?

17 A I wasn't there for the first part, which was  
18 the Rules Committee. And my understanding there was a  
19 split between whether research should be included or  
20 excluded. My understanding is we didn't hold authority  
21 over it anyway. My feeling is is that it didn't really  
22 matter if it was or it wasn't that. I feel like there's  
23 enough people doing research in the world that we really  
24 didn't need it, it wasn't a deal-breaker for me.

25 Q Are you aware that the Board of Medicine voted

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1 on November 4th, 2022, to remove that IRB-approved  
2 clinical exception, but the Board of Osteopathic  
3 Medicine that you would come to sit on did not --

4 A Correct.

5 Q -- and voted not to remove that?

6 A Correct.

7 Q And what is your understanding of why they  
8 voted to keep that in?

9 A I don't know, because I wasn't a member of the  
10 Board at that time, that information wasn't made privy  
11 to me.

12 Q So between November -- between you being  
13 appointed in December, and you taking a vote on the  
14 removal of that section in February, there were no --  
15 were there any discussions between board members as  
16 to --

17 A There wasn't with this board member with any of  
18 the other board members. If other board members had a  
19 discussions I'm not privy to that.

20 Q Are you aware that during the November 4th,  
21 2022, meeting, which I have the meeting minutes for, if  
22 it would be helpful, but I just will ask if you are  
23 aware first, that Drs. Vila -- am I saying that right?

24 A Vila sounds familiar, yes.

25 Q Okay. Dr. Vila and Dr. Hunter provided their

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1 explanation of why they thought the IRB-approved  
2 clinical exception should be removed?

3 A I vaguely recall that conversation -- during  
4 the presentation, yes.

5 Q Okay. And do you recall them talking about  
6 hearing extensive testimony from detransitioners and  
7 that being a part of their decisionmaking?

8 A I don't remember that exactly, but it's very  
9 possible.

10 Q Okay. And at that meeting the Board of  
11 Osteopathic Medicine you unanimously voted to reject the  
12 removal of that exception, right?

13 A Correct.

14 Q Are you familiar with Dr. Patrick Hunter's  
15 affiliations with any other groups?

16 A The only that I know is what's been bought up  
17 at the meetings.

18 Q Has -- did that include his membership with a  
19 group called Genspect?

20 A Possible.

21 Q Okay. What about SEGM, The Society for  
22 Evidence-Based Gender Medicine?

23 A I believe so.

24 Q And are you familiar with SEGM or Genspect?

25 A Not really.

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1 Q Are you aware that they are, sort of,  
2 self-described anti-transgender organizations?

3 MR. PERKO: Object to form.

4 A I believe it if you say so. I didn't really  
5 look them up.

6 BY MS. CHRISS:

7 Q Okay. When you were appointed to the Board on  
8 December 6, 2022, did Dr. -- did you take someone's  
9 place?

10 A I would assume so. Usually they don't create  
11 new board positions, they are usually replacing somebody  
12 that's no longer on the board. That's my assumption.

13 Q Was it your understanding that Drs. Schwemmer,  
14 Gadea, and Mendez were removed from the Board when you  
15 and several others joined?

16 A I really didn't know who the previous board  
17 members were.

18 Q Okay. No problem?

19 A It's like when a physician leaves a practice,  
20 bygones, I don't know who they were.

21 Q I won't tell.

22 A I don't care. I got to focus on what I got to  
23 focus on.

24 Q Okay. And when the Boards published their  
25 joint notices of public hearing on the proposed rules on

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1 January 9th is it your understanding that the Board of  
2 Medicine rule, and the Board of Osteopathic Medicine  
3 rule, differed slightly, in that the Board of  
4 Osteopathic Medicine rule still included the exception?

5 A Yes, it's my understanding.

6 Q Were you present at the February 10th, 2023,  
7 hearing?

8 A I sure was.

9 Q And you participated in this hearing?

10 A I did.

11 Q What is the purpose of a public hearing?

12 A It's to give the public an opportunity to speak  
13 on the topic, whether it be from a professional  
14 standpoint or a personal standpoint.

15 Q And you are aware, I think you mentioned  
16 earlier, that there were requests presented to the Board  
17 for the hearing, petitions for the hearing?

18 A Yes, that's my understanding.

19 Q And are you aware that four out of six of the  
20 requests for the hearing were from folks urging the  
21 Boards not to adopt the rules?

22 A I didn't pay attention as to how many were for  
23 or against, and I didn't create the agenda.

24 Q Right. You reviewed the reading materials --

25 A But I reviewed the statements --

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1 Q -- prior too?

2 A Yes, I did. Like 10,000 pages, yeah.

3 Q Do you recall reviewing -- I'm going to mark  
4 this as Exhibit 8. Did you review this petition --  
5 sorry, petition for a rule hearing by a group called  
6 Gender Analysis?

7 (Plaintiffs' Exhibit Number 8 was marked for  
8 identification.)

9 A I reviewed it, yes.

10 BY MS. CHRISS:

11 Q So you are familiar with the allegations  
12 therein?

13 A Yes.

14 Q Did the Boards considered this in their  
15 decisionmaking?

16 A I don't know what they used in their  
17 decisionmaking, I can only speak to what I used in mine.

18 Q Okay. Did you consider it?

19 A I reviewed all of it, and what everything tells  
20 me here is that nobody knows what's good and what's  
21 wrong and what's bad and how this is and how to do it  
22 and how to treat it. So what I gather from hearing the  
23 stories and reading this, and reading the medical  
24 literature, is that no one knows what causes  
25 transgender, no one knows is it medical? Is it

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1 psychological?

2           No one knows what's the best route of  
3 treatment, and everyone's hoping to find the best  
4 answer. And that the medical people are very divided  
5 over what they believe, and even the community is  
6 divided over what it needs. So from everything that I  
7 read in the pros and the cons, it tells me that I've got  
8 some people who feel very strongly on the one end, very  
9 strongly on the other, and they both have some good  
10 arguments, and some of them have some not so great  
11 arguments.

12           But the reality is we don't know what we don't  
13 know and we don't really know what the best path of  
14 treatment is and this is a relatively new field and it  
15 has -- going to have some repercussions down the road.  
16 And even though science tries to move forward and try  
17 the best path for the best routes of treatment, we don't  
18 even really know what is the best path of treatment.

19           **Q     So the answer is, yes, you reviewed that**  
20 **document --**

21           A     Yes.

22           **Q     -- in your decisionmaking?**

23           A     Yes.

24           **Q     Okay. Are you aware that every major medical**  
25 **association in our country supports the provision of**

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1 **gender-firming care for transgender individuals for whom**  
2 **it is medically necessary?**

3 MR. PERKO: Object to form.

4 A I am aware that those board members who submit  
5 that is, but not every member who sits on all of those  
6 societies agree with the statements that are submitted.  
7 So your statement is accurate, but I think that it's  
8 leading saying that every member of all those societies  
9 back those statements. That is not factual.

10 Q If I did state that, that was not the intent of  
11 my question --

12 A Just being clear.

13 Q -- I stated every major medical organization  
14 support these treatments?

15 A I believe so.

16 Q Okay. And have you spoken to any of the  
17 members of the -- I think you said the board members of  
18 these organizations who have expressed to you they  
19 disagree?

20 A Oh, I know a lot of people on the Pediatric  
21 Endocrine Society, I know a lot of people on the  
22 Endocrine Society, I know people who are still members  
23 of the AP who do not agree with the statements. I know  
24 people who are starting to withdraw from those groups.  
25 I know a lot of people are afraid to speak up, but

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1 there's a lot of people who feel that the Endocrine  
2 Society made this statement so the American Academy of  
3 Pediatrics backs it. They are not experts. They are  
4 relying on the experts to state that statement. So are  
5 they really trained and experienced on it? No. But  
6 that's just like when the American Heart Disease says  
7 that you need an hour of exercise, the AAP is going to  
8 back the experts.

9 So all of these people backed the experts, but  
10 the experts are not correct on everything. There's a  
11 lot the experts don't know.

12 Q Do you follow the Endocrine Society Guidelines,  
13 generally, in other provision of other types of care?

14 A Generally, yes.

15 Q And when you were providing treatment for  
16 gender dysphoria you stated previously in the deposition  
17 that you followed the Endocrine Society Guidelines?

18 A Yes, I wanted to believe that it could help. I  
19 wanted to believe it.

20 Q Are you aware of any medical organization that  
21 opposes the treatment of gender dysphoria?

22 A No, I'm not aware.

23 Q So just returning for a moment to the  
24 November 4th hearing that we spoke about. There were  
25 two individuals who provided information on their

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1 petitions for the hearing; is that correct?

2 A For the?

3 Q Who requested the hearing.

4 A For the hearing for February?

5 Q Yes.

6 A Or November?

7 Q Did I say November? I apologize.

8 A I thought you did, that's why I got confused.

9 Q So sorry. I tried to memorize all these dates.

10 A Same. It's hard.

11 Q February 10th, 2023, there were two individuals  
12 that spoke about their petitions, correct?

13 A To my knowledge, yes.

14 Q And one of those was Mr. Wilson from the  
15 Florida Department of Health?

16 A Yes, I believe so.

17 Q And he encouraged the Board of Osteopathic  
18 Medicine to remove the research exemption?

19 A Correct.

20 Q Did you -- do you recall during that meeting,  
21 or that hearing, hearing from multiple doctors that  
22 provide treatment for gender dysphoria in the state of  
23 Florida?

24 A Yes, I do recall hearing.

25 Q Including Dr. Michael Howler and Dr. Paul

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1 Arons?

2 A Uh-huh.

3 Q And do you recall them testifying about their  
4 personal clinical experience in treating many minors who  
5 experience gender dysphoria?

6 A Yes.

7 Q And do you recall their testimony about the  
8 positive benefits that their patients received through  
9 this treatment?

10 A Yes.

11 Q Did the Board of Osteopathic Medicine take the  
12 public comments into consideration before voting?

13 A I don't know what all -- I can only speak as  
14 myself, because we didn't talk. I heard everything that  
15 they said, and I listened. Some of it was very  
16 heartbreaking and emotional and moving, so I listened  
17 wholeheartedly with an open mind to hear everything they  
18 had to say.

19 Q And did it impact your opinion at all?

20 A It did, but it didn't change my opinion that  
21 there's so many unknowns that it's not very safe for  
22 someone under the age of 18.

23 Q Is it accurate that the -- actually, I should  
24 just show you. One moment. Mark this as Plaintiffs' 9.  
25 So under Board of Osteopathic Medicine on the first page

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1 you see your name, members present?

2 (Plaintiffs' Exhibit Number 9 was marked for  
3 identification.)

4 A Yes.

5 BY MS. CHRISS:

6 Q Okay. If you would just turn to the very back  
7 where it says: Dr. DiPietro -- am I saying that  
8 correctly?

9 A Yes.

10 Q Called the Board of Osteopathic Medicine  
11 meeting to order at 4:21 p.m. Dr. DiPietro asked the  
12 Board of Osteopathic Medicine members if there was any  
13 motion to change or modify the rule as it currently  
14 stands. Dr. Ducatel made a motion to remove the current  
15 research exception in order to mirror of Board of  
16 Medicine rule. There was no discussion between members.  
17 The motion to remove the current research exception was  
18 seconded and approved unanimously and the meeting --  
19 summarizing -- the meeting was adjourned at 4:23 p.m. A  
20 motion to adjourn the meeting was approved unanimously  
21 at 4:23 p.m.

22 A Correct.

23 Q So I'm not great at math, but it seems like it  
24 was two minutes between the calling to order and the  
25 adjournment. Why are -- I guess I should ask, to the

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1 best of your knowledge, you can only speak for yourself,  
2 why was there no discussion of the information that the  
3 Board had learned during the meeting?

4 A It was offered, but I, myself, had been sitting  
5 there for the whole time and had read all the things and  
6 went through everything else, so I had time to see what  
7 I had, and I knew where I was going to go with it. I  
8 suppose everyone else felt the same.

9 Q So just -- the previous vote, November 4th,  
10 unanimously everybody voted to reject the removal of the  
11 exemption, then February, no one -- no discussion, but  
12 in February they unanimously voted to remove?

13 A I wasn't there for November, so I'll take your  
14 word on it.

15 Q Just make sure I got this correct --

16 A But for this meeting the motion was to remove  
17 the research exemption. It was discussed, people talked  
18 about it, it was offered did anybody else want further  
19 discussion on it? I already knew where I was going to  
20 go on it based on everything I was hearing, I assume  
21 everybody else did, and we agreed on it.

22 Q So I believe you stated previously the reason  
23 that you didn't think IRB-approved clinical trials were  
24 necessary, despite stating in your open letter that that  
25 was so important to conduct such trials to gather

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1 evidence, you didn't think that was something that

2 should be happening in the state of Florida?

3 A Agreed. I think that, and I believe that even

4 WPATH and Endocrine Society say more research is needed,

5 more research is needed, but I don't think we need to do

6 it in Florida. I think there's plenty of other

7 institutions in this nation and the world that already

8 started research, so I don't think it needs to be

9 duplicated.

