No. 23-12159

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME III OF XIII

Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
(850) 274-1690

Counsel for Defendants-Appellants Florida Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

Ashley Moody
Attorney General of Florida

Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
(850) 414-3300

Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

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Dated: September 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
Phone: (850) 391-0503
Facsimile: (850) 741-1023
mjazil@holtzmanvogel.com
mbeato@holtzmanvogel.com
Counsel for Defendants-Appellants Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

/s/Joseph E. Hart
Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
Phone: (850) 414-3300
henry.whitaker@myfloridalegal.com
joseph.hart@myfloridalegal.com
Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

District.

42. Defendant Melissa Nelson is the State Attorney for Florida's Fourth Judicial District.

43. Defendant William Gladson is the State Attorney for Florida's Fifth Judicial District.

44. Defendant Bruce Bartlett is the State Attorney for Florida's Sixth Judicial District.

45. Defendant R.J. Larizza is the State Attorney for Florida's Seventh Judicial District.

46. Defendant Brian S. Kramer is the State Attorney for Florida's Eighth Judicial District.

47. Defendant Monique H. Worrell is the State Attorney for Florida's Ninth Judicial District.

48. Defendant Brian Haas is the State Attorney for Florida's Tenth Judicial District.

49. Defendant Katherine Fernandez Rundle is the State Attorney for Florida's Eleventh Judicial District.

50. Defendant Ed Brodsky is the State Attorney for Florida's Twelfth Judicial District.

51. Defendant Susan S. Lopez is the State Attorney for Florida's Thirteenth Judicial District.

52. Defendant Larry Basford is the State Attorney for Florida's Fourteenth Judicial District.

53. Defendant Dave Aronberg is the State Attorney for Florida's Fifteenth Judicial District.

54. Defendant Dennis Ward is the State Attorney for Florida's Sixteenth Judicial District.

55. Defendant Harold F. Pryor is the State Attorney for Florida's Seventeenth Judicial District.

56. Defendant Phil Archer is the State Attorney for Florida's Eighteenth Judicial District.

57. Defendant Thomas Bakkedahl is the State Attorney for Florida's Nineteenth Judicial District.

58. Defendant Amira D. Fox is the State Attorney for Florida's Twentieth Judicial District.

JURISDICTION AND VENUE

59. The Plaintiffs seek redress for the deprivation of their rights secured by the United States Constitution. This Action is initiated pursuant to 42 U.S.C. § 1983 to enjoin the Defendants from enforcing the transgender medical bans and for a declaration that the transgender medical bans violate federal law.

60. This Court has subject matter jurisdiction over the claims asserted herein pursuant to 28 U.S.C. §§ 1331 and 1343.

61. This Court has personal jurisdiction over the Defendants because the Defendants are domiciled in Florida and the denial of the Plaintiffs' rights guaranteed by federal law arises out of and relates to the Defendants' official duties in Florida.

62. Each of the Defendants is a resident of the State of Florida and serve in their official capacity for a government office for the State of Florida. Therefore, venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(1).

63. If enforced, the transgender medical bans would violate the constitutional rights of the Plaintiffs in this judicial district. Therefore, venue is also proper in this district pursuant to 28 U.S.C. § 1391(b)(2).

64. Venue is proper in the Tallahassee Division of the Northern District of Florida under N.D. Fla. Loc. R. 3.1(B) because it is the location of the principal place of business for a majority of the Defendants and where a substantial portion of the acts or omissions complained of herein occurred.

65. This Court has authority to enter a declaratory judgment and to provide preliminary and permanent injunctive relief pursuant to Fed. R. Civ. P. 57 and 65, 28 U.S.C. §§ 2201 and 2202, and this Court's inherent equitable powers.

FACTUAL ALLEGATIONS

I. Gender Identity and Gender Dysphoria

66. Gender identity is an innate, internal sense of one's sex and is an immutable aspect of a person's identity. It is an essential element of human identity and a well-established concept in medicine. Everyone has a gender identity. Most

people's gender identity is consistent with their birth sex. Transgender people, however, have a gender identity that differs from their birth sex. Being made to live inconsistent with a person's gender identity causes discomfort and distress and can interfere with a person's ability to function in a productive and healthy way in matters of daily living.

67. Gender dysphoria is the clinical diagnosis for the distress that arises when a transgender person cannot live consistent with their gender identity. To be eligible for a diagnosis of gender dysphoria, a young person must meet the criteria set forth in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (the "DSM-5").[1] If left untreated, gender dysphoria can cause anxiety, depression, and self-harm, including suicidality.

68. In fact, 56% of transgender youth reported a previous suicide attempt and 86% of them reported suicidality. *See* Ashley Austin, Shelley L. Craig, Sandra D. Souza, and Lauren B. McInroy (2022), *Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors*, J. of Interpersonal Violence, Vol. 37 (5-6) NP2696-NP2718.

69. Research has shown that an individual's gender identity is hard-wired

[1] Earlier editions of the DSM included a diagnosis referred to as "Gender Identity Disorder." The DSM-5 noted that Gender Dysphoria "is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity *per se*. Being diagnosed with gender dysphoria "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012).

and cannot be changed. In the past, mental health professionals sought to treat gender dysphoria by attempting to change the person's gender identity to match their birth sex; these efforts were unsuccessful and caused serious harms. Today, the medical profession recognizes that such efforts put transgender minors at risk of profound harm, including dramatically increased rates of suicidality.

70. Gender dysphoria is highly treatable. Healthcare providers who specialize in the treatment of gender dysphoria follow well-established standards of care and clinical practice guidelines that have been adopted by the major medical and mental health associations in the United States including, but not limited to, the American Medical Association, the American Academy of Pediatrics, the American Association of Child and Adolescent Psychiatrists, the Pediatric Endocrine Society, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.

71. The standards of care for treatment of transgender people, including transgender youth, were initially developed by the World Professional Association for Transgender Health ("WPATH"), an international, multidisciplinary, professional association of medical providers, mental health providers, researchers, and others, with a mission of promoting evidence-based care and research for transgender health, including the treatment of gender dysphoria. WPATH published the most recent edition of its standards of care for the treatment of gender dysphoria in minors and adults in 2022, Standards of Care for the Health of Transgender and Gender Diverse

People, Version 8. (Coleman E, Radix AE, Bouman WP et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend 2022 Sep 6;23 (suppl 1): S1-S259.)

72. The Endocrine Society has also promulgated a standard of care and clinical practice guidelines for the provision of hormone therapy as a treatment for gender dysphoria in minors and adults. *See* Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clin. Endocrinol. Metab. 3869 (2017).

73. The American Medical Association, the American Academy of Pediatrics, the American Association of Child and Adolescent Psychiatrists, the Pediatric Endocrine Society, the American Psychiatric Association, the American Psychological Association, and other professional medical organizations also follow the WPATH and Endocrine Society standards of care and clinical practice guidelines.

74. The treatment of gender dysphoria is designed to reduce a transgender person's clinically significant distress by permitting them to live in alignment with their gender identity. Undergoing treatment for gender dysphoria is commonly referred to as "transition," "gender transition," or "gender affirming care." There are several components to the gender transition process.

75. The precise treatment of gender dysphoria depends on an individualized assessment of a patient's needs.

76. Social transition involves a transgender person taking measures to live

in accordance with their gender identity in all aspects of life. For transgender boys, it means living fully as a boy; for transgender girls, it means living fully as a girl. Social transition can include adopting a name, pronouns, hairstyle, and clothing consistent with that person's gender identity. The steps a transgender person takes as part of their social transition help align their gender identity with all aspects of everyday life.

77. Gender transition may also involve taking prescribed medications, puberty blockers and hormones, to bring a person's body into alignment with their gender identity.

78. There are no medications prescribed to transgender children before they have begun puberty.

79. For a transgender adolescent who has begun puberty, puberty-blocking medication prevents the patient from going through the physical developments associated with puberty that exacerbate the distress experienced by the incongruence between the patient's gender identity and their body. As such, under the WPATH Standards of Care and clinical practice guidelines, puberty-blocking medication may become medically necessary and appropriate after a transgender adolescent reaches puberty to minimize or prevent the exacerbation of gender dysphoria and the permanent physical changes that puberty would cause. In providing medical treatments to adolescents, pediatric physicians and endocrinologists work in close consultation with qualified mental health professionals experienced in the diagnosis and treatment of gender dysphoria.

80. For older transgender adolescents, hormone therapy may also be medically necessary to bring their body into alignment with their gender identity and further treat the gender dysphoria they may experience without treatment.

81. The treatment for gender dysphoria is highly effective. Longitudinal studies have shown that transgender children with gender dysphoria who receive essential medical care, including puberty blockers and hormones, show levels of mental health and stability consistent with those of non-transgender children. Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children Who are Supported in Their Identities*, 137 Pediatrics 1 (2016). In contrast, transgender children with gender dysphoria who do not receive appropriate medical care are at risk of serious harm, including dramatically increased rates of suicidality and serious depression.

II. The Bans Adopted by the Boards

82. On June 2, 2022, Defendant Ladapo sent a letter to the Florida Board of Medicine and the Florida Board of Osteopathic Medicine (collectively, the "Boards") asking the Boards to "establish a standard of care" for the treatment of gender dysphoria, notwithstanding the widely accepted standards of care and clinical practice guidelines established by WPATH and the Endocrine Society.

83. On July 28, 2022, the Florida Department of Health sent the Boards a "Petition to Initiate Rulemaking," asking the Board, among other things, to adopt a

categorical ban on all treatment of gender dysphoria for people under eighteen years of age.

84. On August 5, 2022, the Boards discussed the June 2, 2022 letter from Dr. Lapado and the July 28, 2022 Petition to Initiate Rulemaking. The Boards voted to accept the Petition to Initiate Rulemaking.

85. On September 1, 2022, the Boards each published a Notice of Development of Rulemaking in the Florida Administrative Register (F.A.R.), proposing "rule development to clarify the practice standards for treatment of gender dysphoria in minors."

86. On October 14, 2022, the Boards each published a Notice of Rule Workshop, which would take place on October 28, 2022.

87. On October 28, 2022, the Boards held a Joint Workshop regarding the development of a rule related to "Practice Standards for the Treatment of Gender Dysphoria." At the conclusion of the meeting, the Boards voted in support of proposed rules that would ban puberty blockers and hormones, with an exception for treatment performed as clinical trials under the auspices of the Institutional Review Board. The proposed rules were as follows:

> (1) The following therapies and procedures performed for the treatment of gender dysphoria in minors are prohibited.
>
> (a) Sex reassignment surgeries, or any other surgical procedures, that alter primary or secondary sexual characteristics.
>
> (b) Puberty blocking, hormone, and hormone antagonist therapies.
>
> (2) Nonsurgical treatments for the treatment of gender dysphoria in

> minors may continue to be performed under the auspices of Institutional Review Board (IRB) approved, investigator-initiated clinical trials conducted at any of the Florida medical schools set forth in Section 458.3145(1)(i), Florida Statutes. Such clinical trials must include long term longitudinal assessments of the patients' physiologic and psychologic outcomes.
> (3) Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule may continue with such therapies.

88. On November 4, 2022 the Florida Board of Medicine voted to remove the exception from its proposed transgender medical ban.

89. On January 9, 2023, the Boards published Notices of Public Hearing in the Florida Administrative Register, regarding a joint hearing of the Boards scheduled to take place on February 10, 2023.

90. On February 10, 2023, during the Public Hearing, the Florida Board of Osteopathic Medicine voted to remove the exception from its proposed transgender medical bans.

91. The Florida Board of Medicine filed the following rule with the Florida Department of State on February 24, 2023, with an effective date of March 16, 2023:

> (1) The following therapies and procedures performed for the treatment of gender dysphoria in minors are prohibited.
> (a) Sex reassignment surgeries, or any other surgical procedures, that alter primary or secondary sexual characteristics.
> (b) Puberty blocking, hormone, and hormone antagonist therapies.
> (2) Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule may continue with such therapies.

92. The Florida Board of Osteopathic Medicine filed the following rule with the Florida Department of State on March 8, 2023, with an effective date of March 28, 2023:

> (1) The following therapies and procedures performed for the treatment of gender dysphoria in minors are prohibited.
>
> (a) Sex reassignment surgeries, or any other surgical procedures, that alter primary or secondary sexual characteristics.
>
> (b) Puberty blocking, hormone, and hormone antagonist therapies.
>
> (2) Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule may continue with such therapies.

93. The transgender medical bans include a clause that permits minors being treated with puberty blockers or hormones prior to the effective date of the transgender medical bans to continue to receive those treatments.

94. Transgender minors who were not yet receiving puberty blockers or hormones when the transgender medical bans took effect are barred from obtaining such treatment from a Florida doctor regardless of medical necessity.

95. The transgender medical bans ignore the established medical and scientific consensus that these treatments are medically necessary, safe, and effective for the treatment of gender dysphoria.

96. The transgender medical bans are in direct conflict with state laws ensuring that parents have the right to make medical decisions for their adolescent children. *See* Florida Statutes 1014.02 (which provides that "it is a fundamental right of

parents to direct the upbringing, education, and care of their minor children."); Florida Statutes 1014.03 ("The state, any of its political subdivisions, any other governmental entity, or any other institution *may not infringe on the fundamental rights of a parent to direct* the upbringing, education, *health care*, and mental health of his or her minor child[.]") (emphasis added).

III. The Ban Created by SB 254

97. On May 4, 2023, the Florida Legislature voted to pass SB 254.

98. On May 17, 2023, Florida Governor Ron DeSantis signed into law SB 254, which imposes felony criminal penalties, as well as professional discipline and civil liability, on any health care practitioner who prescribes or administers puberty blocking medications or hormone therapy to a minor "in order to affirm a person's perception of his or her sex if that perception is inconsistent with the person's [birth] sex." Fla. SB 254, § 4, lines 109–16 (2023) (Second Engrossed).

99. Section 4 defines "sex" as the "classification of a person as either male or female based on the organization of the human body of such person for a specific reproductive role, as indicated by the person's sex chromosomes, naturally occurring sex hormones, and internal and external genitalia present at birth." *Id.* at § 4, lines 102–06.

100. Section 4 bars the provision of transition-related care to minors: "Sex-reassignment prescriptions and procedures are prohibited for patients younger than 18 years of age[.]" *Id.* at § 4, line 107.

101. Section 4 defines the prohibited care as the "prescription or administration of puberty blockers for the purpose of attempting to stop or delay normal puberty in order to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex" at birth and the "prescription or administration of hormones or hormone antagonists to affirm a person's perception of his or her sex if that perception is inconsistent with the person's sex" at birth. *Id*. at § 4, lines 109–13; 114–16.

102. Section 5 directs the Boards of Medicine and Osteopathic Medicine to create rules permitting the continued treatment of minors receiving transition-related care before the new law takes effect: "The Board of Medicine and the Board of Osteopathic Medicine shall, within 60 days after the effective date of this act, adopt emergency rules pertaining to standards of practice under which a patient younger than 18 years of age may continue to be treated with a prescription consistent with those referenced under s. 456.001(9)(a)1. or 2. if such treatment for sex reassignment was commenced before, and is still active on, the effective date of this act." *Id*. at § 5, lines 154–61.

103. Section 5 provides: "A patient meeting the criteria of paragraph (a) may continue to be treated by a physician with such prescriptions according to rules adopted under paragraph (a) or nonemergency rules adopted under paragraph (6)(b)." *Id*. at § 5, line 171–74.

104. Section 5 provides that violation of the prohibition on providing sex-

reassignment prescriptions and procedures "constitutes grounds for disciplinary action under this chapter and chapter 458 or chapter 459, as applicable." *Id*. at § 5, lines 207–09.

105. Section 5 provides that violation of the prohibition on providing sex-reassignment prescriptions and procedures also results in criminal liability: "Any health care practitioner who willfully or actively participates in a violation of subsection (1) commits a felony of the third degree, punishable as provided in s. 775.082, s. 213 775.083, or s. 775.084." *Id*. at § 5, lines 210–13.

106. Section 7 creates civil liability for the provision of sex-reassignment prescriptions or procedures to minors. It provides as follows:

> (1) A cause of action exists to recover damages for personal injury or death resulting from the provision of sex reassignment prescriptions or procedures, as defined in s. 246 456.001, to a person younger than 18 years of age which are prohibited by s. 456.52(1).
>
> (2) The limitations on punitive damages in s. 768.73(1) do not apply to actions brought under this section.
>
> (3) An action brought under this section:
> (a) May be commenced within 20 years after the cessation or completion of the sex-reassignment prescription or procedure.
> (b) Is in addition to any other remedy authorized by law.
>
> (4) The cause of action created by this section does not apply to:
> (a) Treatment with sex-reassignment prescriptions if such treatment is consistent with s. 456.001(9)(a)1. or 2. and was commenced on or before, and is still active on, the effective date of this act.
> (b) Sex-reassignment prescriptions or procedures that were ceased or completed on or before the effective date of this act.

Id. at § 7, lines 241–61.

IV. The Transgender Medical Bans Will Irreparably Harm the Plaintiffs

Jane Doe and her daughter Susan Doe

107. Susan Doe is an eleven-year-old transgender girl who resides with her mother, Jane Doe, her father, and her three siblings in St. Johns County, Florida.

108. From an early age, Susan began telling her parents that she is a girl. She began living fully as a girl, with the support of her family and upon advice of her pediatrician by the time she started kindergarten.

109. Susan has been diagnosed with gender dysphoria and that diagnosis has been confirmed by many doctors, including her doctor at the Pentagon. Susan has not been prescribed puberty blockers or hormones to treat her gender dysphoria.

110. Susan's medical providers, including her pediatrician, pediatric endocrinologist, and medical provider on base, continue to monitor her treatment and concluded that it likely will be medically necessary for her to begin puberty blocking medications after she begins puberty, which is imminent. The transgender medical bans, however, will prevent her from obtaining treatment.

Brenda Boe and her son Bennett Boe

111. Bennett Boe is a fourteen-year-old transgender boy who resides in Alachua County, Florida, with his mother, Brenda Boe.

112. Bennett has known that he was not a girl since the third grade. After he began puberty and started experiencing the accompanying physical changes, Bennett

grew increasingly distressed by the mismatch between his body and his sense of himself as a boy. Around that time, Bennett experienced debilitating depression, culminating in an incident of self-harm resulting in hospitalization.

113. Bennett's mother Brenda took Bennett to see medical professionals who diagnosed Bennett with gender dysphoria and recommended treatment, including menstrual suppression medication. With Brenda's consent, Bennett began treatment which has considerably alleviated his depression.

114. Even with that treatment, Bennett continues to experience gender dysphoria as a result of continued pubertal development inconsistent with his sense of himself as a boy.

115. Bennett's doctors believe it may be medically necessary for him to begin hormone therapy after he turns sixteen.

116. Brenda and Bennett fear that the transgender medical bans will prevent him from being able to treat his ongoing symptoms of gender dysphoria with hormone therapy.

Carla Coe and her daughter Christina Coe

117. Christina Coe is a nine-year-old transgender girl, and one of three triplets, who resides in Duval County, Florida with her mother, Carla Coe, her father, and her siblings.

118. From an early age, Christina began to say to her parents that she is a girl.

119. At age five Christina began to express distress including suicidal ideation and a desire to harm herself.

120. Since entering the third grade, Christina has been living as a girl in all aspects of her life. She has not expressed a renewed desire to harm herself.

121. Carla and her husband fear that Christina will not be able to get the medical care she needs after she begins puberty because of the transgender medical bans.

Fiona Foe and her daughter Freya Foe

122. Freya Foe is a ten-year-old transgender girl who resides with her mother, Fiona Foe, her father, her grandmother, and her two siblings in Orange County, Florida.

123. As soon as she could walk and talk, Freya was very feminine in her self-expression, including her choices of clothing and toys.

124. As she grew older, Freya began to express distress about being seen as a boy. Fiona and her husband took Freya to see a psychologist who diagnosed her with gender dysphoria.

125. Shortly before her tenth birthday, Freya's doctor examined her and determined that she had reached Tanner Stage 2, meaning puberty is in progress. In the months preceding this examination, Freya had begun to express distress about the onset of puberty and her performance in school began to decline.

126. In December 2022, Freya's doctors determined that puberty blocking

medication was medically necessary for the treatment of her gender dysphoria. With the consent of her parents, Freya began puberty blocking medication. Since then, Freya's overall wellbeing and performance in school have improved.

127. The transgender medical bans will prevent Freya's medical providers from prescribing hormones to allow her to go through female puberty, medication she may need as her peers continue to develop through puberty.

Gloria Goe and her son Gavin Goe

128. Gavin Goe is an eight-year-old transgender boy who resides with his mother, Gloria Goe, his father, and his siblings in Lee County, Florida.

129. Gavin identified as a boy a very young age, pointing to photographs of boys to let others around him know how he felt. Eventually, he asked his parents why he could not have a boy's name and why people did not believe he was a boy.

130. Gradually over time, Gavin's parents supported him in taking steps to live more fully as a boy.

131. By the time Gavin entered first grade, he was living as a boy in all aspects of his life.

132. Gavin was assessed for gender dysphoria by his pediatrician in 2022, who referred Gavin to a pediatric endocrinologist for further assessment and treatment because of Gavin's age, development, and family history.

133. Gloria made an appointment for Gavin with the pediatric endocrinologist at a clinic for March of 2023. She learned, just before the appointment, that it was

cancelled because the clinic is no longer seeing new patients due to the transgender medical bans.

134. Gloria and Gavin know that irreversible changes can happen in Gavin's body at any time due to the onset of puberty and that he needs to be assessed regularly by a pediatric endocrinologist to determine if and when he needs puberty blockers to effectively treat his gender dysphoria.

Linda Loe and her daughter Lisa Loe

135. Lisa Loe is an eleven-year-old transgender girl who resides with her mother, Linda Loe, her father, and her sibling in Miami-Dade County, Florida.

136. As a child, Lisa identified closely with her female friends and strongly preferred toys and activities more commonly associated with girls.

137. At age nine, Lisa said that she knew she was a girl.

138. Lisa's parents took her to see a psychologist who assisted them in supporting Lisa to live consistently with her gender identity.

139. Lisa was evaluated in Fall of 2022 by a pediatric endocrinologist who confirmed her diagnosis of gender dysphoria and recommended that she return for another appointment in six months because she was likely to start puberty soon.