10 Q So you voted to remove the opportunity and

11 ability of any provider in the state of Florida to

12 conduct that research?

13 A In children, yes.

14 Q You mentioned a moment ago there was testimony

15 that was heartbreaking. Can you just elaborate on what

16 testimony you found heartbreaking?

17 A It's very -- as a physician, and maybe as a

18 person, as a human being, to hear someone suffering,

19 it's very hard to hear. I mean, I also see it in my

20 clinic that's it's heartbreaking. You know, I think

21 hearing some of the stories of what families were going

22 through and the struggles that they are having, it's

23 hard not to, you know, be moved by somebody experiencing

24 a struggle. I mean, we see at in our clinic too with

25 kids who have cancer, and long-term diabetes, I mean,

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1 anyone who has a medical disorder, which I'm not saying  
2 it's a mental disorder, I'm saying a medical disorder,  
3 they are going to have struggles and it's hard to see  
4 people struggling.

5 And as a physician we want to help, which is  
6 one of the reasons why we wanted to believe the  
7 guidelines and were willing to entertain the guidelines,  
8 even though they were loose, is if it could provide some  
9 help and support. And we couldn't make ourselves a  
10 center, but if we could help a little bit of support  
11 until they could get into the place they really needed  
12 to be, then we were okay with it at first.

13 But when we really started to experience the  
14 negative side and see where things were going, it just  
15 didn't seem reasonable or feasible anymore. It seems  
16 like this has exploded and that there's really not any  
17 real regulation on anything. That these treatments are  
18 being caused and given to kids at younger and younger  
19 ages and stages.

20 Q Did you credit the testimony of the doctors  
21 that spoke directly to you about the tremendous positive  
22 benefits these treatments have had on their patients?

23 MR. PERKO: Object to form.

24 A I heard what they said. I also know they are  
25 living in a bubble and they believe what they want to

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1 believe too. So -- there are also people who said that  
2 it proved benefit for them. But why does it have to be  
3 under 18? If they are choosing to spend the whole rest  
4 of their life, and that's what they want to do, why  
5 can't they wait until they are 18? What's a couple more  
6 years until that frontal lobe fully forms, that they can  
7 make truly informed decisions about what they want to do  
8 with their life and who they want to and where they want  
9 to go and if they want to have children.

10 Most 14-year-olds aren't really thinking about  
11 fertility. Even if our cancer kids, when you are saying  
12 there's a likelihood will all this chemotherapy you are  
13 not going to have children, you know, should we harvest  
14 eggs, you're having a conversation, and they don't  
15 understand. So to me to put a pause on it until they  
16 are 18 seems reasonable, since there's not enough data  
17 to support all of this and what's going to happen down  
18 the road. Seems reasonable to put a pause until they  
19 are 18.

20 Q Do you believe that no minor patients benefit  
21 from this treatment?

22 A I think that it's very hard to say. There  
23 probably is a small group, but you are throwing out the  
24 baby with the bath water. I mean, you have so many,  
25 there might be a small that has some benefit, but there

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1 might be a bigger amount that have a negative benefit,

2 so what do you do?

3 Q And you are basing this off the 10 individuals

4 that you've personally provided treatment for, witnessed

5 their treatment, and the two that you mentioned received

6 what you deem inappropriate care from Duke?

7 A And the reading and the data and the testimony

8 and talking with my friends and some of my other friends

9 at the other centers that I previously mentioned.

10 Q Do you believe that the doctors who provided

11 the testimony about the benefit their patients are

12 receiving, that they are wrong about their patients

13 benefitting from this?

14 A I think they want to believe that there is

15 benefit and that there is no harm in it, but they don't

16 actually know what the long-term harm is. The challenge

17 we also have is when you are looking at the data you

18 have to separate out from the trans-female to the

19 trans-male, because testosterone is euphoric, it's one

20 of the reasons why it's a controlled substance.

21 So when taking a look at psychological impact

22 on health, if I'm giving you a medication that's going

23 to boost your hemoglobin and give you more energy and

24 increase your muscle mass, psychologically you are going

25 to have some improvement. So is it that they are just

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1 taking testosterone and that's better than taking  
2 Wellbutrin or an antidepressant or an anti-anxiety?  
3 Nobody knows.

4 But that's why it's so hard to interpret the  
5 data, is because you have a lot of confounding  
6 principles. And I think a lot of people don't  
7 understand that maybe the trans-males were happier than  
8 the trans-females because we were getting a euphoric  
9 medication. And that was only a two-year study from the  
10 NIH, it didn't tell you what was going to happen five  
11 years, 10 years down the road.

12 MS. CHRISS: If we could take a brief break  
13 then come back on the record.

14 (Break taken at 3:22 p.m. until 3:33 p.m.)

15 (The deposition of MONICA MORTENSEN, D.O.  
16 continues in Volume 2.)

17 \* \* \* \* \*

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CERTIFICATE OF OATH.

STATE OF FLORIDA)  
COUNTY OF DUVAL)

I, Kelly G. Broomfield, the undersigned  
authority, certify that MONICA MORTENSEN, D.O.,  
personally appeared before me on September 28, 2023, and  
was duly sworn.

WITNESS my hand and official seal this 8th day  
of October, 2023.



Kelly G. Broomfield, Stenographic Reporter  
Notary Public - State of Florida  
My Commission expires: September 30, 2025  
My Commission No. HH 164930

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1 REPORTER'S CERTIFICATE

2

3 STATE OF FLORIDA)

4 COUNTY OF DUVAL)

5

6 I, Kelly G. Broomfield, Stenographic Reporter,  
7 certify that I was authorized to and did  
8 stenographically report the deposition of MONICA  
9 MORTENSEN, D.O.; that a review of the transcript was  
10 requested; and that the transcript, Volume 1, pages  
11 1-181, is a true and complete record of my stenographic  
12 notes.

13 I further certify that I am not a relative,  
14 employee, attorney, or counsel of any of the parties,  
15 nor am I a relative or employee of any of the parties'  
16 attorney or counsel connected with the action, nor am I  
17 financially interested in the action.

18

19 DATED this 8th day of October, 2023.

20



21

22 Kelly G. Broomfield, FPR  
23 Stenographic Reporter  
24 LEXITAS

25

26

27

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Jane Doe

vs.

Joseph Ladapo

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Deposition of:

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September 28, 2023

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

CIVIL NO.: 4:23-cv-00114-RJ-MAF

JANE DOE, et al.,

Plaintiffs,

v.

JOSEPH A. LADAPO, et al.,

Defendants.

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DEPOSITION OF

MONICA MORTENSEN, D.O.

VOLUME 2 (Pages 182 - 266)

Thursday, September 28, 2023

3:33 p.m. - 5:45 p.m.

LEXITAS Florida  
100 North Laura Street  
Suite 1002  
Jacksonville, Florida 32202

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1 \* \* \* \* \*

2 (The deposition of Monica Mortensen, D.O.  
3 continued from Volume 1.)

4 DIRECT EXAMINATION (cont'd)

5 BY MS. CHRISS:

6 Q So Dr. Mortensen, just very briefly, we have  
7 discussed the development promulgation of the rules  
8 creating the standards of care for minors, the treatment  
9 of gender dysphoria. Now I'd like to ask a couple  
10 questions about SB 254 and the implementing rules and  
11 regulation -- or implementing rules. So I presume you  
12 are familiar that SB 254 was signed into effect on May  
13 17, 2023?

14 A Correct.

15 Q You are familiar with the content of that?

16 A Yes.

17 Q Okay. Do you have any understanding of why the  
18 legislature passed that law?

19 MR. PERKO: Object to form.

20 A No.

21 BY MS. CHRISS:

22 Q Are you aware that the companion bill to SB 254  
23 was called HB 1421?

24 A I'm not sure. I don't remember all the numbers  
25 and letters.

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1 Q Would you believe me if I told you it was?

2 A I think I could believe you on that, yes.

3 Q Okay. Did any of the members of the Board of  
4 Medicine play a role in the legislature's development of  
5 SB 254 or HB 1421?

6 MR. PERKO: Object to form.

7 A I personally did not. I don't know about the  
8 others.

9 BY MS. CHRISS:

10 Q Were you asked to speak to the legislature?

11 A No.

12 Q Are you aware that the Board of Medicine chair,  
13 Scot Ackerman, was invited to speak with the  
14 legislature?

15 A No, I did not.

16 Q So SB 254 required that the Boards develop  
17 emergency rules and informed consent forms; is that  
18 correct?

19 A Correct.

20 Q Just before we get into that, are you -- let me  
21 back up. You were one of the individuals who authored,  
22 drafted, the emergency -- the informed consent form?

23 A The emergency consents forms, yes.

24 Q And are there nonemergency consent forms?

25 A Well, my understanding is is that they need to

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1 go to -- this was just a draft and that there will be  
2 permanent consent forms.

3 Q Who's working on the permanent consent forms?

4 A It goes back to the Rules Committee.

5 Q Which you are on?

6 A Correct.

7 Q Do you know when that's happening?

8 A I want to say end of November there's going to  
9 be a meeting to discuss.

10 Q Okay. And is that about the informed consent  
11 forms for adults and minors?

12 A Correct.

13 Q Is there any other area of treatment where the  
14 Boards have required an informed consent form with this  
15 level of prescribed content?

16 A I don't know, I haven't reviewed what the  
17 Boards have done in years past.

18 Q You are not familiar with any of the other  
19 informed consent forms the Boards of Medicine have  
20 created?

21 A No.

22 Q Dr. Mortensen, are you aware of any informed  
23 consent forms that include substantive requirements  
24 within them?

25 A For pain management and for -- or opioid

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1 consents they do have requirements in them.

2 Q And what are those requirements?

3 A Typically, that you have to agree to see your  
4 counselor, that you have to have screenings for opioid  
5 use, whether it be a urine test, a hair test, that you  
6 agree to fill your prescriptions, that you agree not to  
7 misuse or abuse your prescriptions, that they will often  
8 be laboratory tests they have to do.

9 Q Have you, in your clinical practice, used any  
10 informed consent forms that included substantive  
11 requirements?

12 A In the center that I worked at in their  
13 behavioral health department they did have pain  
14 management consent contracts and forms.

15 Q But you, in your clinical experience, used  
16 those forms?

17 A I did not use those forms because I didn't  
18 prescribe those substances, but I did review those forms  
19 and discuss those forms.

20 Q So when you were drafting the informed consent  
21 forms for the Board of Medicine, you didn't look at  
22 other informed consent forms they promulgated in the  
23 past?

24 A That the Board did? No.

25 Q If we could turn back to Exhibit 1, which is

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1 your expert report. Page 9, paragraph 25.

2 A Uh-huh.

3 Q Where you discuss SB 254. This discusses  
4 how -- what we just discussed, that you were tasked with  
5 creating emergency rules. What is your understanding of  
6 why the legislature created requirements for adults?

7 MR. PERKO: Object to form.

8 A I don't know.

9 BY MS. CHRISS:

10 Q The Board of Medicine rules that we discussed  
11 previously did not affect adults, correct?

12 A Correct.

13 Q And why were you tasked with creating these  
14 informed consent forms?

15 A I think because I have experience with these  
16 medications and that I had drafted the consent form for  
17 our center, so I believe that's why I was asked to do  
18 it.

19 Q And that was the informed consent form for  
20 Nemours regarding puberty blocking medication?

21 A Correct.

22 Q Are you aware of why the SB 254 restricted  
23 APRNs, and NPs, non-physicians, from providing care?

24 A I do not know why.

25 Q The specific language of SB 254, are you

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1 familiar enough with it that you don't need to look at  
2 it or would it help to look at it?

3 A It would certainly help to look at it.

4 Q Dr. Mortensen, go to page -- luckily they are  
5 numbered on the bottom, so that's helpful.

6 A That will help me a lot.

7 Q Page 7 of 10, please.

8 A Okay.

9 Q So here it states: Is sex reassignment  
10 prescriptions or procedures are prescribed for or  
11 administered or performed on patients 18 years of age or  
12 older, consent must be voluntary, informed, and in  
13 writing on forms adopted by the Board of Medicine and  
14 the Board of Osteopathic Medicine. Consent to sex  
15 reassignment prescriptions or procedures, if voluntary  
16 and informed, only if the physician to prescribe or  
17 administer the pharmaceutical product or perform the  
18 procedure has, at a minimum, while physically present in  
19 the same room. And then there are three bullet points.

20 A states: Informed the patient of the nature  
21 and risks of the prescription or procedure in order for  
22 the patient to make a prudent decision.

23 B: Provided the informed consent form, as  
24 adopted in rule by the Board of Medicine and the Board  
25 of Osteopathic Medicine, to the patient.

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1 And C: Received the patient's written  
2 acknowledgment before the prescription or procedure is  
3 prescribed, administered, or performed. That the  
4 information required to be provided under this  
5 subsection has been provided.