140. Lisa was evaluated again in March of 2023 and her doctor confirmed that she has reached puberty and advised that it would be necessary to begin puberty blockers within approximately three months. The doctor also advised that the transgender medical bans made it impossible for the doctor to prescribe puberty

blockers to Lisa.

141. Irreversible changes are occurring in Lisa's body at this time, which are causing her significant distress. Lisa and her family cannot meet her urgent medical needs because of the barriers they are facing in Florida finding the medical care she needs.

Patricia Poe and her son Paul Poe

142. Paul Poe is a nine-year-old transgender boy who resides with his mother, Patricia Poe, and his sister in Miami-Dade County, Florida.

143. From a young age, Paul began asking consistently to use the boys' bathroom and to be referred to as a boy and a brother.

144. Paul began wearing boys' clothing, using a boy's name when away from home, and, with the advice and support of a therapist, living as a boy at school and in all other aspects of his life.

145. In late 2022, Paul's body began changing with the onset of puberty. Patricia took him to see a pediatric endocrinologist who determined that Paul was far enough along in puberty that he may need puberty blockers. The pediatric endocrinologist recommended that Paul see a psychologist to confirm his medical need for puberty blockers.

146. In February 2023, a psychologist evaluated Paul and determined that he needs to begin treatment with puberty blockers to alleviate his gender dysphoria. Paul began treatment at that time.

147. Shortly thereafter, Paul's pediatric endocrinologist told Patricia that the endocrinologist was unable to continue prescribing or monitoring the treatment in light of the transgender medical bans. Paul's family must find medical providers outside of Florida to secure the care he needs which presents a hardship to the family and potential harms because of disruption to the continuity of his care, as long as the transgender medical bans are in effect.

CLAIMS FOR RELIEF

COUNT I

Deprivation of Substantive Due Process
Parent Plaintiffs Against All Defendants in Their Official Capacities
Violation of Parent Plaintiffs' Right to Direct the Upbringing of Their Adolescent Children
U.S. Const. Amend. XIV

148. The Plaintiffs incorporate paragraphs 1–147 of the Second Amended Complaint as if set forth fully herein.

149. The Parent Plaintiffs bring this Count against all Defendants.

150. The Fourteenth Amendment to the United States Constitution protects the rights of parents to make decisions "concerning the care, custody, and control of their children." *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality). That fundamental right includes the liberty to make medical decisions for their minor adolescent children, including the right to obtain medical treatments that are recognized to be safe, effective, and medically necessary to protect their adolescent children's health and well-being.

151. The transgender medical bans violate this fundamental right by preventing the Parent Plaintiffs from obtaining medically necessary care for their minor adolescent children.

152. By intruding upon parents' fundamental right to direct the upbringing of their adolescent children, the transgender medical bans are subject to strict scrutiny.

153. The Defendants have no compelling justification for preventing parents from ensuring their adolescent children can receive essential medical care. The transgender medical bans do not advance any legitimate interest, much less a compelling one.

COUNT II
Deprivation of Equal Protection
All Plaintiffs Against All Defendants in Their Official Capacities
U.S. Const. Amend. XIV

154. The Plaintiffs incorporate Paragraphs 1–147 of the Second Amended Complaint as if set forth fully herein.

155. Plaintiffs bring this Count against all Defendants.

156. The Equal Protection Clause of the Fourteenth Amendment, enforceable pursuant to 42 U.S.C. § 1983, provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. Amend. XIV, § 1.

157. The transgender medical bans single out transgender minors and prohibit them from obtaining medically necessary treatment based on their sex and transgender status.

158. Under the Equal Protection Clause, government classifications based on sex are subject to heightened scrutiny and are presumptively unconstitutional.

159. Transgender-based government classifications are subject to heightened scrutiny because they are sex-based classifications.

160. Because transgender people have obvious, immutable, and distinguishing characteristics, including having a gender identity that is different from their birth sex, they comprise a discrete group. This defining characteristic bears no relation to a transgender person's ability to contribute to society. Nevertheless, transgender people have faced historical discrimination and have been unable to secure equality through the political process.

161. As such, transgender classifications are subject at least to intermediate scrutiny.

162. The transgender medical bans do nothing to protect the health or well-being of minors. To the contrary, the transgender medical bans undermine the health and well-being of transgender minors by denying them essential medical care.

163. The transgender medical bans are not narrowly tailored to further a compelling government interest, substantially related to any important governmental interest, or even rationally related to a governmental interest. Accordingly, the transgender medical bans violate the Equal Protection Clause of the Fourteenth Amendment.

RELIEF REQUESTED

WHEREFORE, Plaintiffs request that this Court:

(1) issue a judgment, pursuant to 28 U.S.C. §§ 2201–2202, declaring that the transgender medical bans violate the United States Constitution for the reasons and on the Counts set forth above;

(2) temporarily, preliminarily, and permanently enjoin the Defendants and their officers, employees, servants, agents, appointees, or successors from enforcing the transgender medical bans;

(3) declare that the transgender medical bans violate the Fourteenth Amendment to the United States Constitution;

(4) award the Plaintiffs their costs and attorneys' fees pursuant to 42 U.S.C. § 1988 and other applicable laws; and

(5) grant such other relief as the Court finds just and proper.

Respectfully submitted this 17th day of May, 2023.

/s/ Simone Chriss
Counsel for Plaintiffs

SOUTHERN LEGAL COUNSEL

By: /s/ Simone Chriss
Simone Chriss
Florida Bar No. 124062
Chelsea Dunn
Florida Bar No. 1013541
1229 NW 12th Avenue
Gainesville, FL 32601
(352) 271-8890
Simone.Chriss@southernlegal.org
Chelsea.Dunn@southernlegal.org

HUMAN RIGHTS CAMPAIGN FOUNDATION

Cynthia Cheng-Wun Weaver*
NY No. 5091848
Jason Starr*
NY No. 5005194
Ami Patel*
CA No. 325647
1640 Rhode Island Avenue NW
Washington, D.C. 20036
(202) 993-4180
Cynthia.Weaver@hrc.org
Jason.Starr@hrc.org
Ami.Patel@hrc.org

NATIONAL CENTER FOR LESBIAN RIGHTS

Christopher F. Stoll*
CA Bar No. 179046
Kelly Jo Popkin*
NY Bar No. 5698220
National Center for Lesbian Rights
870 Market Street, Suite 370
San Francisco, CA 94102
Tel. 415-365-1320
cstoll@nclrights.org
kpopkin@nclrights.org

GLBTQ LEGAL ADVOCATES & DEFENDERS

Jennifer Levi*
Chris Erchull*
18 Tremont, Suite 950
Boston, MA 02108
(617) 426-1350
jlevi@glad.org
cerchull@glad.org

* Admitted by *pro hac vice*

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that, on May 17, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system. I further certify that I served by process server the foregoing on the following non-CM/ECF participants:

Ashley Moody
Office of the Attorney General
State of Florida
PL-01, The Capitol
Tallahassee, FL 32399-1050

Ginger Bowden Madden
Office of the State Attorney, 1st Judicial Circuit
190 W. Government Street
Pensacola, FL 32501

Jack Campbell
State Attorney's Office
Leon County Courthouse
301 S. Monroe St, Suite 475
Tallahassee, FL 32301

John Durrett
310 Pine Ave. SW,
Live Oak, FL 32064

Melissa W. Nelson
Ed Austin Building
311 West Monroe Street
Jacksonville, Florida 32202

William Gladson
Office of the State Attorney
Citrus County Courthouse
110 North Apopka Ave.
3rd Floor RM 2-372
Inverness, FL 34450-4293

Bruce Bartlett
PO Box 17500
Clearwater, FL 33762-0500

R.J. Larizza
251 N Ridgewood Avenue
Daytona Beach, FL 32114

Brian S. Kramer
120 West University Avenue
Gainesville, Florida 32601

Monique H. Worrell
415 North Orange Avenue
Orlando, FL 32801

Brian Haas
930 E Parker St.
Lakeland, FL, 33801

Katherine Fernandez Rundle
E.R. Graham Building
1350 N.W. 12 Avenue
Miami, FL 33136

Ed Brodsky
Criminal Justice Building
2071 Ringling Blvd.
Suite 400
Sarasota, FL 34237

Susan S. Lopez
419 N. Pierce Street
Tampa, Florida 33602

Larry Basford
421 Magnolia Avenue
PO Box 1040 – 32402
Panama City, FL 32401

David A. Aronberg

401 North Dixie Highway
West Palm Beach, FL 33401

Dennis W. Ward
530 Whitehead Street
Suite 301
Key West FL, 33040

Harold F. Pryor
Broward County Judicial Complex
201 Southeast 6th Street, Suite 07150
Fort Lauderdale, Florida 33301

Philip G. Archer
2725 Judge Fran Jamieson Way
Building D
Viera, Florida 32940-6605

Thomas Bakkedahl
411 S. 2nd Street
Fort Pierce, FL 34950

Amira D. Fox
Lee County Justice Complex Center
2000 Main Street, 6th Floor
Fort Myers, Florida 33901

/s/ Simone Chriss
Simone Chriss
Counsel for Plaintiffs

Doc. 63

Doe v Ladapo: 4:23-cv-114

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE, FLORIDA

JANE DOE, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:23cv114
	)	
vs.	)	Tallahassee, Florida
	)	May 19, 2023
JOSEPH A. LADAPO, et al.,	)	8:30 A.M.
	)	
Defendants.	)	
	)	

TRANSCRIPT OF PLAINTIFFS' PRELIMINARY INJUNCTION AND TEMPORARY RESTRAINING ORDER HEARING
BEFORE THE HONORABLE ROBERT L. HINKLE,
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiffs,

GLBTQ Legal Advocates & Defenders
By: JENNIFER L. LEVI
Attorney at Law
jlevi@glad.org.com
18 Tremont Street
Suite 950
Boston, Massachusetts 02108

Human Rights Campaign Foundation
By: CYNTHIA C. WEAVER
Attorney at Law
cynthia.weaver@hrc.org
1640 Rhode Island Avenue NW
Washington, DC 20036-3200

APPEARANCES: Cont'd

For the Plaintiffs: Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorneys at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

For the Defendants: Holtzman Vogel Baren, et al.
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(*Call to order; parties present.*)

THE COURT: Good morning. Please be seated.

We're here on Doe versus Ladapo, and the plaintiffs' motion for temporary restraining order or preliminary injunction. I'll hear from the plaintiffs first.

MS. LEVI: Yes, Your Honor.

Good morning, Your Honor. I'm Jennifer Levi, and I represent the plaintiffs in this case who, as you said, are seeking a TRO to prevent SB-254, a law that criminalizes the provision of medical treatment that transgender minors need to live as transgender minors, that went into effect just two days ago. We're asking the Court to issue an order that enjoins the law from remaining in effect.

As you know we've also filed a preliminary injunction seeking to halt the effect of the Board of Medicine's rules that prevent doctors from prescribing puberty blockers and hormones to transgender adolescents, like SB-254 in a different form, barring transgender adolescents from living consistent with their gender identity.

I'll be happy to turn to the argument regarding the likelihood of success on the merits, but I wanted to start by addressing the irreparable harms that these plaintiffs face in the absence of a TRO being issued by this Court.

The movants in this case are three transgender

adolescents, all of whom have been diagnosed with gender dysphoria, all of whom are either on the cusp of puberty or actually have had confirmation that they have entered Tanner Stage 2, pubertal development, and all are not able to initiate puberty blockers because of the bans on treatment.