6 Did I read that correctly?

7 A Yes, you did.

8 Q And that is the language that the, sort of,  
9 conferred the duty upon you-all to create these forms,  
10 correct?

11 A Yes, it did.

12 Q These were the only requirements that were by  
13 law had to be in the informed consent forms, correct?

14 A Correct.

15 Q There was no requirement that the forms reflect  
16 any particular risks or benefits, correct?

17 A Correct.

18 Q There was no specific language that had to be  
19 included, correct?

20 A Correct.

21 Q There was no requirement for any certain number  
22 of initials, places to initial?

23 A Correct.

24 Q Or for a witness to sign?

25 A Correct.

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1 Q And it says -- it says you must inform the  
2 patient of the nature and risks of the prescription.  
3 Does that -- would you understand that to mean the  
4 prescription at issue in the informed consent form, the  
5 prescription being prescribed?

6 A Yes.

7 Q And going back to Exhibit 1, on page 9,  
8 paragraph 26, you state: I and another member were  
9 asked to create draft consent forms to submit to the  
10 committee for review and further development. Who was  
11 the other member?

12 A Dr. Benson.

13 Q And that's the same Dr. Benson from -- who you  
14 wrote the letter with?

15 A Correct.

16 Q You say since -- the beginning of that sentence  
17 I left off, I apologize. Since I am also a pediatrician  
18 endocrinologist, I and another member. But you were  
19 tasked with creating the adult consent forms as well?

20 A Correct.

21 Q And you did say this earlier, but you don't  
22 have any experience treating adults?

23 A Correct.

24 Q And you don't provide treatment for gender  
25 dysphoria for adults or for minors?

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1           A       Correct.

2           Q       How did you create these forms?

3           A       So initially when my friend had sent me the  
4 ones for the pubertal ones, we also had ones for  
5 feminizing and masculinizing, because their center did  
6 all of that. So I still had those. So I used that,  
7 those two, as a basis, because many of the side effects  
8 and risks are going to be the same, but I reviewed it,  
9 and double-checked literature, and looked at the  
10 prescribing information guidelines, and all of that. I  
11 adapted it as best I could, then we then duplicated for  
12 the adults and took out certain language and tried to  
13 adjust it appropriately.

14          Q       And remind me who the friend is that sent those  
15 forms?

16          A       The ones from Texas I think were from Priti  
17 Patel.

18          Q       And has that been -- what pronoun does that  
19 person use?

20          A       She/her.

21          Q       Did she have any other involvement in this  
22 process?

23          A       No, not at all. And that was years ago when we  
24 first started with Nemours doing the consents.

25          Q       Did you confirm whether her institution had

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1 revised the informed consent forms in the years since?

2 A No, because I think she stopped doing  
3 transgender, I'm not 100 percent.

4 Q So you are not aware of what forms that  
5 institution uses today?

6 A Correct.

7 Q And did you work Dr. Benson on this?

8 A No.

9 Q So how did you come up with the same --

10 A He submitted his own.

11 Q So you had two separate drafts?

12 A Correct.

13 Q Do you know how he came about creating his?

14 A I didn't ask or talk to him, because of the  
15 Sunshine Law. We didn't want to make any risk that  
16 there would be any wrongdoing, so we didn't discuss it.

17 Q During the subsequent board meeting when the  
18 forms were discussed, and you were all asked many  
19 questions, did it -- did you then understand how he went  
20 about creating the forms?

21 A I don't know if he was specifically asked how  
22 he created the forms. I believe I shared, but I don't  
23 know if I was specifically asked or if I specifically  
24 shared either.

25 Q Have you ever previously developed an informed

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**1 consent form outside of your area of expertise?**

2 A I didn't develop, but I've reviewed, like I  
3 said, about the pain management contracts at the former  
4 center that I worked at.

**5 Q How long did you take to create the forms?**

6 A These consents.

**7 Q The first draft that you brought to the Board?**

8 A The first draft I brought to the Board? Oh, my  
9 gosh, at least 60 hours, if not more.

**10 Q 60 hours?**

11 A Yeah, at least 60 hours.

**12 Q Over the course of?**

13 A Several weeks. I think two, two weeks or so, I  
14 pretty much had a full day of work, come home, eat  
15 dinner, then I would look, read, research, write, and  
16 put in full days on the weekends as well.

**17 Q What did you research and read?**

18 A So I went back to the stuff that was provided  
19 to us. I went back to the Endocrine Society and WPATH.  
20 And then I reviewed some of the literature that was  
21 attached to those, then I did a PubMed search as well.  
22 I went to Lupron's web site to verify side effects and  
23 information, prescribing guides from there.

24 I went to look up the testosterone, it's a  
25 generic, but I looked up brand for that. I reviewed

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1 stuff on birth control pills and different forms of  
2 estrogen. I even had gone to, like, you know, when you  
3 Google, I did Google, just because that's what people  
4 see, so I wasn't really using it for, like, a medical  
5 source, but sometimes it's very helpful to see what  
6 people are reading. So if people are reading that  
7 that's this, where is this information coming from, see  
8 if there's a medical link or whatever. So those were,  
9 kind of, a lot of different sources that I looked at.

10 Q What experts on the treatment of gender  
11 dysphoria did you consult with?

12 A I didn't.

13 Q Did you consult with anyone with experience  
14 treating gender dysphoria?

15 A No, I did not.

16 Q Have you ever -- are you aware of any other  
17 instances where an informed consent form was developed  
18 without the input of an expert in that treatment?

19 A I'm not aware.

20 Q I assume the answer is no, but are you aware of  
21 whether Dr. Benson consulted with any experts?

22 A I don't know. I also didn't know what I was  
23 privy to do either, because, unfortunately, if you are a  
24 member of the Board you have to be careful that you are  
25 not representing the Board. So, you know, part of the

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1 problem of reaching out to some of the experts is now  
2 they are talking to you as board member, and I can't  
3 talk as a board member. So there's, kind of, a lot of  
4 stipulations in that as well, so it's, kind of, hard to  
5 say, well, who am I allowed to talk to? Who can't I  
6 talk to? So I, kind of, felt since I was a board member  
7 and I'm not supposed to represent the Board, I didn't  
8 know I could go outside the purview of what I could find  
9 from my literature search and everything else. So I  
10 didn't know if I was allowed to reach out and contact  
11 various experts to help with the consents.

12 Q Did you ask anyone if you were permitted to do  
13 so?

14 A I think I got so imbedded in it that I just did  
15 what I could, the idea was this was an emergency consent  
16 that was never meant to be permanent and that we would  
17 be getting feedback as it was presented, and that  
18 would hopefully be good enough for the time being. And  
19 that we could then get further input as to how to change  
20 them.

21 Q So just to be clear, did anyone specifically  
22 tell you you couldn't reach out to experts outside of  
23 the Board?

24 A They did not specifically say that.

25 Q And did the Board -- you know, I understand the

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1 Sunshine Laws prohibit discussions outside of these  
2 public meetings, but during the various public meetings,  
3 hearings, and such, did the Board together discuss  
4 bringing in experts in the treatment of gender dysphoria  
5 to guide the development of the informed consent forms?

6 A I believe it was mentioned, but I don't know  
7 that we got any offers, or I don't know if anybody  
8 reached out on behalf of the Board to an expert.

9 Q So the best of your knowledge there were not  
10 outside experts consulted?

11 A To the best of my knowledge, yes.

12 Q And no one on the Board of Medicine or Board of  
13 Osteopathic Medicine, in your -- apologies. No one in  
14 your Rules Committee that was working on these has  
15 clinical experience in the area of gender dysphoria,  
16 correct?

17 A As far as I know.

18 Q Okay. How many -- scratch that.

19 Were there multiple drafts of your informed  
20 consent forms?

21 A We put in -- the first meeting I had submitted  
22 the Nemours one, I submitted the  
23 feminizing/masculinizing one, and the puberty blocker  
24 that my friend had given me. I think I had found  
25 another one or two that I had submitted. Then I'm not

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1 sure if Dr. Benson submitted anything. Then at the  
2 first meeting everybody felt there was so much to go  
3 through and in order to get this done in a timely manner  
4 it was better to task one person from the osteopathic  
5 and one member from the Board to pull it together so we  
6 had a working draft that we could edit.

7 Q You state in paragraph 27 of your report,  
8 expert report, Exhibit 1, you reviewed the guidelines  
9 from the Endocrine Society and WPATH and the medical  
10 literature. You say: I also wanted to view this  
11 process through the eyes of a patient to see what  
12 barriers or information they were receiving, so I went  
13 to chat rooms to see what concerns people were posting  
14 and Google search engine since this are common tools  
15 people use to gather information.

16 In your experience is it common to rely on  
17 things like chat rooms in developing an informed consent  
18 form?

19 MR. PERKO: Object to form.

20 A Sorry. I wasn't relying on them for the  
21 expertise of what would be in them, I was using them as  
22 a guide to see what people were seeing. So I think one  
23 of the examples in the forum was nipple discharge, and  
24 one of the experts saying, that's not true. And yet in  
25 the chat room there was a whole bunch of people saying

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1 that that's what they experienced and they were never  
2 told about it, they had no idea. Saying is this weird?  
3 Is this wrong? Is there something wrong? Do I have  
4 cancer?

5 So it was, kind of, a nice way of seeing what  
6 people knew and what they didn't know. Now, could they  
7 have already been told that? Sure, it's a possibility.  
8 But having it in writing, and having them sign off on it  
9 seemed to be a better route.

10 BY MS. CHRISS:

11 Q Did you correspond with any of these  
12 individuals to confirm the validity of what they shared  
13 online?

14 A No. But to be fair, I did not put nipple  
15 discharge in there because they said nipple discharge,  
16 it was already in the consent. So I didn't say they  
17 said they had these side effects and put that in my  
18 consent. In the consents were only what was found in  
19 the medical literature.

20 Q Do you recall the specific medical literature  
21 studies that you relied upon?

22 A I believe I put most of them in the  
23 bibliography.

24 Q Of your expert report?

25 A Correct.

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1 Q And you are familiar with the Endocrine Society  
2 Guidelines criteria for gender-affirming hormone therapy  
3 for adolescents?

4 A Yes.

5 Q And you are familiar with the WPATH standards  
6 of care statements that require -- specifically require  
7 that individuals -- that the provider assess the  
8 capacity of the individual to consent for this specific  
9 treatment, that their mental health concerns are  
10 addressed, and that they've been informed of affects  
11 impacting reproductive function?

12 A Correct.

13 Q Those are all already in the WPATH standard of  
14 care?

15 A Yes.

16 Q And the Endocrine Society Guideline also  
17 assesses the adolescents capacity to consent?

18 A That is correct.

19 Q Were you -- when you were looking at chat rooms  
20 and Google and such, were you searching for -- you  
21 stated to see what barriers or information they were  
22 receiving. Were you specifically looking for negative  
23 side effects or did you spend any time looking for  
24 individuals reporting positive experiences?

25 A I wasn't looking specifically for one thing.

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1 That's the things with chat rooms is anybody can put  
2 anything in it, so there's positive, but I have a  
3 feeling that people have a tendency more to complain and  
4 not so much say the positives. So I wasn't using that,  
5 as I stated earlier, as to what to put into the  
6 consents, I just wanted to see did I address some of  
7 that?

8           Some of the things that was happening at the  
9 meeting, which I like the public speaking, because we  
10 actually learned a lot of different things in the  
11 process of, you know, one of them was, Hey, my parents  
12 are in the military, my grandmother is my guardian.  
13 Does it have to be two? Does it have to be a parent?  
14 Can a parent go in via video, you know, talking about  
15 how often they are being seen, what timeframe. So, you  
16 know, it was really important to hear their side of what  
17 they were telling us was going to be the barriers that  
18 they were going to have, and that's what I was also  
19 seeing that, that's what they said, and they are saying  
20 it here online too.

21           **Q     Were there --**

22           A     Is there anything else that they didn't say  
23 this is on here?

24           **Q     Were there folks that provided testimony, like**  
25 **what you just mentioned, that urged -- urged a lack of**

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1 **barriers to this care?**

2 A What do you mean urged a lack of barriers?

3 Q Folks that have either had positive experiences  
4 with this care and need it for their well-being or, you  
5 know, parents whose children need access to this care  
6 who shared with you, you know -- you were talking about,  
7 I think, barriers in the context of risks and things  
8 like that, but did you assess and take into account the  
9 barriers that you were told these informed consent forms  
10 would create for people to get needed medical?

11 MR. PERKO: Object to form.

12 A I wasn't guided to what to put in the form, but  
13 that was one of the things of why we extended timeframes  
14 of, you know, one of the questions was that we were  
15 hearing from families and from patients was my current  
16 provider is afraid to prescribe to me now because the  
17 law has changed and the consent isn't there. But the  
18 consent isn't there and nothing is in place, so they  
19 should be doing business as usual. So they viewed that  
20 as a barrier, which I don't understand why. Like, why  
21 if you -- if the law has not been started and the  
22 consent is not in play, why are providers not providing  
23 care? I couldn't speak to that. I didn't know why.  
24 But that was one of the things about emergency consents  
25 is you guys got to get these done as soon as possible,

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1 my provider doesn't feel comfortable unless they have  
2 the consent there.

3           Then we didn't want to have, like, here's the  
4 day that the consents are in, you got to have them  
5 signed in 24 hours. We talked about, like, three  
6 months, four months, six months. And seeing that many  
7 people are supposed to be seen every three to  
8 six months, we said, why don't we do six months.  
9 Someone even brought up, like, telemedicine. I don't do  
10 all my visits in-person. So we're, like, let's at least  
11 give a six month window so they have at some time during  
12 that scheduled appointment between today and six months,  
13 they are likely to have a scheduled appointment, they  
14 can do the consent in-person at the time of their visit.

15           So we were listening as to what they were  
16 telling us were perceived barriers and trying to  
17 accommodate and adjust appropriately.

18           **Q     Do you have any reason to believe that**  
19 **individuals who are receiving this care hadn't already**  
20 **completed the informed consent process and signed**  
21 **a written consent form prior to initiating treatment?**

22           A     Some of the statements that the audience had  
23 provided on their experience did make me question as to  
24 what kind of consents that they either received or did  
25 they really understand. So one example is the bone

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1 mineral density scan. And a person had said, I get a  
2 blood test and that tells me how strong my bones are.  
3 I'm a bone specialist and I was, like, I don't know of  
4 any blood test that speaks to how dense somebody's bones  
5 are. So that person came up for the comment, because we  
6 said, hey, you had mentioned to Dr. Ackerman during the  
7 break, come up and speak more on what you are talking  
8 about, this blood test.

9           And the blood test, as they described it, is  
10 what we refer to as a complete blood cell count. And  
11 that looks at your bone marrow, of how well your bone  
12 marrow is producing your white blood cells, your red  
13 blood cells, your platelet, it speaks nothing to how  
14 strong your bones are. But this person is adamantly  
15 saying that their provider said this is in lieu of a  
16 DEXAscan, I don't need a DEXAscan because I get this  
17 blood test. So it's hard to say is there a  
18 miscommunication? Is it the person who's providing the  
19 care? It's kind of hard to say. But at least having a  
20 consent in writing to say what a test is and why it  
21 should be done and why it's important to have this done,  
22 we felt was important to include in the consents.

23           **Q     Are you aware of whether that person signed an**  
24 **informed consent form or not?**

25           **A     I am not aware.**

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1 Q And are you aware of what that informed consent  
2 form might have contained?

3 A No. I'm also aware that many people knew these  
4 consents were coming and they never bothered to send  
5 their consents to the Board either.

6 Q How do you mean?

7 A Well, everybody knew that this emergency thing  
8 was passing and so you have all these people who were  
9 doing it and if they already had written consents they  
10 could have submitted their written consents to us to use  
11 as a basis.

12 Q Did the Board reach out to any of the providers  
13 provide in the state that provide treatment for gender  
14 dysphoria in multidisciplinary clinic setting and have  
15 extensive experience, did they request they send in  
16 their informed consent forms?

17 A No, we did not. To my knowledge we didn't  
18 request. I know I personally did not request.

19 Q So the Board can't say one way or the other  
20 what other entity's informed consent forms look like?

21 MR. PERKO: Object to form.

22 A That is true.

23 BY MS. CHRISS:

24 Q Do informed consent forms usually include  
25 potential benefits as well as potential risks?

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1 A Yes. They can.

2 Q Is there a reason why the informed consent  
3 forms that you-all developed don't discuss the benefits?

4 MR. PERKO: Object to form.

5 A The challenge is to say how much of a benefit  
6 it is as to the data isn't 100 percent secure as to  
7 whether or not it has great impact or not. So that's,  
8 kind of, the challenge, you don't want to falsely  
9 advertise and say this is going to take care of all of  
10 your depression and your anxiety and you're not going to  
11 any suicide risks if you take these medications.

12 Q So just to tie this up. The Board did not  
13 reach out to any providers in the state who provide  
14 gender-affirming care to this population for their  
15 inform on the informed consent forms risks or benefits?

16 A To my knowledge, I'm not aware if the Board  
17 did. I can only speak that I didn't.

18 Q Are you aware of any other informed consent  
19 forms that don't include benefits and only include  
20 risks?

21 A I don't. I'm not aware.

22 Q Okay. You state in paragraph 30 of your expert  
23 report on page 10: I was asked by the defendants to  
24 address the comments regarding the emergency consents.  
25 The other comments not related to consents will be

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1 addressed by other experts, however, there is some  
2 overlap. What you are you talking about here? First of  
3 all, who do you mean when you say defendants?

4 A I meant by where here it says the defendants.  
5 Joseph Ladapo. I was asked by counsel to give my expert  
6 opinion.

7 Q Okay. So in paragraph 30 -- so paragraph 29 is  
8 talking about public comment at the meeting, so I wasn't  
9 sure if in paragraph 30 you were talking about  
10 addressing the public comments or just addressing --

11 A No. No. Just addressing the comments in  
12 regards to -- as we stated earlier, there were seven  
13 expert statements that were sent by various people, but  
14 I was asked to specifically focus in on the consents.

15 Q Understood. Okay. So comments you meant  
16 expert reports?

17 A Yes.

18 Q I understand. You state in paragraph 31 on the  
19 next page that these were emergency consents that needed  
20 to be submitted swiftly. These were never intended to  
21 be the final consents and we addressed that we would  
22 need to make updates. The Rule Committee is currently  
23 working on updates.

24 What will be different in the revised versions?

25 A Well, it all depends what happens at the

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1 meeting, so it depends on what other people are going to  
2 bring to the Board and what other information is going  
3 to be submitted. So I think some of the things I  
4 mentioned in here about some of the timeframe, about the  
5 laboratory testing. So I -- pretty much, anything -- if  
6 this was going as-is, but if there was something I  
7 thought was going to be a potential change, I had  
8 mentioned it in my statement. As to what I would  
9 propose as a change, I can't speak for what the other  
10 board members are going to propose as far as changes.

11 **Q So all the board members get to provide input**  
12 **make amendments and such?**

13 A Yes. So what will happen is is they, well,  
14 like, I'm going to review it again, I'm going to make  
15 any kind of edits that I think are warranted. The  
16 surgical consents definitely need to be revamped. Then  
17 I will submit the draft, then people will also submit  
18 whatever it is they want to submit. Then a discussion  
19 and a meeting will be had.

20 **Q What do you mean the surgical consents**  
21 **definitely need to be revamped?**

22 A I felt that there was so much different options  
23 that it's also an evolving, and I'm not a surgeon, and  
24 so I was hoping to get more input from a surgeon, but I  
25 feel that it should be separated out for what are the

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1 surgeries that you would get as a trans-man versus a  
2 trans-woman. Just like we did feminizing verse  
3 masculinizing. So I feel like having the information  
4 for a surgery that you are not going to have seems  
5 irrelevant.

6 So I think it needs to be cleaned up a bit I  
7 think some of the verbiage needs to change in regards to  
8 this is evolving. There might be some procedures that,  
9 you know, they are going to do. We did say in our  
10 consent that your surgeon likely that's their own  
11 consent that will go over the risks and benefits of the  
12 specific procedure that you are having, but I  
13 definitely, from my opinion, feel like that needs to be  
14 revamped. So I'm planning on separating them out,  
15 putting them -- cleaning them up, submitting that as a  
16 draft, then seeing what everybody else's input would be.  
17 Then hopefully, other people will have submitted some  
18 examples as well.

19 Q Has the Board considered involving an expert in  
20 this treatment?

21 A I know Dr. DePietro said she was going to reach  
22 out to somebody that she knew who was doing  
23 gender-affirming surgeries to see if they could help  
24 review and provide consents.

25 Q And who's that?

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1 A She didn't say who it was.

2 Q Are you aware of the letter that you-all  
3 received from JAPC who sent in a letter about a concern  
4 about the informed consent forms?

5 A Do you have an exhibit?

6 Q I sure do. Hoping I could get you talking  
7 while I find it. The Joint Administrative Procedures  
8 Committee. I've handed you what we marked as  
9 Exhibit 11, a letter from the Joint Administrative  
10 Procedures Committee. The first page is directed at, it  
11 appears, the Board of Medicine. And the second one is  
12 directed at the Board of Osteopathic Medicine. Do you  
13 see that?

14 (Plaintiffs' Exhibit Number 11 was marked for  
15 identification.)

16 A Yes.

17 BY MS. CHRISS:

18 Q And it appears that they asked you to explain  
19 the Boards statutory authority for requiring that adults  
20 receiving these medications undergo a thorough  
21 psychological and social evaluation performed by a  
22 Florida licensed board certified psychiatrist or a  
23 Florida licensed psychologist before beginning HRT and  
24 every two years thereafter.

25 What was the statutory authority for that

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1 requirement?

2 MR. PERKO: Object to form.

3 A I thought that part was removed?

4 BY MS. CHRISS:

5 Q Right. So I think it was removed as a result  
6 of this letter. I was just wondering if you knew what  
7 the statutory authority was for those requirements?

8 MR. PERKO: Object to form.

9 A I think when we were establishing guidelines  
10 that we, kind of, looked and we were concerned about the  
11 psychological impact, and there is a high association of  
12 depression, anxiety, ADHD, neurodivergent population  
13 that we felt that the risk was still there for suicide,  
14 that it would be important for them to be evaluated and  
15 assessed, but we removed it.

16 Q And what's your understanding of why you  
17 removed it?

18 A Well, one of the things is I believe that it  
19 wasn't in the guidelines for WPATH, and for Endocrine  
20 Society for the adults. So it seemed reasonable to  
21 remove that, based on that, you know, so I felt, like,  
22 yeah, that seems reasonable that we can remove that.

23 Q Is it your understanding that the remainder of  
24 the informed consent form requirements are aligned with  
25 the Endocrine Society and WPATH Guidelines?

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1           A     I think a majority is, but I think there is  
2 some deviation from them, but I can't remember what off  
3 the top of my head what are the deviations.

4           **Q     Okay. We'll come back to that. Where did your**  
5 **decision, I guess, to include that requirement initially**  
6 **come from?**

7           A     Well, we initially had it in the pediatric one.

8           **Q     Right.**

9           A     So we moved it over, we, kind of, talked about  
10 should we include it or not include it? So because of  
11 the high risk for that population we decided to include  
12 it, then we decided, nope, we probably shouldn't include  
13 it, so we removed it.

14          **Q     Are you aware of any research showing that**  
15 **these treatments significantly reduce suicidal ideation?**

16          A     I'm sure there is some literature, there's all  
17 sorts of different literature, but I think there was  
18 this study from Norway that was showing 20 to 30 years  
19 out after treatment that they still had a high risk and  
20 association of depression, anxiety, and thoughts of  
21 suicide.

22          **Q     Is that compared with individuals that did not**  
23 **receive gender-affirming care or --**

24          A     That's only gender-affirming care.

25          **Q     -- the general population? Right. And are**

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1 those individuals, is the comparator, the general  
2 population?

3 A I believe it's just comparing within its own  
4 population, saying that out of this population  
5 40 percent of them still had thoughts of suicide or  
6 depression in their lifetime.

7 Q What study was that?

8 A I want to say it was out of Norway, I might  
9 have included it in my statement. So I'm not sure where  
10 the reference is. I do have on page 25, Item 68, where  
11 it says: Suicidality is still a huge concern in the  
12 adult population as well, because the estimate lifetime  
13 prevalence of suicide attempts among transgender  
14 population, as high as 40 percent, this is with treated  
15 patients. So I have to actually look at the reference,  
16 but I'm fairly certain that was from the study from  
17 Norway.

18 Q And are you aware whether the patients in that  
19 study received gender-affirming care as minors?

20 A I do not know.

21 Q Okay. You mention needing to inform folks  
22 about the risk of suicide when receiving  
23 gender-affirming care. Is it equally important to  
24 inform folks of the risk of suicidal ideation and  
25 suicide when not receiving these interventions?

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1 A Yes.

2 Q And do the informed consent forms include that  
3 information?

4 A I think it's in the very -- I'm looking at it,  
5 I thought this was the consent. I think it's where it  
6 says other, in the first or second page, where it talks  
7 about other options. It talks about seeing psychology,  
8 and that they should still have mental health  
9 assessments.

10 Q So what I am asking is in the same way you  
11 advise that the risk -- the increased risk of suicide  
12 ideation for receiving this treatment, should there also  
13 be a parallel in informing them of the risk of suicide  
14 and suicidal ideation when not receiving this treatment?

15 A Yes.

16 Q Is that something you intend to include in the  
17 next iteration of the consent forms?

18 A I guess we can make it clear, but I thought in  
19 the opening paragraph of other options that it was  
20 included. I'd have to -- I don't know if you have a  
21 copy of the consent?

22 Q Not at the moment. Do you know of any other  
23 evidence that gender-affirming treatment for gender  
24 dysphoria does not reduce suicidality?

25 A Sorry, repeat that?

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1 Q Do you know of any other evidence, other than  
2 this, what you mentioned previously, any other evidence  
3 that the treatments for gender dysphoria don't reduce  
4 suicidality?

5 MR. PERKO: Object to form.

6 A I don't know that there's enough data just for  
7 whether it does or it doesn't, because there's not  
8 enough studies that have actually said that. That's the  
9 problem of all of this being low grade data, there isn't  
10 anything saying this is a population that was treated  
11 and this is a population that wasn't treated.