I want to speak just specifically to a couple of their circumstances.

Gavin Goe is a transgender boy, lived for years as a boy, and he was referred by his pediatrician in June of 2022 to pediatric endocrine specialist for continued assessment to determine whether he has entered into Tanner Stage 2. He had an appointment scheduled for March, just a couple months ago, that was cancelled because of the Board of Medicine bans.

THE COURT: What's going to happen if I enter the injunction?

MS. LEVI: Your Honor, if you enter the injunction, doctors, we have confirmed this, will continue to provide the treatment that the patients need. And I will say, we have seen in similar cases in Alabama and in Arkansas where there were immediate orders that were entered by federal district courts enjoining those laws from remaining in effect, that the care the transgender adolescents need was continued.

THE COURT: Those states probably don't have the resent history Florida does of retaliating against individuals who took a position adverse to the State. But your doctors

are willing to go forward.

MS. LEVI: We have confirmation from doctors that the reason they wouldn't provide care is because of SB-254, and that if there was an injunction issued by this Court, that they would go forward in providing that care.

And just to say, I do understand your point about the history of retaliation, but in Alabama there also was criminal penalties associated with the law and, you know, a similar response and knowledge from the clinic that the law was coming, and the issuance of a very swift order was essential to the continuation of care.

In any case, as I said, Gavin Goe had an appointment cancelled in March. Lisa Loe, who also was referred to a pediatric endocrine specialist, had an appointment that took place in March that confirmed the fact that she has entered in pubertal development of Tanner Stage 2. And Susan Doe, who has had ongoing medical monitoring by the U.S. Health Youth Gender Program has submitted documentation from her doctor that she is on the cusp of puberty, could enter puberty any day.

So I know Your Honor has been hearing for the last week and a half the serious harms that adolescents with gender dysphoria that's untreated will experience; and, of course, these plaintiffs are experiencing that as well as the disruption of their peer social interactions, the impact on

their body image, their sense of self that will have long lasting repercussions if they can't get the care that they need.

But in addition I want to address, to highlight the fact that the plaintiffs are seeking a TRO because of the draconian and sweeping punitive measures that are incorporated within SB-254, including of course the criminal penalties, the potential civil penalties up to 20 years after the completion of treatment, as well as the professional discipline threats to not just the M.D.s who are regulated by the Board of Medicine, but also to the advanced practice registered nurses and physician assistants who also can, under Florida law, prescribe care.

And we are asking for a TRO in this case for the very classic reasons of preserving the edifice of the health care institutions that are currently in place designed to provide this care. It is, you know, likely, it's predictable, without a swift order from this Court, doctors will be assigned to other areas of practice; these clinics will accept different patients; endocrinologists who have specialties to treat gender dysphoria, but also other specialized pediatric conditions like diabetes, will be transferred, patient rolls will change. And that could happen so swiftly that by the time that this Court could rule on the merits, these plaintiffs won't have the opportunity and the health care

infrastructure won't exist as it does prior to today.

THE COURT: Is that already ongoing? I mean, my understanding, I guess, is that the clinics aren't taking patients now.

MS. LEVI: Well, my understanding is that, as of two days ago, that clinics were continuing to accept patients to do the monitoring and the assessment. It's absolutely true that after the Board of Medicine's rule passed, some clinics turned patients away. We saw that in the case of Gavin Goe. But there are other clinics that are looking to this Court to see what happens, and those are the doctors who have said to us that they would continue to provide care; that if SB-254 and, of course, the Board of Medicine rules as well, were enjoined, that they will be able to maintain the practices that they have held.

THE COURT: When I say my understanding, that's what I gather from the evidence in instances like Gavin Goe.

MS. LEVI: Well, that's correct.

THE COURT: Give me some background on what there is. There's the clinic at University of Florida, a clinic at University of Miami.

MS. LEVI: Yes.

THE COURT: A Johns Hopkins clinic in, I guess it's St. Petersburg, somewhere there in the Bay Area.

MS. LEVI: That's correct. Nicklaus Children's

Hospital had been providing care and is no longer providing care.

THE COURT: Where else in the state does one get this care?

MS. LEVI: There are individual endocrinologists, there are individual doctors who -- I know you heard testimony this week who have referred, work in collaboration with the multidisciplinary centers, but also may have specialties to provide practice for adolescents. The plaintiffs that we represent have been referred to specialty practices by their pediatricians. Pediatricians have worked in close collaboration with those speciality clinics. So my understanding, those are the primary centers, but not exclusively the places where people are seeking care.

THE COURT: Part of the defense express concern is -- expressed concern is not everybody practices at the level that should be required or should be followed for treatment of this. Not everybody has a multidisciplinary team. There's testimony about a 20-minute interview and then straight to these drugs. I don't know that anybody had instances where it happened.

What does the record show about whether, in fact, that goes on?

MS. LEVI: It's not demonstrated in the case of the plaintiffs that I represent who, as I've said, have either had

ongoing care and coordination between their pediatrician and multidisciplinary speciality practices. I haven't seen anything in the record that demonstrates as you said that what the State's fear has been carried out.

But more significantly, to the extent that that's the concern, the sweeping ban, criminalization, civil liability for 20 years is hardly tailored to that specific concern. I mean, to say there is a recognition that nobody disputes the fact that transgender dysphoria is a real and serious condition, and that without treatment adolescents will suffer, and this ban is far from tailored to the concerns that the Court was raising -- that the defense is raising, I guess.

I'm happy to turn to the merits.

THE COURT: Please.

MS. LEVI: Plaintiffs argue that, because the medical rules and SB-254 facially discriminate on the basis of transgender status; and, therefore, because of sex, that they are subject to strict scrutiny or at least heightened review.

The laws, both the Board of Medicine's rule and SB-254, facially target transgender people, transgender adolescents, by prohibiting the treatments that are integral to transgender identity -- that is to the conduct, gender transition that defines the group -- the prohibited treatments are precisely those that a transgender person needs to transition and thus live and thrive as a transgender person.

SB-254 couldn't be clearer in the language of the statute by prohibiting -- this is the statutory text -- *treatments that affirm a person's perception of his or her sex if that perception is inconsistent with the person's birth sex*. In other words, if a person is transgender. That's the classification that is baked into it. And the same treatments are prohibited under the Board of Medicine rules.

Defendants argue that the analysis of *Geduldig* or *Dobbs* applies; and rather than being a transgender classification, the laws regulate a medical condition, but as I said, you could look through SB-254, and you won't see a medical condition specifically identified that doesn't refer to the underlying condition of gender dysphoria. Specifically, it refers to a prohibition, as I said, of the treatments that affirm a person's gender identity, or somebody has a gender identity that's inconsistent with their birth sex.

And so it couldn't be clearer on the face of the statute itself, and by targeting the specific treatments in the Medical Board's bans, that the laws create a facial classification targeting transgender people; therefore, discriminates both on the basis of transgender status and also sex.

I can speak more specifically to the reasons why *Geduldig*, *Dobbs*, and *Adams*, in those cases the court and other

courts explaining those decisions have explained that you don't have to be pregnant or have an abortion to be a woman.

Here, the prohibited treatments are precisely those treatments that individuals need to be transgender. I don't think there is any real argument that you can't, on the face of the statute, determine the class that it's focused on. That's what the courts in Alabama and Arkansas found as well.

So it's not that the bans prohibit treatment that happen to be used by transgender minors, they prohibit treatments because they are used by transgender minors. And so we argue that strict scrutiny, at minimum, heightened review applies to the statute and the medical ban.

THE COURT: What do you do with -- one of the things they argue is, they basically tell me, go listen to the argument. There was an oral argument in the Alabama case. I haven't gone to listen to the argument. But I take it it didn't go well for the plaintiffs, and we live in the world we live in, and the panel will do as it will.

Of course, the *Adams* case wound up *en banc*, and it's a -- it will be a long time before this is settled. But it's likely that whatever the Circuit does in the Alabama case, it's going to control what happens in this case between the time of that decision and the time of any *en banc* decision or Supreme Court review, Supreme Court review in this case or Arkansas or somewhere else. Tell me how you think this is

going to play out over time.

I enter an injunction and the doctors provide this treatment, and next week or next month or three months from now, but probably not much more than three months from now, there is a Circuit decision. What's going to happen?

MS. LEVI: I was at that argument, Your Honor. I take a very different view than the State in this case. The bench said to the oralist to please address equal protection argument initially because of the existence of *Glenn v. Brumby* and the recognition that the Eleventh Circuit actually was a forerunner to establishing the law that the Supreme Court later recognized, which is that discrimination against transgender status is sex discrimination, and asked my co-counsel in Alabama, Jeff Doss, to start by addressing the equal protection argument because of the panel's purported view of that being very strong under *Glenn v. Brumby*.

Mr. Doss actually said, you know, appreciate the bench's, at least, consideration of the parental rights argument, which we make here as well, explained to the court that it's a parental right to medical decision-making to ensure that a child can get well-established, evidence-based medication and treatment. That's been endorsed by major medical associations, as you know. The trial I know has reflected all of that information. I think Mr. -- Mr. Doss made the argument, and actually my perception, which might

have been harder to -- I mean, this is just to answer your question, I don't know how the Eleventh Circuit is going to rule.

THE COURT: I learned a long time ago, you can't watch an argument and know how a case is going to come out.

MS. LEVI: Absolutely. All I want to say is my perception is that there is a very real possibility that the Eleventh Circuit decides to affirm the District Court's opinion on the basis of equal protection -- it may be on the basis of equal protection or parental rights. I can't predict, I don't know.

But, again, I think that's an important example where at least at the moment the controlling precedent is the District Court's decision, and the care has been ongoing. Of course, I don't know how the Eleventh Circuit is going to rule. I do think that *Glenn v. Brumby* is controlling. I also think that *Adams* is distinguishable.

In the *Adams* case the court said that there was a policy that applied to all students, didn't depend on how students looked or acted. This law is completely distinct from this. I mean, this law is a law that only applies to transgender minors and denies them the treatment that they need to affirm a gender identity.

So I think there is a very strong possibility that the Eleventh Circuit affirms the Alabama decision. It maybe

does so on both equal protection, parental rights. I can't speak to that. But given the established law in the Eleventh Circuit, I think it will be really important for this Court to enjoin the law as the District Court did, and then, yes, it will be revolved in the future as it is.

I'm happy to address the parental argument, if that would be helpful.

THE COURT: Whatever you wish. You've got a few minutes left and --

MS. LEVI: I'm happy to. I also want to make sure I have answered all of your questions, Your Honor.

THE COURT: I think that's what I had on my list to make sure I asked you.

MS. LEVI: Okay. Well, then with the few minutes remaining, we do argue that -- plaintiffs' also argue that strict scrutiny applies because these bans interfere with well-established parental rights, not in a high level of generality, but a very specific articulation of parents' rights to obtain established medical care for their children where it is well established, recognized, demonstrated to be effective. It's one of the oldest fundamental rights that's been recognized by the Supreme Court.

The State argues that the plaintiffs haven't argued it at the level of generality addressing the very specific medical treatment that would be requested. To require that

kind of demonstration of the right would really eviscerate the right. It's not the approach that the Eleventh Circuit has taken in *Vendenberg*, which it has not walked away from. And we do think by sweepingly preventing parents from being able to secure the medical care that their children need, that it sweeps more broadly than the State has authority to do so.

I know that the State has also argued that there can't be a right that isn't otherwise secured to adults, but in the foundational cases *Meyer versus Nebraska, Pierce versus Society of Sisters*, where the Supreme Court established that right. It was about parental rights, you know, different aspect of a parental right, but it was about educational -- making decisions about educating one's children. There is no right to education, and yet the interpretation, the disruption of the State on parents being able to exercise that autonomy was recognized as a right.

We think that also triggers heightened scrutiny as did the Alabama and the Arkansas courts as well. And then looking at the statute and the medical bans and applying heightened scrutiny, we think it's crystal clear. Going to your earlier question that, where you have no dispute over the existence of the underlying medical condition, the seriousness of that medical condition when it's untreated, the only established treatment is that which is being enjoined, no alternative treatment has been demonstrated to be effective in

care, that the State hasn't demonstrated that the treatment is experimental and can't demonstrate that it's experimental. But even if that were to be the case, it doesn't justify a categorical ban on the treatment for all adolescents for whom we know it to be an effective treatment.

And just to kind of return to where I started, we do ask this Court to issue a TRO because people have been looking, including the health care providers, looking at the potentiality of this law getting passed, which just happened two days ago, and a swift order from this Court will preserve the health care institutions and the edifice that exists to provide care so that it's still there once the Court has the opportunity to resolve the case on the merits.

THE COURT: I do have a couple of questions. One goes to the TRO aspect of this.

Where do you stand on letting the other defendants know that we are here, and what do you want to do about it?

MS. LEVI: So we have the summonses ready to go and to be served. We are moving as expeditiously as possible to notify all of the defendants. We would ask you to issue the TRO ex parte while we can make that happen as quickly as possible. And we are prepared to move to the merits phase as quickly as possible. We believe and appreciate the full record that the Court has been developing over the course of the week and a half.

THE COURT: When can you try the case?

MS. LEVI: We can try the case as quickly as the defendants would agree to it. We have very few additional witnesses that we would want to put on. It would include a couple of our plaintiffs. We have an additional medical provider from the University of Florida, Health Care System. We have a bioethicist from the University of Miami who we think can provide an important perspective to this Court, but --

THE COURT: But you can do that, if I set a trial in June, you say you would be there.

MS. LEVI: Yes, we would, Your Honor.

THE COURT: I had a specific question about Dr. Bruggeman -- I'm not sure I said the name correctly.

MS. LEVI: Yes, that's right.

THE COURT: Is Dr. Bruggeman doing research at UF or treating -- I know doing research, but doing research on this or just treating these patients?

MS. LEVI: She's treating these patients, yes. She's a clinician, yes.

THE COURT: All right. You said you have summonses ready to go, but you haven't had any contact with the Attorney General's Office or the State Attorneys' Offices or --

MS. LEVI: We haven't yet. We honestly have been doing all we could to get the TRO on file and are moving -- I

mean, we have the summonses ready to go.

THE COURT: And if I entered a preliminary injunction against the Secretary, do you know whether that's enough for your doctors? I mean, if I did that, it would be a clear indication of my view of the merits and, frankly, it would make it pretty clear what's going to happen next; although, as always, the new party comes in, I give the new party a chance to be heard, and then it sometimes happens that a new party has something new to say and persuades me of its position. So it wouldn't be a guarantee that the same result would follow against the Attorney General or against the State Attorney, but there would be some indication.

I would think that that would be enough to keep a university from dismantling its program, but whether that would be enough to lead a doctor to say, I'm going to provide this care, even though there's a threat of criminal prosecution out there, I don't know.

MS. LEVI: I believe it would be a powerfully important decision that, as you said, would indicate the likely outcome, that would be the standard in the assessment. I can't, without confirming, represent what the doctors will do. There's obviously a tremendous concern about the criminal prosecution. That's why we had to bring in the State Attorneys, but I think that would be powerfully important, but I can't represent, you know.

THE COURT: All right.

Let me hear from the other side. Mr. Jazil?

Before you get into the merits, tell me where you are on representation. Who do you represent and what do you know about the co-defendants?

MR. JAZIL: Good morning, Your Honor. I represent the Boards of Medicine and the individual board members. I do not represent the State Attorneys.

And, Your Honor, because of that, the Boards of Medicine don't have jurisdiction over the criminal liability provision that's being challenged. I'm happy to answer the Court's questions regarding those provisions; however, I don't have authority to --

THE COURT: Is the Attorney General a defendant? Do you represent the Attorney General?

MR. JAZIL: I do not, Your Honor.

THE COURT: And I guess, while we are still dealing with things that really aren't in your bailiwick, is this a statewide prosecutor issue?

I know they passed a law recently to give the statewide prosecutor additional jurisdiction. And we may be beyond what is in your bailiwick or what you want to speak to. I know they expanded the jurisdiction of the statewide prosecutor. I don't know whether anybody has challenged that under the Florida Constitution. State Attorneys are elected

constitutional officers. I'm not sure the legislature can just take their jurisdiction away, but maybe so. That's a Florida issue I certainly don't know the answer to.

Some of this probably does involve more than one county. Some of these individual plaintiffs are crossing county lines to get to their providers.

Do you know whether it's a statewide prosecutor issue or just a State Attorney issue?

MR. JAZIL: Your Honor, I believe it can become a statewide prosecutor issue as you described it, if they are crossing jurisdictional boundaries from circuit to circuit. I do not believe that this issue would be subsumed within the changes that have been made to the statewide prosecutor jurisdiction. I think those deal with election-related issues, under the theory that elections have a statewide impact beyond one circuit.

THE COURT: All right. Back to the real issues.

MR. JAZIL: Your Honor, I'm happy to begin with whichever issue you would like for me to address first. I know my friend talked about the irreparable harm issues, the equal protection issues, and the due process issues. I can address those in any order that Your Honor would prefer or comment on --

THE COURT: Probably do briefly on irreparable harm. These plaintiffs' doctors certainly think they're going to

suffer irreparable harm.

MR. JAZIL: Yes, Your Honor. I know my friend provided the Court some information about what the doctors may or may not do, but just looking at the record and the affidavits that have been provided, we've got an affidavit from Dr. Rachel Roe, who is Susan Doe's physician. She last saw Susan Doe in November of 2022 and said that the onset of puberty was imminent. She then provided a declaration -- pardon me -- a letter or declaration in April of 2023 saying that *She may have already begun puberty based on my last assessment*, which again was in November of 2022.

I don't think it tells us whether or not the patient has started Tanner Stage 2 puberty. So I make that note, Your Honor.

The other physician's note that is in the record is from Nicole Bruno. She is the physician for Gavin Goe. She last saw Gavin Goe in 2022, it's unclear when, and says that puberty may begin now or within the next few years.

Those are the two physicians who provided letters. We don't have the medical records for these patients in the record.

So, Your Honor, I would simply note that irreparable harm is a high standard. Irreparable harm based on doctors' notes alone, which are a little unclear about whether or not Tanner Stage 2 puberty has begun and treatments must be

administered, is a little vague. All we are left with then are the affidavits from the parents who are then speculating about whether or not Tanner Stage 2 has or has not begun.

So I would submit to the Court that that in and of itself is not enough for irreparable harm.

And if we look at the Dekker case by analog, when we got the medical records for these individuals in the Dekker case, the medical records cut both ways. The medical records include material that supports the prescription of puberty blockers, cross-sex hormones, and surgeries, but then it also supports the perspective of the State, where you have someone who has seen a patient once, that someone is a mental health intern with ten hours of training, and diagnosed someone. You have testimony where someone with lots of both mental and physical comorbidities had a 20-minute consultation about whether or not to use puberty blockers and cross-sex hormones.

And, Your Honor, I note that that experience that we are seeing from the Dekker case is inconsistent with even what the WPATH and Endocrine Society folks suggested the appropriate way to treat these issues. It's broad multidisciplinary teams who take a thorough examination of a person, sometimes over time, weeks, months, years, and then prescribe these treatments.

So, Your Honor, I would submit on the irreparable harm prong, my friends for the plaintiffs have not satisfied

their burden.

Moving on -- well, Your Honor, I would also like to touch briefly on the physician issue. We're speculating at this point that physicians with a PI would or would not issue treatments. I don't know what in the records support that contention. So I would leave it there.

Your Honor, moving on --

THE COURT: Of course, it's clear the only reason they wouldn't provide treatment is because of the State action. Surely, the State can't hold off otherwise appropriate injunctive relief by saying, we're going to prosecute you, and we don't care whether a district judge enters an injunction. It's not quite standing in the schoolhouse door, but it's the same idea, isn't it?

I mean, you really, the State -- I'm right that the State has -- well, you can understand how a doctor would be concerned about the approach the State of Florida has taken to those who oppose the State's position including on gay rights or transgender issues. You got a State Attorney that was fired in an Executive Order that said in so many terms that his position on transgender issues was a reason for the firing. This morning's news -- yesterday's just full of the ongoing spat between the Governor and Disney. There's a lawsuit pending in this court where Disney says, look at all of the changes because we took a position on gay rights or

transgender issues. Just took a position. And the governance of Disney has changed dramatically.

So you can see how a doctor would be concerned and might not think that just a district judge's injunction would be enough to alleviate the concern; isn't that right?

MR. JAZIL: That's true, Your Honor. I think there's a slight little complication in that analysis.

One, Your Honor, "the State" is too broad a phrase as the recent League of Women Voters' case from the Eleventh Circuit pointed out. One can say that the legislature is doing what the governor would like them to do, but the legislature is a separate entity with separate authorities. The constitutional officers who would be charged with implementing the criminal provisions are also separate constitutional officers and as --

THE COURT: Colleagues of the one that got fired.

MR. JAZIL: Yes, Your Honor.

THE COURT: Held the same constitutional position as the one that got fired.

MR. JAZIL: Yes, Your Honor. And the Attorney General is also a separate officer who's separately elected, has separate powers and authorities. The fact that I can't speak for all three of them is indicative of that as well, Your Honor.

THE COURT: Fair enough. But, look, if the problem

is that -- I raise the question, are the doctors really going to do this, we can deal with that. If the conclusion is, on the merits, the plaintiffs are entitled to win; and if they don't get care, they are going to suffer irreparable harm, then we can deal with the so what after that.

I mean, one thing the State has sought to do is to make sure that, even if there is not a doctor in Florida that will provide care, these people can't go anywhere else in the country to get care, right? The State of Florida is trying to make sure that they can't go to Boston and get care.

MR. JAZIL: Your Honor, I will confess, I don't recall reading that in the bill, but --

THE COURT: Well, here's what the bill says, if they just threaten, and I think that means talk about, getting care, we'll take the children away from the parents. Tell me what's the reason for that other than animus. These kids who probably need parental support as much as any kid in the state, and the State of Florida passes a law that says, if the parents even seek out good medical advice, we'll take them away from their parent. What would support that other than just flat animus?

MR. JAZIL: Your Honor, two points there:

One, I am getting up to speed on some of the language in this bill.

Two, that is in Section 1 of the bill which isn't

being challenged here, which deals with child custody issues.