12 Q So you are not aware of the risks of  
13 withholding treatment or banning treatment?

14 A Correct.

15 Q When you were creating the informed consent  
16 forms did you consider these statements provided by  
17 medical providers who provide treatment for gender  
18 dysphoria in Florida, including Dr. Kristin Dayton,  
19 who's a pediatric endocrinologist, who has been  
20 providing care for this population for six years through  
21 a multidisciplinary clinic?

22 A Yes, I looked at all the data that was  
23 submitted.

24 Q And did you consider the recommendation of Dr.  
25 Paul Arons who is a physician and the former chair of

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1 the Florida Department of Health Institutional Review  
2 Board?

3 A I'm sure I did.

4 Q In your clinical practice would you present  
5 information to your patient that you knew to be untrue?

6 A Not knowingly, no.

7 Q When you provide informed consent for your  
8 patients for the various endocrine disorders that you  
9 mentioned treating, do you individualize the informed  
10 consent or what you are sharing with them to the needs  
11 of that patient?

12 A I usually will not skip, I will say these are  
13 the side effects going from most common to least common.  
14 For example, a birth control pill. So there's a risk of  
15 blood clots. What gives you that risk? Being over 35,  
16 not an issue. Being a smoker. Here's an opportunity,  
17 do you smoke? If they say, yes. It's a risk, we need  
18 you to stop. Or if they say no, I say, please don't  
19 start. Is there a family history of blood clots? A lot  
20 of times the patient isn't going to know, but the parent  
21 will be, like, actually, my sister had a blood clot when  
22 she was on a birth control pill. Well, that's an  
23 absolute risk. So is there anyone else in the family?  
24 Maybe I need to do some other testing to look for  
25 clotting disorders before I proceed with this treatment.

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1           So I usually list them, but focus more in on  
2 the area that might pertain more to. I think the  
3 example was one of the experts was talking about acne,  
4 and that's the idea of consent. You don't really have a  
5 history of liver disease and you don't have a family  
6 history of this? Correct? Correct. But, you know, I  
7 am worried about the acne, let's have a conversation  
8 about the acne and what your risks are and what that is.  
9 It's meant to be used as an open forum to assess a  
10 person's risk and say, that's of little to no risk for  
11 you, I'm not really concerned.

12           And a parent might say, actually, I'm  
13 concerned. I was just diagnosed with breast cancer. So  
14 it gives an opportunity for the family and the patient  
15 to assess what their concerns are and then the doctor to  
16 assess and address what their concerns are.

17           **Q**     So in the prescribing of puberty blocking -- or  
18 Lupron, the testosterone, estrogen, the other  
19 medications you mentioned earlier, you are able to have  
20 back and forth dialogue and, sort of, tailor the  
21 informed consent process to the patient. Are you aware  
22 of any other medication that you prescribe that  
23 requires -- that removes your, what's the word I'm  
24 looking for here? Discretion. Discretion in what you  
25 discuss with the patient?

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1 MR. PERKO: Object to form.

2 A I'm not sure what you are asking.

3 BY MS. CHRISS:

4 Q In any of the treatments that you provide for  
5 your patients that have endocrine disorders that might  
6 require things, like, Lupron testosterone and estrogen,  
7 you have discretion in the informed consent process you  
8 engage in, correct?

9 A What do you mean by discretion?

10 Q What you were just describing, was your  
11 professional expertise in knowing what to discuss with  
12 the patient, what might be relevant to the patient. You  
13 have discretion in how that informed consent process  
14 takes place, correct?

15 A I'm not quite sure I understand, but, I mean, I  
16 basically go through the risk and all of the risk and  
17 how I think a potential risk might be towards a certain  
18 person versus another. So is there some  
19 individualization? Yes, but it starts with a  
20 generalization going over all of the effects and zeroing  
21 in on the ones that I might have more concerns on or the  
22 family might have more concerns on.

23 Q None of those are written consents?

24 A Correct.

25 Q Just for the treatment of gender dysphoria?

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1 A Correct.

2 MS. CHRISS: If we can take five minutes, that  
3 would be great.

4 (Break taken at 4:26 p.m. until 4:40 p.m.)

5 BY MS. CHRISS:

6 Q Dr. Mortensen, just returning for a moment to  
7 an earlier topic. Is it appropriate for someone who's  
8 not an expert in an area of care to create informed  
9 consent forms on that area of care?

10 MR. PERKO: Object to form.

11 A Well, the challenge is that we were advised  
12 that we had to do it, so someone had to do it. No one  
13 else stepped up. No one else delivered, so we did the  
14 best that we could.

15 BY MS. CHRISS:

16 Q Right. Sorry, so not specific to what you-all  
17 did, but, generally, do you think it's appropriate for  
18 someone to create informed consent forms who is not an  
19 expert in the provision of that type of care?

20 MR. PERKO: Object to form.

21 A I would say that consent forms typically are  
22 not drafted by just one person, there is usually a  
23 committee and a review process as well. So, for an  
24 example of a trainee, they are going -- they might not  
25 be an expert of having ten years plus experience, they

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1 are going to develop a consent form, but it will be  
2 reviewed by the IRB, usually there's an ethicist,  
3 there's usually a lawyer, there's usually their mentor.  
4 So can consent forms be written by someone who's not an  
5 expert? Absolutely. But usually they're not completed  
6 and signed off on until a committee or group approved  
7 them.

8 MS. CHRISS: My colleague just noted that the  
9 lap top is on mute.

10 (Off-the-record discussion.)

11 BY MS. CHRISS:

12 Q So moving in paragraph 78 of your expert  
13 report, which is on page 30, you discussed fertility.  
14 Is it your view that puberty blockers have permanent  
15 negative effects on fertility?

16 A It depends on what indication you are talking  
17 about.

18 Q Just, generally, is it your view that  
19 puberty --

20 A I think it's hard to generalize, because  
21 puberty blockers are used for different scenarios and  
22 have been approved for different indications. So if you  
23 are going to ask me is generally when you use a puberty  
24 blocker for the indication of central precocious puberty  
25 is there a concern for fertility, I often bring it up

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1 with families, and they often mention is that the data  
2 supports that there isn't, but there's always a  
3 possibility.

4 Q So in the informed consent form you state that  
5 puberty blockers can interfere with fertility, but isn't  
6 it accurate that the Endocrine Society Guidelines state  
7 there's no data on its impact on fertility?

8 A So if you are currently using a puberty blocker  
9 you are likely not to get pregnant, so you are having  
10 issues with fertility while you are on it. It doesn't  
11 state long-term fertility.

12 Q But what evidence do you have to support that  
13 it does have permanent impacts on fertility?

14 A There's not enough evidence to support if it  
15 does or it doesn't because 90 percent of kids who go on  
16 puberty blocker go on to testosterone and estrogen,  
17 which can also impact fertility. Many of them will  
18 often have a gonadectomy, whether they are removing the  
19 testicles or the ovaries, and that's going to have an  
20 impact on fertility. So even the long-term data is hard  
21 to say because there's not a lot of cases of people who  
22 were just on puberty blockers for this indication who  
23 did not go through the rest of the cycle to see what's  
24 going to happen.

25 Q So there isn't data to -- there isn't data to

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1 support that there is a long-term impact on fertility?

2 A Or that there isn't.

3 Q Right. There isn't data to suggest either way?

4 A Correct.

5 Q So Dr. Mortensen, you're mandating disclosure

6 of a risk in these informed consent forms that you

7 aren't sure is even a risk; is that your testimony

8 today?

9 A There are some things it's unclear what the

10 risk is, but that's the idea of an informed consent of

11 saying that there's a fertility, so just so you are

12 aware -- and that's the thing about people who go on

13 puberty blockers, and even birth control pills, the

14 likelihood is you are not going to be pregnant. There's

15 still could be break through and you can get pregnant,

16 so you have to think of that, but there also could be a

17 risk that there's a likelihood that you are not going to

18 be pregnant while you are on this medication.

19 Q But there is data to support that there's no

20 impact on fertility?

21 A In the indication of using it for central

22 precocious puberty.

23 Q And there's not data to support that there is a

24 certain negative impact on fertility?

25 A It's hard to stipulate whether there is or

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1 there isn't, because there hasn't been published data to  
2 say there is or there isn't.

3 Q Is there any medical reason to think that an  
4 adolescent who is given puberty blockers to treat gender  
5 dysphoria and then ceases taking those will not regain  
6 fertility?

7 A It's likely that they will regain fertility if  
8 they don't take the hormone replacement therapy, it's  
9 very likely. And that was when I was doing it that I  
10 would say, that we don't know, but that's also what your  
11 experts testified as well, when we used it for  
12 precocious puberty we didn't really see an issue with  
13 fertility down the road. We haven't really used it in  
14 this age group for this duration, even if that's one,  
15 two, or three years, so we don't know what the outcome  
16 is. If we are basing it on data from a different group,  
17 it doesn't seem likely, but there's always a risk.

18 Q In paragraph 80 of your report you state on  
19 page 31, you state that the quoted statement comes  
20 directly from the Lupron package insert?

21 A Uh-huh.

22 Q The documents states that, quote: Puberty  
23 blockers can interfere with fertility.

24 A Uh-huh.

25 Q But the Lupron package insert says that these

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1 changes are, quote, reversible upon cessation of  
2 treatment. Correct?

3 A Correct.

4 Q Is there a reason that the full statement was  
5 not included?

6 A It also, I believe, in the consent said that  
7 many of these things can be reversible, but some of them  
8 can be permanent.

9 Q Does the informed consent form include this  
10 language, that they are reversible upon cessation of  
11 treatment?

12 A I believe that it is more in the beginning that  
13 even with the feminizing and masculinizing that many  
14 things can be reversible.

15 Q Paragraph 85 of your report on page 34  
16 regarding cognitive development. You say that there's  
17 no long-term data on cognitive impacts of puberty  
18 suppression medications to treat gender dysphoria.  
19 Correct?

20 A Correct.

21 Q But that is not what the informed consent forms  
22 say. The informed consent forms state that puberty  
23 blockers may cause stalling of typical cognitive or  
24 brain development in minors. Correct?

25 A Correct.

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1 Q Yet there's no long-term data to support that?

2 A Correct. But it also depends on if you are  
3 taking a look at someone who's going through puberty and  
4 they get testosterone and estrogen, the brain is going  
5 to change. Someone's 12, 13, 14 and they are going  
6 through puberty, their cognitive and mental development  
7 is going to change when exposed to cross-sex steroids.  
8 By giving them a puberty blocker that progression and  
9 maturity isn't going to happen. That brain development  
10 is not going to happen because it's not being exposed to  
11 hormones that it's usually exposed to at that time.

12 Q As you state in your report, there's no  
13 long-term data on these cognitive impacts?

14 A Correct.

15 Q Okay. Dr. Mortensen, earlier in your  
16 deposition you testified that you didn't include the  
17 information I asked about with regard to benefits of  
18 this treatment because, as you stated, there wasn't  
19 long-term data, yet you are including risks in the  
20 informed consent forms that equally have no long-term  
21 data.

22 A Correct.

23 Q Why is that?

24 A Because there's limited data as to what the  
25 benefit is, and it's very -- by looking at the data it's

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1 hard to say it can help with some, it might not help  
2 with others, it might worsen others, it really hard to  
3 say whether or not how much benefit someone gets. So  
4 typically when someone is going through a treatment and  
5 they are going to say, Doc, is this going to cure me of  
6 cancer, what are my odds? Doc, what are the odds that  
7 I'm going to have this, that, or the other? You're  
8 purely speculating as to, yes, this is going to help you  
9 or not help you, you don't know.

10 So part of the informed consent, the people who  
11 are giving the consent should be able to explain what  
12 their experience is, and I have no doubt that they are  
13 saying, in my experience, this is the benefit that I  
14 see. And that is likely -- and in the community they  
15 are all sharing the benefits that they are seeing. They  
16 are sharing some of the sad things that happen too, but  
17 I think that it -- if I'm sitting here saying, and you  
18 are asking me my opinion as to does this 100 percent  
19 cause improvement or is it shown 100 percent, or even a  
20 high percentage, I can't say that. I can say that some  
21 studies show that there may be improvement.

22 Q So that's not the question, Dr. Mortensen, as  
23 to why you didn't say this 100 percent will improve.  
24 The question is why, if there's no data to support it,  
25 including the risk of puberty blockers may cause

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1 stalling of typical cognitive or brain development in  
2 minors. Why is that not speculative?

3 A I don't think I understand what you are asking.

4 Q You've made clear that there's no long-term  
5 data supporting this, and when explaining why not to  
6 include benefits you said, because there's no long-term  
7 data, it is speculative. The statement that you  
8 included in the informed consent form about the impact  
9 on cognitive development is equally speculative, yes?

10 A In your opinion, but not in mine. I don't view  
11 that as speculative.

12 Q So no long-term data to support benefits is  
13 speculative, no long-term data to support risks is not?

14 A In the consent it says that, and you can phrase  
15 the consent, but we don't know, there isn't data that  
16 supports it one way or the other. But in the Endocrine  
17 Society Guidelines it says limited data is available  
18 regarding the effects on brain development. And there's  
19 animal data that suggests there is. So it's hard to  
20 say. I mean, you have the Endocrine Society Guidelines  
21 saying that they don't really know, there's limited  
22 data.

23 Q Dr. Mortensen, looking at paragraphs 86  
24 through -- well, start with paragraph 86 of your report  
25 regarding masculinizing and feminizing medication

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1 dosing. The informed consent forms for masculinizing  
2 and feminizing medications for minors state that, quote:  
3 This medicine and dose that is recommended is based  
4 solely on the judgement and experience of the minor's  
5 prescribing physician. Correct?

6 A Correct.

7 Q Paragraph 87 you state you agree -- or let's  
8 turn to paragraph 87 on page 34. Apologies.

9 MR. PERKO: Page 87 on 34?

10 A Item 87 on page 35.

11 BY MS. CHRISS:

12 Q Paragraph 87, page 35. You say they are  
13 correct that there are clinical practice guidelines in  
14 the Endocrine Society Guidelines and they should be  
15 followed by clinicians to guide treatment regimens.  
16 Yes?

17 A Correct.

18 Q And in the Endocrine Society Guidelines the  
19 guidelines provided gradually increasing dose schedule  
20 for the induction of puberty in minors using  
21 testosterone or estrogen?

22 A Correct.

23 Q Your report states: However, this is not  
24 always the case.

25 What do you mean by that?

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1           A       So there are guidelines on to -- I go on to  
2 say: The dosing for adolescents is based on hypogonadal  
3 adolescents and pubertal induction.

4                   And so there are different centers that do  
5 different things in regards to pubertal induction and  
6 dosing. When you look at the research as to what dosing  
7 and what regimens were used, different dosings at  
8 different centers, and even when we contacted in regards  
9 to that publication for the New England Journal and  
10 asked if they could provide what doses they used, they  
11 couldn't even stipulate as to all the centers, because  
12 it was a multicenter trial that were doing the exact  
13 same pubertal induction.

14                   So it's a guideline as to how people should do  
15 it, but not everybody follows the guidelines. And  
16 sometimes that's from their own expert opinion. I'm not  
17 saying that it's wrong. I think that's, kind of, how  
18 this statement is being misconstrued, that your provider  
19 has experience in this, they are going to do it based on  
20 their experience. Some people for replacement of  
21 estrogen therapy and pubertal induction in Turner  
22 Syndrome use estrogen patches, some of them use pills,  
23 some of them have use injections, none of that is  
24 necessarily wrong, they are just going based on because  
25 there isn't even some longitudinal data on that as well.

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1           So it's not saying the provider is doing  
2 anything wrong, it's saying that your provider is -- it  
3 was actually designed to help support the provider or  
4 the physician in saying that you are going to go based  
5 on their experience. You know, my experience is I  
6 prefer to use estrogen patches because it bypasses the  
7 liver, there's less risk of liver dysfunction. Johnny  
8 Jones down the road might like the pills because that's  
9 what they are very comfortable with doing. Is Johnny  
10 Jones wrong? Am I wrong? No, they are both options,  
11 they are both in the guidelines, but there's also  
12 recommendations and some people might push them quicker  
13 or later based on how old they are.

14           So even though they have the recommendations in  
15 there, it also depends on the age the patient presents  
16 for treatment. It's vastly different from treating  
17 somebody on a pubertal blocker inducing their puberty  
18 starting at zero versus somebody who presented at 16 or  
19 17, has already been fully virilized that you are  
20 starting estrogen in, like, an adult.

21           **Q     Is having dosing flexibility common?**

22           A     Yes. That's why there are so many different  
23 doses of medication. What works for one might not work  
24 in another.

25           **Q     So the process you just describe sounds very**

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1 individualized, based on the expertise of the provider.  
2 Why does this need to be included in these informed  
3 consent forms that the provider is not allowed to  
4 modify?

5 A So that statement actually helps protect the  
6 provider, so it's interesting to me they view as a  
7 negative and want to modify it. It actually gives them  
8 a lot more accessibility and also a chance to  
9 individualize. We are not saying you stick to these  
10 guidelines and dose it exactly like that. We are saying  
11 you are going to rely on your person and their  
12 experience with using these medicines to dose  
13 accordingly they would.

14 I did quote an article in here about looking at  
15 transgender population and how they change their doses  
16 and why they change their doses, and part of it is  
17 because they don't believe their doctor is prescribing  
18 them enough. Some of them think their doctor is  
19 prescribing them too much. So it's actually in an  
20 effort to establish that relationship with the patient  
21 of this is my area of expertise, I dose it based on the  
22 patients I have worked with.

23 Q Is this dosing flexibility is not unique to  
24 gender-affirming care, right?

25 A That is correct.

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1 Q We're talking about, you know, patient-doctor  
2 relationship. Do you think it undermines the informed  
3 consent process when the physician has to state, you  
4 know, these are not risks that are supported by data, I  
5 don't agree with these, and this didn't reflect my views  
6 or my experience with this treatment?

7 MR. PERKO: Object to form.

8 A So a lot of times when we have it, and you are  
9 going through an informed consent because when we are  
10 doing medications that are new or different or new  
11 procedures or techniques, you say here's what we believe  
12 some of the risks are. Here are some of the known  
13 beliefs that we know that could happen because of this  
14 scenario. This is why I believe this is a reasonable  
15 path for you because you have limited risk based on X,  
16 Y, and Z, and based on my opinion, I think this would be  
17 a right regimen for you. But you are the patient, I'm  
18 informing you, you tell me are there any things you are  
19 concerned about in regards to this? Let's have a  
20 conversation, then you ultimately decide if this is the  
21 course you want to pursue.

22 Q And in paragraph 87 you criticize the lack of  
23 high quality studies to determine dosing and timing  
24 schedule. Are all of the medications that you prescribe  
25 in your practice supported by high quality studies to

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1 **determine dosing?**

2 A No. I previously stated that even for Turners  
3 Guidelines they change over the years, but there's  
4 different guidelines. Even the Endocrine Society  
5 Guidelines have different regimens of whether it's pills  
6 or whether it's patches. There are some studies, but  
7 some of them are limited. I often explain that. Many  
8 times it's, this is my experience in using this  
9 medication. This has been the experience, based on this  
10 group that has done this, this is the literature that  
11 has it. You just explain what you know and what you  
12 don't know.

13 **Q So this sounds like a common experience with**  
14 **prescribing medications, generally?**

15 A Exactly.

16 **Q So why just the treatment of gender dysphoria**  
17 **do we need these rigid consent forms?**

18 A I think it stems a lot from the  
19 detransitioners, and I think it stems a lot from  
20 lawyers. No offense.

21 **Q What detransitioners you are referring to?**

22 A So there's a lot of detransitioners in the  
23 media, a lot of them are saying I was not aware, I  
24 didn't realize this was a side effect, I didn't realize  
25 that this could happen, they didn't inform me of this.

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1 I don't know if they did or they didn't, but having it  
2 written makes it a lot easier. Having a signed document  
3 that I did review this with you, instead of going in  
4 front of a judge and saying, I reviewed the side effects  
5 and blah, blah, blah. But did you list out every side  
6 effect? Is that just a smart phrase that you are saying  
7 that says you covered all that? It he said versus she  
8 said of what was really said, what was really  
9 documented.

10 I think the most concerning thing with the  
11 detransitioners is they are saying they were not  
12 informed and that they also weren't well-diagnosed and  
13 that they were misdiagnosed. And I think a lot of  
14 people in the transgender society would state that those  
15 detransitioners were probably never trans to begin with.  
16 But that's a means to protect everybody in the  
17 situation. This is a very different situation,  
18 especially for children. These medicines can have an  
19 impact for the rest of their life. So to pause and  
20 spend 10 minutes to review things as to risks and  
21 possibilities for something that's going to impact you  
22 for the rest of your life seems like a fair use of time.

23 **Q You have no basis upon which to believe these**  
24 **providers weren't already spending those 10 minutes, or**  
25 **probably much more, providing these risks and benefits**

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1 to their patients, correct?

2 A If you go based on what some of the  
3 detransitioners.

4 Q Can you point me to specific detransitioners?

5 A I believe Chloe was one of them saying that she  
6 wasn't really aware and that she really didn't  
7 understand what all of it meant.

8 Q So setting a standard of practice for the  
9 provision of medical care for an entire community based  
10 on one individual's experience, is that something you've  
11 seen happened in other context?

12 MR. PERKO: Object to form.

13 A I don't think it's one individual's experience,  
14 because the number of detransitioners seem to be going  
15 up. As I state earlier, in Europe they put, kind of, a  
16 pause on things.

17 Q Did a single detransitioner state that they  
18 received treatment in the state of Florida?

19 A Not to my knowledge.

20 Q Did a single detransitioner name a Florida  
21 medical provider or institution where they received care  
22 that was inappropriate?

23 A Not that I know of.

24 Q Can you name another detransitioner, other than  
25 Chloe Cole, who's experience has impacted your views on

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1 this?

2 A I mean, not by name, just by things I've seen  
3 or read or saw.

4 Q In your clinical experience, you never  
5 witnessed or experienced a person regret the treatment  
6 they received for gender dysphoria?

7 A Not in my personal experience, no.

8 Q Two follow-up questions, one, what is the basis  
9 for your statement that the number of detransitioners  
10 are going up?

11 A I don't know where I had read it, I don't know  
12 if I put it in here, but it seems like, number one,  
13 there was a dramatic rise in the number of people  
14 stating they had gender dysphoria and that there's also  
15 been a rise on -- all of the published data on the  
16 detransitioners seems to be before 2019, and not after  
17 this big shift, this big drive, especially here in the  
18 United States. Because in 2017 it wasn't very mainstream  
19 to use these medications for this indication.

20 So the data of detransitioning is based more on  
21 overseas data, and some data here, up to 2017, '18.  
22 It's not -- I believe someone had said it's up to  
23 30 percent. I even think on the NIH funded one that was  
24 in JCM where they said the number of patients that they  
25 had, I think that they had 300 patients and it went down

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1 to 200 patients that they had studied. So that means  
2 they had a 30 percent or more dropout in their  
3 population, which in a research study is, kind of,  
4 unfathomable that you would have that much of a dropout  
5 rate.

6 Q Is it true, and I won't go through the entire  
7 administrative record with you and all the public books,  
8 we've both read them, is it accurate that there are a  
9 tremendous number of statements from transgender  
10 individuals who have received gender-affirming care and  
11 have had positive experiences?

12 MR. PERKO: Object to form.

13 A I don't know how much you mean by tremendous,  
14 but, yes, there was some very positive statements that  
15 were made.

16 BY MS. CHRISS:

17 Q And is it true that at least at the  
18 February 10th, 2023, hearing there were a vast majority  
19 of individuals testifying about their positive  
20 experiences with this treatment and imploring the Board  
21 to allow them to continue accessing this treatment?

22 MR. PERKO: Object to form.

23 A That is true.

24 BY MS. CHRISS:

25 Q And you can't name another detransitioner or

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1 individual that you heard of, other than Chloe Cole, who  
2 came from out of state to provide this care at the  
3 request of the state?

4 A I mean, I'm very bad with names, but I don't  
5 recall from the state of Florida.

6 Q Are you aware that the detransitioners whose  
7 names we looked at earlier who testified at the public  
8 hearing were -- almost of them were retained as  
9 witnesses by the state of Florida in the case of Dekker  
10 v. Weida?

11 A No.

12 Q You stated earlier that detransitioners and  
13 lawyers were driving this. What did you mean by lawyers  
14 driving this?

15 A Well, that what one of the things that my  
16 friend from Seattle General had said, that they were  
17 very concerned of the lawsuit that they had and it  
18 seemed based on what they were seeing there were  
19 concerns there's likely going to be detransitioners and  
20 there's likely going to be lawsuits. And that was back  
21 in 2017. I think it's fair to say there's lawsuits  
22 worldwide from detransitioners. So it wasn't something  
23 that wasn't predictable that was going to happen.

24 So in an effort to protect patients so that  
25 they're fully informed and consented and to protected

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1 the provider and to protect the institution as well,  
2 that's why we created informed consents for our center.

3 Q The incident that you mentioned that your  
4 friend relayed to you was regarding an individual with  
5 cerebral palsy, correct?

6 A Correct.

7 Q Who's not receiving treatment for gender  
8 dysphoria?

9 A Correct.

10 Q Is it fair to say there are many medical  
11 malpractice lawsuits brought all the time for all sorts  
12 of inappropriate treatment provided?

13 A I'm sure there are.

14 Q And that people regret treatment they receive  
15 in various areas of medicine?

16 A I'm sure they do. That's why there's lawsuits.

17 Q And has the Board adopted rules or consent  
18 forms about any other area of treatment based on  
19 malpractice lawsuits or a suggestion of inappropriate  
20 care not even within the state that the Board is  
21 regulating?

22 MR. PERKO: Object to form.

23 A The Board -- oh, sorry. The Board hasn't  
24 adopted, but why do you think there are surgical consent  
25 forms? Why do you think there are consent forms every

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1 time you walk into a hospital to consent to treat? When  
2 you walk into a clinic you have to sign a form to  
3 consent to treatment. When I do genetic testing I have  
4 to sign it, I have to have a witness sign, I have to  
5 have a parent sign it, and that's just for a genetic  
6 test.