THE COURT: Because these parents aren't going to be intimidated, apparently, and so they haven't come forward and said, oh, we're scared to do what's in the best interest of our children because of this. So it's not challenged here, but it's part of the statute that can certainly be analyzed on the question of animus. And part of what you do to analyze animus is look at this statute and what could support it and what could the State have been thinking. So that's my question:

What could the State have been thinking to say that, if a parent -- it's kind of written in the passive voice backwards and it has the word "threat," but I don't know what that quite means, but it seems to me that, if the parent talks with a doctor, maybe one of these doctors who's testified who provides gender care and is considering thinking about, proposes -- threatens, proposes, in context, I'm not sure what the difference is -- proposes to get care, we can take the child away from the parents. I'm not sure that the statute doesn't say, you can take the kids away just because they brought the lawsuit.

What would be the reason for that?

By the way, the State already has a whole dependency system set up. They've got separate sections in the state court system. Any parent that's not doing what the parent

needs to do, that child can be taken away already.

So with all that dependency background already there, the State passes a statute specifically addressing trans kids that says, if you seek care, we can take the children away from the parents. As I say, it seems to me, animus is an explanation. I'm at a loss to understand what the additional explanation for that provision could be.

MR. JAZIL: Your Honor, a couple of points. As you're going through your animus analysis, yes, in consideration of the whole bill language in its entirety is an appropriate thing for the Court to do.

Second, Your Honor, and I'm happy to file an errata on this, but to the extent that Chapter 61 deals with child custody disputes, and it's a dispute between one parent and another about whether or not to provide these services, and that's the trigger for a child being taken into the custody of the State, if there is a dispute between the two, one explanation could be, well, it's dealing with a minor child, you're dealing with informed consent issues, which are difficult for minor children, and if you have a dispute between two parents, the way to preserve the status quo in that instance, arguably, is to keep the kid from getting the --

THE COURT: So the parents --

MR. JAZIL: -- puberty blockers --

THE COURT: -- are in dispute about whether the kid should go to public school or to a private school, and the State, with its infinite wisdom and better assessment of what's good for a child, thinks, well, we will just take the child away and we'll make the decision. Surely not.

MR. JAZIL: Your Honor, it's different than the public school/private school example. This is at its core whether or not we should have certain treatments for a certain diagnosis; and if that certain treatment --

THE COURT: Parents don't agree about whether to give a COVID vaccine, what we need to do is just have the State take the child away.

MR. JAZIL: Your Honor, if the point is -- I understand the Court is making an example to point out the situation, but, Your Honor, I would posit that if it's a health, safety, welfare issue, and the State says, we are going to take the child away and do a certain treatment on the child because we believe it's in the best interest of the child, there are some instances where that's appropriate.

The due process case from the Eleventh Circuit my friend mentioned. It was a case where a father opposed the use of a catheter, and the State took the kid in custody, did the operation, and then the father sued saying I have substantive due process rights on the care of my child. And part of the discussion from the Eleventh Circuit was, well,

look, if in an emergency, the State needs to take the kid and do a surgery and can't get you on the horn to get your consent, we should be able to do that.

Some of the other Eleventh Circuit cases dealing with mask mandates, the Alabama case that dealt with the mask mandate. Parents are saying we don't want masks, the State saying you should have masks. It was allowed. A 1905 case, shots for influenza, same point, Your Honor, that when it comes to health, safety, welfare, it's a little different than the school-choice example.

THE COURT: It is. And the State of Florida -- I get it, the State thinks, by golly, even though your own expert said, no, no, the State shouldn't be making this decision, the parents should, they ought to get good medical advice, and then the parents and child ought to make the decision, that's what your own expert said, that this care is sometimes the proper care, and that it ought to be up to the parent. But the State says, oh, no, no, we know so much better than the parents and the doctors, we're going to make this decision, and if we have to, we're going to take the kids away. I get it, it's a remarkable position.

I do understand the question is who gets to make the decision. Does the legislature get to make the decision? Do the parents get to make the decision? And then if the legislature decides it really does know better than the

parents, and that the legislature is going to make the decision one size fits all, we've already decided we are going to make the decision, then the question becomes, is that a decision that the legislature is entitled to make? I'm not the medical person, but I am the one that makes the initial decision on the constitutional law question.

MR. JAZIL: Yes, Your Honor. I would like to address some of Dr. Levine's testimony.

As I understood his testimony, there are three major frameworks for treatment here. There's the reparative model, which is sometimes called "conversion therapy," on one end of the continuum. On the other end you have the gender-affirming model that says, we're going to support the kid in the chosen gender, and eventually if the kid needs it, puberty blockers, cross-sex hormones, surgery. And Dr. Levine was advocating sort of the middle ground. This may not be his phrase, but I'll call it the ambivalence model, where you're not trying to get the kid back into the natal sex and you're not trying to affirm the kid in their chosen gender.

So the middle ground, the ambivalence model, is what I thought he was advocating for, Your Honor. And he's laying out choices, and at the end of the day, yes, parents have a role in how those choices are selected, but so do the policymakers in the State, Your Honor, is the position I take. And if at the end of the day, the State is choosing among

those points on the continuum, it can draw a line and say that this is the perspective of the State, and the State in its efforts to manage the health, welfare, safety of its citizens is drawing a line in a certain place. And that is what I would argue the State has done, Your Honor.

THE COURT: What is inconsistent with what the State has done with this view of its action: What the State has decided is that people should not be trans?

MR. JAZIL: Your Honor, I do not think that that is what the State has decided. If we take a look at --

THE COURT: What's inconsistent -- what would the State do differently if what it decided was, being trans is immoral or contrary to our religion, just not to be done, we are flat against trans; these people, in the words of the legislator, are mutants and basically shouldn't exist, so we want to see to it that there are no trans individuals. What would the State have done differently from what it has done?

MR. JAZIL: Your Honor, if we begin with the supposition that every transgender person has gender dysphoria and, therefore, needs these treatments --

THE COURT: That's not true, and your own doctors say that is not true.

MR. JAZIL: That is not true, Your Honor, I agree that is not true. And, again, for purposes of your question, I am assuming that is true to make the point that, if every

transgender person has gender dysphoria and, therefore, needs these treatments, then what the State would do is say, okay, we're going to prohibit these treatments for everyone, not just minors, everyone. Also what the State could do, which is what the testimony is in the Dekker case, not every transgender person has gender dysphoria, what the State could do is say, okay, look, we're going to do the reparative model. All of these psychotherapies that are available for all three models -- reparative, affirmation, and the ambivalence model -- forget all that, we're going to do just the reparative model; that is the only therapy that could be allowed in the State for folks who have transgender health issues.

THE COURT: That would plainly be unconstitutional under the current law of the Circuit, right?

MR. JAZIL: That would, Your Honor, but that is what the State could do if it were trying to suggest that transgenderism itself is the issue.

THE COURT: The State could do that if it wanted to overtly violate the constitution as currently interpreted in the Eleventh Circuit in a case that the anti-trans community won.

MR. JAZIL: Your Honor, states often lay out statutes to set up test cases to take them up on appeal. That seems to be a trend. So, if the question the Court is asking is what

the State could have done --

THE COURT: Fair enough.

MR. JAZIL: So, Your Honor, just sticking to the equal protection issue, the sex-based discrimination argument, the argument is on its face discriminates based on sex. I point out the language in *Adams* talks about sex-based discrimination being discrimination based on biological sex. That is what *Adams* said. Then the analysis becomes, well, okay, why is it that we should have heightened scrutiny when it's not sex-based discrimination or discrimination based on an immunocal characteristic; again, *Adams* talked about immunocal characteristics being the trigger for heightened scrutiny --

THE COURT: *Adams* didn't overrule *Glenn versus Brumby*.

MR. JAZIL: *Adams* did not overrule *Glenn versus Brumby*, nor did it overrule *Bostock*. Both cases, however, talk about sex stereotypes in a workplace environment. In a workplace environment, a man, a woman, a transgender man or transgender woman in employment context, usually no difference, and that would be appropriate. But if we're talking about, again, the health-related aspects, we also had testimony in Dekker, at the chromosomal level, people aren't changing. So, Your Honor, I note that --

THE COURT: Let's use sex to mean sex assigned at

birth or sex determined at the chromosomal level. So here's my question:

A doctor determines that two 15-year-olds need to be treated with testosterone. The doctor prescribes testosterone for each of the two 15-year-olds. It's legal for one; it's illegal for the other. How do we know which one it's legal for and which one it's illegal for? And the answer is, one is a boy and one is a girl assigned at birth, they have different sex. That's the only difference that determines under the Florida statute whether it's legal or illegal; isn't that right?

MR. JAZIL: No, Your Honor. I think under the Florida statute the question becomes: Is it being given to affirm a perception of his or her sex that is inconsistent with the sex that's defined prenatally?

THE COURT: But the only way to answer that question is to know whether it's a boy or a girl. If it's a boy -- using these terms to mean natal sex -- if it's a boy, it's legal; if it's a girl, it's illegal under the statute a hundred percent of the time.

MR. JAZIL: True.

THE COURT: You can't say that in *Adams*, you can't say that in *Geduldig*. And the same thing about nine-year-olds treated with GnRHa. Whether it's legal or not depends on whether it's a natal boy or a natal girl a hundred percent of

the time.

MR. JAZIL: So I take it Your Honor's point that based on the *Geduldig* test and the *Adams* test what we are talking about is sex-based distinctions.

THE COURT: Absolutely. I don't think you'll be able to give me any case where the only difference in the two classes we're talking about for equal protection purposes correspond 100 percent with sex, and the scrutiny applied is not strict. I shouldn't say "strict." Intermediate.

MR. JAZIL: Intermediate. Your Honor, that's fair. A couple of points about that.

One, if we do that analysis and we look at the diagnosis of gender dysphoria rather than sex, and we're doing the analysis to see, okay, if one group includes -- and the point has been made that this is targeted to transsexuals. So if one group includes both gender dysphoria, one group includes both -- includes trans, and the second category is not gender dysphoria, it includes both trans and natal males and natal females, so if it --

THE COURT: But it doesn't, and that's the point. Your doctors said it, and you agreed with it just a minute ago. This doesn't apply just to people with dysphoria. This applies to all trans individuals. So you can be a trans person without dysphoria, but a trans person still in need of puberty blockers and cross-sex hormones to support your trans

identity, and this statute prohibits that. This statute does not allow treatment of people who are trans but not -- but do not have dysphoria.

MR. JAZIL: Understood, Your Honor. And I was making the distinction between gender dysphoria and the sex point that Your Honor made, because the preliminary injunction is seeking to enjoin two different things here. It is seeking to enjoin the statutes, which do not mention gender dysphoria, and the rules, which do mention gender dysphoria.

So if we're doing the analysis for the statute, what Your Honor said, biologic-based sex, intermediate scrutiny, if we're doing the analysis for the Board of Medicine rules -- pardon me, Your Honor, I'm a little under the weather -- they talk about gender dysphoria. So, if we're doing the *Geduldig* and *Adams* analysis for the rule, it would be gender dysphoria is a --

THE COURT: You think under the rule it's okay for a doctor to prescribe puberty blockers and cross-sex hormones for a trans child if the trans child does not have dysphoria. And kind of a follow-up, what planet do you live on? I mean, really? And, look, if all the plaintiffs really needed was a doctor to say this child doesn't have gender dysphoria, and you told these clinics, look, you can treat these kids as long as they don't technically have gender dysphoria, I just don't think that's what the Board of Medicine would say is fine, do

you?