7 BY MS. CHRISS:

8 Q When you say the Board hasn't adopted, what do  
9 you mean?

10 A Well, when you are saying -- I thought you had  
11 asked had the Board adopted any of those types of  
12 consents or any other medical conditions related to  
13 adopting consents.

14 Q Does the Board adopt rules and consent forms  
15 for any condition in which there's a fear there might be  
16 a rise in lawsuits about?

17 A I believe they had the rules in regards to the  
18 Brazilian butt lift, rules for that because there was  
19 misuse, abuse, and lawsuits for that too.

20 Q But that demonstrated misuse, abuse, and  
21 lawsuit --

22 A Yes.

23 Q -- not speculative, correct?

24 MR. PERKO: Object to form.

25 A Correct.

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1 BY MS. CHRISS:

2 Q Moving to paragraphs 89 and 90 where you  
3 reference WPATH. And you quote from WPATH. Is it  
4 correct that these are quotes from WPATH Standards of  
5 Care 7?

6 A Might be 8. I think we are at 8 now for WPATH.

7 Q I believe these statements are from WPATH 7,  
8 but.

9 A I have to check and see.

10 Q Okay. Are you aware that the SOC8 does provide  
11 a specific hormone regimen with specific doses provided?

12 A From WPATH?

13 Q Uh-huh.

14 A No, I'm not aware.

15 Q That's for both adolescents and minors -- I  
16 mean adolescents and adults. You are not aware?

17 A No.

18 Q Okay. Paragraph 90 -- paragraph 93 on page 37  
19 you discuss the permanency of certain effects of  
20 testosterone. Dr. Bruggeman rebutted this statement in  
21 the informed consent forms that certain effects could be  
22 permanent. You say that she should provide references  
23 to prove this. Dr. Mortensen, what references do you  
24 have to support the suggestion in the forms that these  
25 changes from testosterone are permanent?

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1           A       Well, I can certainly look them up for you, but  
2 there are -- there's documented literature of people  
3 going on testosterone that it has given them permanent  
4 voice change that can't go back, that have permanent  
5 facial hair or chest hair that can't go back. That have  
6 impacted fertility or caused polycystic ovarian syndrome  
7 that can't be reversed.

8           **Q       Is there any evidence to support your statement**  
9 **that testosterone has any negative impact on bone**  
10 **density for transgender men?**

11          A       I think that that was something we were going  
12 to revise, because it didn't seem based on the most  
13 recent data that it would impact transgender men, we  
14 were going to revise in the consents.

15          **Q       For your statement in paragraph 93 regarding**  
16 **the permanent impact of testosterone, can you provide**  
17 **your source for me today that you relied upon?**

18          A       For?

19          **Q       For this statement that the following changes**  
20 **could be permanent with regard to testosterone.**

21          A       I mean, I'd have to look it up, I can't say it  
22 off the top of my mind. But I think it's been very well  
23 established that if you take testosterone your voice  
24 will permanently change and the hair will permanently be  
25 there.

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1           **Q     Are there other permanent effects from**  
2 **testosterone?**

3           A     There can be fertility, that's been  
4 demonstrated in polycystic ovaries.

5           **Q     And what data supports those statements?**

6           A     I'd have to look and see, but I'm pretty sure  
7 it's in the bibliography, because I believe it was  
8 brought up later in one of my statements.

9           **Q     Those aren't the -- okay. In paragraph 94, in**  
10 **support of this statement on the forms that treatment**  
11 **with testosterone increases the risk of certain cancers,**  
12 **you treat to WPATH's statement that there's not enough**  
13 **evidence to determine the type and frequency of cancer**  
14 **screenings for this population.**

15                   **How does that lack of evidence support the**  
16 **statement in the informed consent form that there's an**  
17 **increased risk?**

18           MR. PERKO: Sorry, counsel, are you referring  
19 to paragraph 94?

20           MS. CHRISS: Yes. Current where she says: Dr.  
21 Shumer and Dr. Bruggeman state currently they do not  
22 support that testosterone increases the risk of  
23 endometrial, ovarian, or breast cancer, et cetera.

24           A     So the WPATH statement says there's not enough  
25 to determine the appropriate type and frequency of

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1 cancer screening for this population, but breast and  
2 uterine cancer are listed in the Endocrine Society  
3 Guidelines on Table 10 as medical risks. And I did  
4 provide a reference, as well, that talked about cancer.

5           So it's been .95 there's been documented cases  
6 that demonstrated trans-men can develop endometrial  
7 carcinoma while on endogenous testosterone therapy. The  
8 prevalence of endometrial cancer in trans-men is not  
9 clearly identified. The incidents have let it hard to  
10 determine, will often be different if their uterus is  
11 removed. It's also been well-documented in women with  
12 polycystic ovarian syndrome that they have a higher rate  
13 of endometrial cancer, and that's because they make  
14 their own testosterone. So we know testosterone can  
15 cause a risk in endometrial cancer for women with  
16 polycystic ovarian syndrome. Then it also looks like  
17 based on Dr. Seay's data as well.

18           There's also, in Section 97, talking -- going  
19 on breast cancer as well, saying there's still a role  
20 and that there have been trans-men who have been found  
21 to have breast cancer. Then .973 cases ovarian cancer  
22 in trans-men undergoing gender-affirmation are recorded  
23 in the literature. All three received testosterone  
24 therapy. That's from --

25           **Q       You cite to Seay, S-E-A-Y, to say: The**

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1 prevalence of endometrial cancer in trans-ment is not  
2 clearly identified. But the fact that -- that there  
3 is -- that cancer is a potential is not -- does not  
4 support the statement that there's an increased risk,  
5 correct?

6 A If you are a biological female and have too  
7 much testosterone, whether it be from polycystic ovarian  
8 syndrome or congenital adrenal hyperplasia, it's  
9 well-documented in the literature that you have an  
10 increased risk of endometrial cancer. The challenge of  
11 the data is that many transgender men end up undergoing  
12 a hysterectomy. So the risk is gone once they remove  
13 the uterus, but we also don't have a lot of long-term  
14 data, but we do know those that still have their uterus  
15 have a risk for it.

16 Q Going back to just the conversations we've been  
17 having about fertility and cancer risks and cognitive  
18 risks, et cetera, when you are talking about these  
19 risks, I'm trying to understand if there's no long-term  
20 data supporting that these -- that there are long-term  
21 negative effects, help me understand why including those  
22 risks on these forms is not speculative?

23 MR. PERKO: Object to form.

24 A Because there is -- I'm sorry.

25 Because there is some data that already shows

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1 that cancer has happened.

2 BY MS. CHRISS:

3 Q So talking about then --

4 A So I'm not speculating, there's actually cases  
5 that have been demonstrated.

6 Q So when it comes to fertility and the impacts  
7 on cognitive, the things where you agreed in your  
8 testimony, that there is no long-term data suggesting  
9 permanent impacts, long-term impacts, do you apply the  
10 same standard of certainty when you are looking at risks  
11 and benefits?

12 MR. PERKO: Object to form.

13 A I often tell families that there are many  
14 things in medicine that we just don't know yet, and this  
15 is what I know at that point that's been demonstrated  
16 and documented. This is what is speculative, or could  
17 be likely, based on this happens in this. Then there's  
18 also the category of we just don't know. That's why you  
19 have an individualized person of determining whether or  
20 not they want to assume that risk or not. Oftentimes --  
21 that's with pretty much almost everything.

22 So even though I prescribe growth hormone and  
23 it's been well-used over 30-plus years, I often say,  
24 sometimes we don't know how your child -- could that bad  
25 reaction have been from growth hormone? It hasn't been

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1 demonstrated in the literature, but who's to say it's  
2 not possible?

3 BY MS. CHRISS:

4 Q What level of evidence is required to list a  
5 risk?

6 MR. PERKO: Object to form.

7 A For what I listed in here is whatever I came  
8 cross in literature that had shown. So if there was  
9 nothing that was shown, that there wasn't any breast  
10 cancer or there wasn't endometrial cancer, I wouldn't  
11 have included it. If there was already demonstrated  
12 data that this has happened, it was typically included.

13 Q What long-term data supported permanent --  
14 potential permanent impacts on fertility?

15 A So there was data on here to support that going  
16 on testosterone can cause polycystic ovaries, but can  
17 also cause ovarian issues, and that that could impact  
18 fertility, so that's already been demonstrated in the  
19 literature. Then, again, once they have surgery or had  
20 their ovaries taken out, they're definitely going to be  
21 infertile, but that's also the case for the men as well,  
22 that estrogen is going to have an impact on their sex  
23 drive, it's going to have an impact on their sperm  
24 count, it's going to have an overall impact on their  
25 fertility as well. It doesn't mean -- nothing in there

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1 says you will 100 percent become infertile, it says that  
2 there's risks.

3 Q So what level of evidence is required to list a  
4 benefit?

5 MR. PERKO: Object to form.

6 A I don't know, but that's when I often say what  
7 evidence do I have? And the evidence that I have is  
8 from the Endocrine Society that's all low-grade,  
9 peer-reviewed, or group data, that says there could be  
10 some benefit. None of them were high-grade data. Very  
11 few were moderately-grade data.

12 BY MS. CHRISS:

13 Q Is it important to let people know how likely a  
14 risk might be?

15 A Yes.

16 Q Is it important to let people know how likely a  
17 benefit might be?

18 A Sure.

19 Q So why are there no indications of the benefits  
20 of these treatments?

21 A Because I don't think the jury's out on how  
22 much benefit there is and that it doesn't benefit  
23 everybody.

24 Q Does it have to benefit everyone? Does  
25 everything on here, does every risk on here apply to

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1 **everyone?**

2 A No, but I don't know that if you are going to  
3 put somebody on a medication that can impact them down  
4 the road for the rest of their life that you have to  
5 have some kind of certainty that that is going to help  
6 that person. And a lot of the data doesn't support that  
7 a majority of people -- I mean, for the adults a  
8 40 percent risk of suicide and death. That doesn't seem  
9 like a high -- that this medication management is the  
10 greatest route to go.

11 If I was giving somebody something for their  
12 blood pressure and it only helped 60 percent, I don't  
13 know that that would be the best treatment route for  
14 this person.

15 **Q Do you inform these folks of the percentage**  
16 **risk, the risk of suicide of not receiving treatment for**  
17 **gender dysphoria?**

18 A I don't know --

19 MR. PERKO: Object to form.

20 A Sorry. I don't know what the risk is, and I  
21 haven't seen any data that says here's a group of people  
22 that we didn't treat and that they committed suicide.

23 BY MS. CHRISS:

24 **Q So you don't list any potential benefits**  
25 **regardless of the quality of evidence that supports**

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1 **them?**

2 A In the opening statement it says that there has  
3 been some studies to show some benefit.

4 **Q But throughout the form it is solely risks?**

5 A If you ever see a consent for a surgical  
6 procedure the whole thing is all about risk. The  
7 opening line is about benefit. If you are getting your  
8 appendix removed because if you don't it's going to  
9 rupture and you could die. And here are the 50 million  
10 things that could potentially go wrong. Then the  
11 surgeon goes through and says, you know, there's a risk.  
12 Same thing with thyroid removal, there's a risk that I  
13 might -- there might be an nick, there might be  
14 bleeding, I could have damage to your vocal chords, I  
15 could damage your parathyroid glands. If that happens  
16 you're going to need this, you're going to need calcium  
17 and Vitamin D. So all of those are discussed in a  
18 surgical consent of the vast majority.

19 Even commercials out there for medications have  
20 the side effects may include blah, blah, blah, blah,  
21 blah, blah, blah, blah, blah. So a vast majority of  
22 consents don't focus on the positive, it focuses on the  
23 negative or the unknown.

24 **Q In paragraph 98, on page 39, the informed**  
25 **consent form states: Taking testosterone causes or**

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1    **worsens migraines.**

2           A     Uh-huh.

3           Q     You respond to Dr. Shumer and Bruggeman by  
4    saying that the data is limited and you cite a study  
5    that was inconclusive on the effects of gender-affirming  
6    hormone therapy on migraines. How does this study  
7    support the assertion that testosterone causes  
8    migraines?

9           A     So in that study it did say that there were --  
10   it was a limited sample, but that 16 reported ongoing  
11   pain, 13 whom endorsed headache, and a majority had  
12   headaches prior, but that's a majority had headaches  
13   prior, they are people that had headaches that didn't  
14   have migraine headaches before they started treatment.

15          Q     Is it true that this study was inconclusive on  
16   the effects of gender-affirming hormones causing  
17   migraines?

18          A     It basically said that more data needed to be  
19   collected.

20          Q     When more data needs to be collected, you take  
21   that to mean it is a risk worth listing on the informed  
22   consent form, but when more data needs to be collected  
23   about the benefit of a treatment that doesn't warrant  
24   being on the informed consent form, correct?

25          A     I'm kind of lost on what you just said there.

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1 Q More data needs to be collected.