MR. JAZIL: Your Honor, I'm looking at their language:

The following therapies and procedures performed for the treatment of gender dysphoria in minors are prohibited.

If the minor is identifying as trans and the minor -- and, again, trans is a strongly felt sense of self. If the minor has, for example, Klinefelter's disease, an extra chromosome, that would be perfectly appropriate to prescribe them puberty blockers, cross-sex hormones, right? If a child is in the process of detransitioning from one gender to the other, and there could be a tapering off period, a withdrawal period, that would be perfectly appropriate under the rule. So I can think of some samples, but I --

THE COURT: Yeah. I think it goes back to what planet do you live on. I think the idea that the Board of Medicine thought that would be okay is just not it. I think more likely -- I think all of this is consistent with the view that trans without more is just not acceptable. There should not be trans people. They should not be treated. We went through that discussion.

MR. JAZIL: I understand, Your Honor. I would like to pull the equal protection --

THE COURT: Your own expert, I mean, this is some consistent -- you have an expert on that signs on to an *amicus*

brief that says this is a false identity, they are masquerading as the other sex, that kind of language.

MR. JAZIL: I understand, Your Honor. And just to --

THE COURT: I have to say, a lawyer of your caliber, as good as you are, has all of the resources the State has, that's the expert you can find?

Dr. Levine, very helpful I thought. And his testimony in his view would support substantial restrictions on how this kind of medical care is provided. And so, if the concern is, there are people prescribing this stuff after a 20-minute interview, then, by golly, make it illegal to do that. Nobody is saying you can't require good quality medical care as a condition to providing this kind of treatment.

MR. JAZIL: I understand, Your Honor. And another way to take a look at Dr. Levine's testimony, as I'm trying to articulate it as best I can, is, if we agree that there is room for some restrictions to provide this care in a safe, effective manner, then who gets to make that choice? Right?

That choice at the end of the day should be given to the policymakers at the Florida legislature. The Florida legislature decides to draw lines on how to make those choices. Do these lines need to be perfect? No. What is it that those lines need to do? Do those lines need to satisfy the floor set by the constitution? The floor set by the constitution, depending on the treatment -- let's take

abortion for one. It's a highly-charged issue, it's one that spurs passions. Abortions have been around forever. Abortions some have said, and a lot of the medical associations did say in *Dobbs*, is safe, effective, et cetera. But a State can completely bar abortion as its appropriate line-drawing exercise.

THE COURT: They can. And *Dobbs* is not a case -- and I don't think there are any cases -- well, we went through the can you treat the 12-year-old, and *Dobbs* is not an exception to the analysis there. Look, *Dobbs* is an enormously -- abortion is an enormously difficult subject. There is a fetus involved, a potential child involved in the *Dobbs* analysis, and that's not true here.

So I get it. *Dobbs* is the law of the land, and it talks about substantive due process, and on and on, and it talks about equal protection. But it doesn't compel the result here where the facts and the two classes in the equal protection analysis are different.

MR. JAZIL: Your Honor, I bring up abortion in part because the *Geduldig* analysis is also an abortion analysis, right? This is whole class concept we come up with from *Geduldig* to *Dobbs* to *Adams* is based in abortion. And Your Honor made the point, you know, what planet am I living on if I think this is going to affect someone other than trans people, but, again, the argument was made in all three of

those cases -- well, in *Geduldig* and *Dobbs*, look, at the end of the day, abortion only affects women. So it's an intermediate scrutiny --

THE COURT: Yeah, I get it. I should not have asked what planet, that was probably a little too glib. All of this stuff is very serious, and every now and then something glib is a pleasant break in an otherwise way serious discussion.

But I don't think I said -- I used the phrase in the way that -- on the issue that you just said. I used it with respect to the question of whether the rule is different from the statute in its scope, whether the rule would allow a doctor to prescribe a puberty blocker or a cross-sex hormone to a trans child just because the child did not have gender dysphoria. I just don't think anybody would construe the rule that way, and I suspect that the explanation for the reference to gender dysphoria in the rule is because nobody had studied this issue carefully enough or looked at the actual facts and medical situation with enough care to understand that there are trans people who do not have dysphoria. But all of the evidence in the case is that there are indeed trans people who do not have gender dysphoria.

MR. JAZIL: Yes, Your Honor. I think Your Honor understands my position. At the end of the day health, welfare, safety regulations defer to the State.

If Your Honor has additional questions, I'm happy to

answer them.

THE COURT: I did want to ask this:

Carolene Products was decided decades ago. I haven't gone back to look at the date, but it was old when I was in law school, and that was decades ago. But *Carolene Products* footnote four is there, it refers to discrete and insular minorities. The phrase has continued to be referred to, and I don't think anybody has suggested that it's not a construct that is useful in equal protection analysis. So I guess the two-part question is:

First, am I correct that whether a challenged distinction works on a discrete and insular minority is still an appropriate part of the analysis; and, second, aren't trans individuals a discrete and insular minority?

MR. JAZIL: Your Honor, if I could -- you used the phrase "discrete and insular minority," the argument that's made in the papers is that they are a quasi-suspect class. I think functionally the argument is the same.

And there, I pivot to *City of Cleburne* case where Justice Marshall was talking about mentally-handicapped individuals and whether or not they should be treated as a quasi-suspect class and given heightened protections under the constitution; and the Supreme Court said, no. Justice Marshall in his opinion talks about how, for the mentally handicapped, they suffered through Jim-Crow-like issues, long

history of forced sterilizations, all sorts of abuse, et cetera. Even with that history, they weren't given heightened status in an equal protection analysis context.

So I would suggest that, you know, I understand the perspective, but from constitutional tradition, I don't think it crosses the bar to getting heightened protections.

And, Your Honor, I would also point to footnote five in the *Adams* decision where this issue is -- it's dicta. It wasn't decided, but it was touched upon.

THE COURT: Fair enough. And now that you mentioned it, I do recall that, and I will go back and visit it again.

Let me say this about the *City of Cleburne*. First, I think it is a relevant case. I suggest to you, it's very helpful to the plaintiffs, not to the defense. You're right about part of the discussion. There's a lot more to the discussion. The plaintiffs won that case. That is a good example of a case where the Supreme Court said rational basis, but it really has to be rational. Part of the analysis of whether mentally disabled -- that's probably as good a term as any.

MR. JAZIL: I was trying to clean it up, Your Honor.

THE COURT: I understand. At the time they probably used the language "retarded," and we don't use that so much anymore.

Part of the discussion was that class of people has

been able to garner substantial political support. You would be hard-pressed at least lately to point out any substantial political support that the trans community has gotten at least in this State. It also pointed out, which is an important part of the suspect class analysis, that it often is true that treating that class differently makes sense, and so people do get hired based on how smart they are. There are many things that mentally-disabled people can do, many things they cannot.

And so it's not true as it is, for example, for the classic suspect class, race, that the characteristic often is a legitimate basis for different treatment.

You turn to trans individuals, it's a lot more like race. What is the instance where it would be legitimate to treat a trans individual differently? Maybe choosing a bathroom, and that's what *Adams* says. There's privacy concerns of others, and although we don't allow customer preference to support racial discrimination, for example, there are privacy concerns, they are legitimate. There was intermediate scrutiny in the case. But the court held this survived it.

But it's hard to understand why the trans community wouldn't get intermediate scrutiny if there is hardly ever any legitimate basis for treating the trans community differently. What's wrong with that analysis, other than footnote five cuts against it?

MR. JAZIL: Footnote five cuts against it. There's also discussion in the *en banc* opinion in *Adams*. It talks about when heightened scrutiny should apply, and the court -- I don't have the pin citation, Your Honor, but -- the court talks about immutable characteristics. It lays out certain ones that are immutable, such as sex -- biological sex, race, national origin. And, again, Your Honor, I simply point out that the testimony in this case has been, when we're talking about the transgender identity, the deeply held sense of self, and it can change over time. And so, Your Honor, I point out that that discussion would cut against it.

THE COURT: The idea that it's not immutable is a complicated question. It's an easy question if you believe, as some of the people on your side seem to believe, that it's just made up and it's not really a thing; that these people are just masquerading as somebody of the other sex, that it's a false identity, and that theme runs through some of this.

MR. JAZIL: I understand, Your Honor.

THE COURT: It's been a good discussion. I think I'm out of questions, and it's the kind of thing we could talk about for hours.

MR. JAZIL: Your Honor, I would just like to highlight the second part of your question about treating the trans people differently and when would that be appropriate.

And, Your Honor, again, I would posit that it would

be appropriate in the medical context. In an employment context like *Bostock* and *Brumby*, it would not, and that's been settled.

Your Honor, I know you're referring to Dr. Hruz's testimony and some of his *amicus* briefs. Again, the point of his testimony was to talk about the fact that at the chromosomal level things don't change and he critiqued the study. So the chromosomal stuff, I would simply urge the Court to separate from his personal views.

Thank you, Your Honor.

THE COURT: Fair enough. Thank you.

Rebuttal? I think you need to talk to me about the medical records for the particular plaintiffs.

MS. LEVI: Well, I mean, we have, as Mr. Jazil represented, there are letters from the doctors who referred them to endocrine specialists. They weren't able to get appointments, at least the two that had more longstanding referrals.

THE COURT: Here's the concern. I do think that the record suggests that this treatment ought to be provided with great care, with a multidisciplinary approach. I don't think there is anything in the record suggesting that anybody in Florida has been treated any other way. I don't think -- I could be wrong -- I don't think the record has any indication of any actual individual in Florida who has not been

appropriately treated or who has come to regret it. At the earlier administrative stage they had some people from out of state that had some dramatic testimony about how they regretted the treatment they got.

But the record does suggest that this care ought to be provided with care, with a multidisciplinary team. And I do think that, before you get an injunction saying you're entitled to this care, you probably need to establish that indeed this has been through that kind of multidisciplinary approach, and this is not something that was made haphazardly, but a decision that was made appropriately. And I haven't gone back and focused on the actual record on this. What do we have?

MS. LEVI: We have one plaintiff who is under the supervision of the University of Florida, Health Gender Program; we have one client who was referred to Johns Hopkins' Child Adolescence Program; and we have one child who was referred to Nicklaus.

So all of these are patients whose parents are doing what they have been recommended by their pediatricians to do. And what you have are the letters from the doctors showing the referrals to those gender health specialty programs and/or testimony from the parents about the approach that they are taking.

THE COURT: And so when I go back through and

flyspeck the record, I'm going to find that there's a record of long-term care, evaluation? One of the things that Dr. Levine said, some of it certainly rang true, parents know more than the doctors, but parents don't always tell the doctors everything they know. And he was concerned that, if you didn't see the patient over a substantial period of time, you wouldn't necessarily develop the level of trust that you need to make sure you got all of the information, to make sure you are doing this right.

I know the University of Florida because I'm in the State and I know the reputation the institution has. But what's in the record that shows that the gender clinic is providing care at that level, other than just my assumption that the University of Florida surely is doing this right?

MS. LEVI: What you will find in the record is testimony from the parents about the persistent identification of the children. You will see in the record the parents' testimony that they sought care from doctors, that they got an appropriate diagnosis of gender dysphoria, and they are trying to take this next step to ensure that comprehensive evaluation of care. As I said, for one of the plaintiffs, she was able to actually get the blood work to make a determination that she's initiated Tanner 2 stage puberty. We have a child who was turned away, not able to get the blood work done. And so what the injunction we are asking you to issue would do would

not be necessarily an order that's going to, you know, in any way require the next medical step. That's for the judgment of the doctors that these plaintiffs are working with. They can't even get the comprehensive health assessment that would make the determination of readiness.