2 A Uh-huh.

3 Q That's of sufficient level of evidence for you  
4 to list the risk of increased migraines, increased risk  
5 of migraines, but more data needs to be collected is  
6 also the reason you're stating you are not putting the  
7 benefits of these treatments on these informed consent  
8 forms, correct?

9 MR. PERKO: Object to form.

10 A The consents says that more data does need to  
11 be collected in regards to the benefit, but there were  
12 some studies that showed there can be benefit.

13 BY MS. CHRISS:

14 Q Paragraph 101, on page 41, you discuss the  
15 Finasteride.

16 A Yes.

17 Q We agree Finasteride is not used to treat  
18 gender dysphoria?

19 A It's used to treat a side effect from the  
20 treatments of gender dysphoria.

21 Q Even if this medication is likely to be used by  
22 transgender men experiencing hair loss, why is it  
23 included in the section title how is testosterone taken?

24 A I'd have to take a look at the consent.

25 Q And in paragraph 104 on page 42 you state that

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1 Dr. Shumer's statement that, quote: Trans-women should  
2 follow the same guidelines for breast cancer. Did I  
3 skip -- sorry. Should follow the same guidelines for  
4 breast cancer --

5 A Number 104?

6 Q Yes.

7 MR. PERKO: That's not what it says.

8 A That's not what it says.

9 BY MS. CHRISS:

10 Q You are correct. Which one -- apologies. 103  
11 you say: Dr. Shumer's statement that a transgender  
12 woman -- trans-women should follow the same guidelines  
13 for breast cancer screening in non-transgender women is  
14 very misguided. Hold on. Yeah. Sorry. The last  
15 sentence of paragraph 103: Dr. Shumer's -- I think you  
16 meant Shumer -- statement that trans-women should follow  
17 the same guidelines for breast cancer screening and  
18 non-transgender women is very misguided. But his report  
19 cites to a 2019 peer-reviewed study to support this  
20 assertion, correct?

21 A I believe so.

22 Q That study made the same recommendation?

23 A I believe so. But I think the WPATH Guidelines  
24 said that they aren't -- that it hasn't been established  
25 what kind of guidelines that they should have, whether

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1 or not -- because some of the cases that have been found  
2 have been in 30 and 40-year-old transgender men, which  
3 normal breast screening for cancer usually occurs after  
4 the age of 40.

5           So it's not really clear as to when they should  
6 start screening, but at the very least they should be  
7 made aware that breast cancer is a risk. Like every  
8 woman they should be doing breast cancer screening on  
9 themselves, checking for lumps and bumps. It's quite a  
10 challenge when they have breast implants, because  
11 sometimes the breast tissue is under the implant, so  
12 doing a self-breast examination monthly for breast  
13 cancer can be quite challenging. And I guess that's  
14 basically it. They are recommending the same as other  
15 woman, but they are not really sure what the screening  
16 should be, if it should be sooner or later. And I don't  
17 think I said in the consents they needed to start the  
18 screening, I think I just said that breast cancer is a  
19 risk. I'm leaving it up to the physicians to do their  
20 job and tell them about monthly screenings, see if  
21 there's also a family history, if their mother had  
22 breast cancer they would have a risk just like a  
23 biological woman has a risk. Those are conversations  
24 that need to be had, and this opens the door to those  
25 kinds of conversations.

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1 Q Sounds like what you are saying supports that  
2 Dr. Shumer's statement that trans-women should follow  
3 the same guidelines for breast cancer treatment as  
4 non-transgender women isn't misguided?

5 A Oh, no, no. What I said was misguided was  
6 these are exceedingly rare in the adolescent population.  
7 Saying that breast cancers are exceedingly rare in the  
8 adolescent population.

9 Q Moving down to paragraph 104, you -- rebutting  
10 Dr. Bruggeman discussing the permanency of certain  
11 effects of estrogen therapy. Dr. Bruggeman disagreed  
12 with the statement that these effects could be  
13 permanent. And your response is, quote: Again, no  
14 long-term data to support her claim. What references do  
15 you have, or what studies do you cite to, to support the  
16 suggestion in a forum that these changes are  
17 irreversible?

18 A So there is some data about some things, some  
19 are listed, but there's some data to support that some  
20 are irreversible, but she has not shown the data.  
21 There's no long-term data. There's no controlled  
22 studies to show it, but she hasn't showed the controlled  
23 studies that show that it doesn't either.

24 Q And you haven't shown the controlled study that  
25 show that it does?

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1           A       Correct, but I don't know, so that's why we  
2 explain we don't know if it's temporary or permanent.  
3 Some of them have already been known. We know when  
4 women with PCOS who make exogenous testosterone become  
5 virilized and sometimes they can have acromegaly and  
6 deepening voice and hair, and we know that those are  
7 definitely irreversible. That's been well-demonstrated  
8 and documented.

9                       But there are not a lot of circumstances  
10 where in history people have been giving testosterone to  
11 14-year-old females to say whether or not they are going  
12 to come off if, if those effects are going to be  
13 permanent or lifelong, because this is still a  
14 relatively new field in the United States and they've  
15 not been really forthcoming with the data overseas.

16           **Q       Just to be clear, your criteria for listing**  
17 **potential risks is to include every possible risk,**  
18 **including those only reported in a few individuals when**  
19 **causation was not determined, regardless of the level of**  
20 **evidence?**

21                       **MR. PERKO: Object to form.**

22           **A       Correct.**

23 BY MS. CHRISS:

24           **Q       Dr. Mortensen, in paragraph 108 you reference**  
25 **cipro -- I'm not a doctor. Ciproterone acetate, if the**

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1 purpose of these informed consent forms are to inform  
2 and educate, wouldn't it also be prudent to also include  
3 that this is not a treatment that's available in the  
4 United States due to its risk?

5 A I believe that it said in the consent that it's  
6 not available in the United States.

7 Q I don't believe it does. If it isn't  
8 available, what's the point of including it on the  
9 informed consent form at all then?

10 A As I said in my statement that these patients  
11 are very well-educated, they talk, and actually some of  
12 them come from other countries where it is available.  
13 Many of them want to seek options, they can also buy it  
14 online on the Internet, you can get it from Canada. So,  
15 again, if that's the option that they are hearing from  
16 their peers or something they've experienced overseas  
17 and they want to do it, it's important to inform them  
18 it's not a good idea.

19 I don't know why it serves as to confuse in  
20 fear. It's just you might be reading about this, you  
21 might be hearing from your friends, you might be seeing  
22 online that this is a medication that's used. And it is  
23 used overseas, but it's not available here in the United  
24 States and here are some of the risks that are  
25 associated with it and why it's not available here in

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1 the United States. It's just designed to inform, not  
2 confuse and cause fear. It's everyone talks.

3 **Q When -- scratch that.**

4 MS. CHRISS: We are just about done. Let's  
5 take five minutes and we'll come back.

6 (Break taken 5:34 p.m. until 5:41 p.m.)

7 BY MS. CHRISS:

8 **Q Dr. Mortensen, I have one more question for**  
9 **you. Paragraph 52 in your report on page 18.**

10 MR. PERKO: What paragraph, counsel?

11 MS. CHRISS: 52.

12 BY MS. CHRISS:

13 **Q You state: There are also an overwhelming**  
14 **number of physicians and clinicians in the world that**  
15 **understand these are low-quality studies and vague**  
16 **guidelines. What is the basis for you statement that**  
17 **there are and overwhelming number of physicians and**  
18 **clinicians in the world who feel that way?**

19 A Well, it's my opinion that when we are taking a  
20 look at in the world, even here in the United States  
21 it's really hard to quantify a number, but the vast  
22 majority of people that I speak with feel that this is  
23 low-quality evidence. And I think it's also  
24 well-supported and the guidelines themselves say it's  
25 low-quality, low-grade evidence, and that they are

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1 vague. But if all of these physicians agreed that this  
2 was all high quality and the way to go, then why are  
3 they pausing it?

4 Q High quality is not a subjective term that the  
5 physicians determines, correct?

6 A Correct.

7 Q And you understand the grading criteria, we  
8 went over that earlier --

9 A Correct.

10 Q -- that quality does not denote efficacy and  
11 safety in a population.

12 MR. PERKO: Object to form.

13 BY MS. CHRISS:

14 Q So my question is not about the low-quality  
15 studies with vague guidelines, my question is the basis  
16 for your statement that an overwhelming numbers of  
17 physicians and clinicians. So I guess I'm asking who  
18 are these clinicians and physicians?

19 A Well, a number of people that I know, a number  
20 of people that have spoken out. There has been a lot of  
21 news reports with different physicians from different  
22 types of specialties, there's been a lot of specialists  
23 around the world also saying it as well.

24 Q Can you name these folks?

25 A No.

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1           Q       And can you tell me any provider, physician, or  
2       clinician who provides gender-affirming care and has  
3       expertise in this area providing this care in Florida  
4       that agrees with this statement?

5           A       I can tell you that Dr. Hasan and Dr. Torres  
6       who were providing care thought this was vague  
7       guidelines.

8           Q       They did not provide blockers --

9           A       Think did blockers.

10          Q       -- or they provided only blockers, but not  
11       cross-sex --

12          A       That is affirmative care. Gender-affirming  
13       care. But they agreed these were low-grade and that it  
14       was very vague guidelines. It seemed to be very  
15       wishy-washy on when you start, when you don't start.

16          Q       These individuals no longer provide this care?

17          A       Correct.

18          Q       Can you name anyone else that has expertise in  
19       the provision of this care in the state of Florida?

20          A       No.

21                   MS. CHRISS: We don't have any further  
22       questions.

23                   MR. PERKO: Just one question.

24                                   CROSS EXAMINATION

25       BY MR. PERKO:



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CERTIFICATE OF OATH

STATE OF FLORIDA)  
COUNTY OF DUVAL)

I, Kelly G. Broomfield, the undersigned  
authority, certify that MONICA MORTENSEN, D.O.,  
personally appeared before me on September 28, 2023, and  
was duly sworn.

WITNESS my hand and official seal this 8th day  
of October, 2023.



Kelly G. Broomfield, Stenographic Reporter  
Notary Public - State of Florida  
My Commission expires: September 30, 2025  
My Commission No. HH 164930

Monica Mortensen, D.O.  
September 28, 2023

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1 REPORTER'S CERTIFICATE

2

3 STATE OF FLORIDA)

4 COUNTY OF DUVAL)

5

6 I, Kelly G. Broomfield, Stenographic Reporter,  
7 certify that I was authorized to and did  
8 stenographically report the deposition of MONICA  
9 MORTENSEN, D.O.; that a review of the transcript was  
10 requested; and that the transcript, Volume 2, pages  
11 182-262, is a true and complete record of my  
12 stenographic notes.

13 I further certify that I am not a relative,  
14 employee, attorney, or counsel of any of the parties,  
15 nor am I a relative or employee of any of the parties'  
16 attorney or counsel connected with the action, nor am I  
17 financially interested in the action.

18

19 DATED this 8th day of October, 2023.

20



21

22

Kelly G. Broomfield, FPR  
Stenographic Reporter  
LEXITAS

23

24

25

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September 28, 2023

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1 October 8, 2023

2 MONICA MORTENSEN, D.O.  
3 C/O Holtzman Vogel  
4 119 South Monroe Street, Suite 500  
5 Tallahassee, FL 32301  
6 IN RE: JANE DOE, et al., v. LADAPO, et al.  
7 Civil No. 4:23-cv-00114-RH-MAF

8

9 Please take notice that on September 28, 2023, you gave  
10 your deposition in the above cause. At that time you  
11 did not waive your signature.

12 The above-addressed attorney has ordered a copy of this  
13 transcript and will make arrangements with you to read  
14 their copy. Then please execute the Errata Sheet, which  
15 can be found at the back of the transcript, and have it  
16 returned to Lexitas at the email address below for  
17 distribution to all parties.

18

19 If you do not read and sign your deposition within 30  
20 days, the original, which has already been forwarded to  
21 the ordering attorney, may be filed with the Clerk of  
22 the Court.

23

24 If you wish to waive your signature now, please sign in  
25 the blank at the bottom of this letter and return to the  
email address listed below.

26

Respectfully,

27

28 Kelly G. Broomfield, FPR  
29 LEXITAS  
30 Reference Job No. 329487

31

32 I do hereby waive my signature.

33

34 \_\_\_\_\_ DATE \_\_\_\_\_  
35 MONICA MORTENSEN, D.O.

36

37

38

Monica Mortensen, D.O.  
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1 E R R A T A S H E E T

2 DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE

3 IN RE: JANE DOE, et al., v. LADAPO, et al.  
4 Civil Number: 4:23-cv-00114-RH-MAF  
5 Deposition of MONICA MORTENSEN, D.O.  
6 Taken on Thursday, September 28, 2023

7	PAGE NUMBER	LINE NUMBER	SUGGESTION/REASON
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19 Under penalties of perjury, I declare that I have read  
20 the foregoing document and that the facts stated in it  
21 are true.

22  
23 DATE MONICA MORTENSEN, D.O.

24 Email completed Errata to fl.production@lexitaslegal.com

25 Reference Job No. 329487

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