I mean, what you will see in the record, as I said, for Gavin Goe, he was referred in June of 2022. He had to wait that long period of time, nine months. It's not that atypical to get into the gender specialty health centers in order to get the assessment and then the determination of care. I mean, as you are well aware, this is absolutely not for these parents about just getting an order that then gets this medication. That's exactly what they want, is to be able to move into a facility that has the kind of assessment that would make an appropriate determination for the timeframe for the initiation of puberty blockers.

And so what's in the record is the testimony from the parents of their continued work with medical professionals and doctors, the inability to get into a facility, as I said, except for one who did get the blood work who had the determination that she had initiated puberty.

So it seems to me that would be exactly the kind of careful ongoing assessment we would want these parents to be able to get for their children, not a bar from the State that's going to potentially -- and these parents won't do it

but others might -- turn to alternative less. I mean, I think really what the law does is going to unsettle the ability of parents to get comprehensive multidisciplinary care.

THE COURT: Is there a reason why the defense doesn't have the medical records? I take it, you have the medical records.

MS. LEVI: We don't actually have the comprehensive medical records. I mean, the law was passed -- the law was passed, I understand that we have already challenged the Board of Medicine rules, but what we have, what we are able to get within the time that the law passed and filing the case are the letters from doctors -- two, in this case -- to support the request for the injunction.

But there's evidence to support that the parents have, as I said, been taking cautious careful steps to get to appropriate doctors and get the full comprehensive evaluation. I mean, again, what the law is doing is shutting down the care that is essential to evaluate the appropriateness for initiating treatment.

THE COURT: Oh, I get it. But what we're dealing with here is three specific individuals. Shouldn't it be required as a prerequisite to a preliminary injunction that they have received the kind of full analysis, the multidisciplinary analysis, that the standard of care would require?

MS. LEVI: They can't get the full multidisciplinary analysis. I mean, that's --

THE COURT: Well, I mean, up to this point. I don't know how much of that analysis needs to be done. But I take it that what you want is you would like an order today, and you could see the doctor next week, and a week from today you could have the medicine. Now, maybe that's too fast, maybe it's not. But what you're asking for essentially is for me to clear the roadblock so that you can have the medicine immediately, as soon as you can see the doctor and get approved.

Do you think that, as part of that, there should be a condition -- or, as part of that, I should evaluate whether you have actually had the multidisciplinary workup that you need?

MS. LEVI: I don't, Your Honor. We're asking you to enjoin SB-254 because of the impact that it has on impeding patients' ability to get ongoing care and because of the erosion it's going to have on the entire health infrastructure. If this Court doesn't enjoin the law's application to doctors, there's not going to be a way for these plaintiffs to even get into a facility.

THE COURT: You understand that any injunction is going to be in favor of these three individuals, right? I mean, that's the -- leave out for a minute the general law

that applies to federal judges across the board and how one would analyze this; and, frankly, that's how I have been analyzing this my whole time here, but there's Eleventh Circuit law specifically on this. One of these cases was vacated and remanded. I think it was the Medicaid case, *Rush versus Parham*. I think the injunction in that case -- I think I'm thinking of the right case -- was vacated and remanded to limit the injunction to the specific plaintiffs in the case.

MS. LEVI: Well, I have a couple of things to say. I mean, one is, the relief that the plaintiffs are seeking can really only be gotten with a broad facial injunction, again, because of the impact that the law has on the entire health system. In the *Otto* case the order was a facial injunction upon remand from the Eleventh Circuit enjoin the law, not just an exception from the provision for the doctors that brought the particular challenge to the law.

THE COURT: Let me tell you how I have dealt with this, and I'll hear your input on how I ought to deal with it, but this goes not just for the preliminary injunction but the long-term.

Let me tell you, for example, I had the same sex case, so I was the first federal judge with the challenge to same sex marriage in Florida. I entered a preliminary injunction. I entered the preliminary injunction in favor of the specific plaintiffs in the case. I think that was the

appropriate way to enter the injunction.

The Association of Court Clerks -- one of the defendants was a clerk of court who had to issue the marriage license -- they had a lawyer that told them, look, it's still a crime in Florida to issue a marriage license. If you issue these marriage licenses, we don't really care what Hinkle said, if you issue these marriage licenses, it's going to be a crime, you could be prosecuted.

Well, the court clerk filed a motion for clarification that said, I know I have to issue a license to this couple that wants to get married in Washington County -- a little tiny county out west here in the Panhandle -- do I have to issue the injunction to the others? And I entered an order, which I think correctly set out the law. It was just about a page long, it wasn't much, but I think it correctly set out the law, and you can go find it if you're interested in my view on how this ought to work. And I said, look, my injunction just applies to these plaintiffs, and so you have to comply with the injunction. But the constitution applies to everybody, and the class action rule is in the book, and if we need a defense class, that can be done, too, and there are attorneys' fees provided in the statute. So do what you want. And within 24 hours, I think, the lawyers for the Clerks' Association kind of rethought their position. There's probably more explanations than that than my persuasive order,

but they thought better of it, and everybody complied, and there was not another problem. From that point forward, I thing the same sex marriages have gone forward in the State.

I stayed the order, by the way, until the Supreme Court refused to stay the other Circuit decisions around the country. It was pretty clear to me at that point that the Supreme Court, which way the wind was blowing, and so it wasn't stayed beyond that.

That's different from here. You can put a marriage off. You can't put puberty blockers off. So I understand, the State issue is completely different.

But that's what I think the law is in terms of how the injunction can be framed. So I suspect that, if you get a preliminary injunction, and you might well, it's going to be an injunction just in favor of the three plaintiffs. And part of that is going to be, they need to be able to establish that they are indeed -- they have indeed done what they need to do up to the point of going to clinic that can provide this.

So, I'll give some thought to how that would need to be framed, but you should too, and you might want to consider getting those medical records. The defense is going to get them, right? There's not any question that they can subpoena all of those medical records and get them. You can get them a whole lot faster, and you're the one that's asking to go fast. You probably ought to get those records and turn them over.

You can seal them. They can all be filed under seal. I'll try to put that in my order.

MS. LEVI: I want to correct that we do have the medical records for Gavin Goe. I apologize. I just learned from co-counsel that we do have the medical records now.

THE COURT: I understand. You're not the one that got them, but somebody did.

MS. LEVI: Absolutely. And I want to clarify that for the Court. We have them for Gavin Goe, we have them for Susan Doe, and we will quickly get them for Lisa Loe as well. There is also a document affirming that treatment that's been provided to Susan Doe, the one person that we don't have the medical records for, is provided in a multidisciplinary setting, and that's provided by the clinical doctor, Dr. Bruggeman, at the UF Gender Health Program.

But I do want to go back to the issue about the scope of the injunction. I absolutely understand Your Honor's concern in this context, but I also want to say, there are some very significant differences between access to health care and getting a marriage license. As we talked about, the law is so sweeping in its scope in terms of the threats not just to doctors, but all of the health care providers that are involved in this as well, the APRNs, nurse practitioners, and then -- you know, I appreciate your reference to Section 1, which we are not challenging at this time, but which I suspect

we may challenge in the future, that is so draconian in terms of the risks that anyone takes in terms of accessing this care, that I have great concerns that a narrow preliminary injunction is not going to necessarily effectuate the outcome, because, as I said --

THE COURT: I get it. You don't want the clinic shut down.

MS. LEVI: Or if not shut down, dramatically transformed. I mean, as you know, they're specialty health clinics, it's a small population, there's a degree of high level expertise among the health providers in them. As you know, as we all know, getting a medical appointment is not, unfortunately, as easy as picking up the phone and getting it scheduled, and these are appointments that people waited for for many months that got cancelled.

I feel confident that if we have an injunction, you know, we can work very closely with these families to ensure these kids, adolescents, who are in really dire circumstances that at the moment will provide care, but I don't have the same confidence about the breadth of the understanding of the likely outcome in the case when you have a statute that has 20-year criminal penalties, up to 20-year civil liability for the treatment. And I do think it's more like the outcome in *Otto* where you have a facially unconstitutional statute that's going to dramatically impact the provision of the health care

system, and I'm happy to forward to the Court the follow-on order that was issued after the remand from the Eleventh Circuit in the *Otto* case. And just to say --

THE COURT: I can get it.

MS. LEVI: I know.

THE COURT: I assume it's on the electronic filing system.

MS. LEVI: Yeah. What I want to say is that, the State has no interest in enforcing an unconstitutional law, and given the fact that the statute itself anticipates ongoing continued care even for patients who are receiving care at the time that the law was passed, pending the 60-day adoption of the Board of Medicine rules, the difference here is having an additional small group of adolescents having undisrupted care while this Court resolves the question of the case on the merits.

And I would suggest, particularly looking at the balance of equities here, that a broad facial ruling, given the animus that you focused on, given the language of the statute, given the impact broadly on the health care institutions that are responding to the statute, that the balance of the equities absolutely tips in favor of a broad facial injunction, and that's what we ask the Court for.

THE COURT: All right. Thank you.

The motions are submitted. I take them under

advisement.

I suppose procedurally I should set a deadline for the other defendants to respond. You think you can get them served today, I take it.

MS. LEVI: We can get them served today. I'm told that six have already been executed by the clerk. We are waiting on the other 14. And as soon as that happens, we'll get them served as quickly as we possibly can. We have no interest in delay.

THE COURT: You are waiting on the clerk's office to finish 14 of them. I'm sure they are working on that as quickly as it can be done, but I can assure that they are. You'll want to get them also some kind of scheduling order that I will get done pretty quickly. Just make sure they know that this is pending, so we can get all that done as soon as they can work out their representation and so forth. That won't be immediate. If you have 67 State Attorneys, but maybe not. How many State Attorneys?

MS. LEVI: I think there are 20.

THE COURT: Oh, I'm sorry. There is not one in each county, there is one in each circuit, of course. We had that discussion yesterday.

But you have 20 State Attorneys. The ones you care most about are the three or four or maybe five or six that are actually involved with these three plaintiffs. So it seems to

me what you want is the State Attorney in the circuit where the care would be provided, and the State Attorney probably where the plaintiffs live. So, if you're prioritizing these, get notice to those quickest.

MS. LEVI: Okay. For the record, Your Honor, I can also answer the question you asked me earlier about the multidisciplinary centers where care is provided just so that we have that, given that we are focused on the locations.

So, they include the University of South Florida, Endocrinology Clinic; Orlando Health; Joe DiMaggio in Broward County; Spectrum in Orange County; Nemours in Orange County; Carruthers in Duval County; University of Florida; and University of Miami. So there are extensive number of specialty clinics around the state that are providing the care, and we will hustle to get all of those State Attorneys.

THE COURT: All right. Very good.

Those motions are under advisement. Let's take a 15-minute break. We will start back into the trial in Dekker at 10:20.

(*The proceedings concluded at 10:06 a.m.*)

* * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy are noted within the transcript.

Judy A. Gagnon — 5/21/2023

Judy A. Gagnon, RMR, FCRR — Date

Registered Merit Reporter

Doc. 81

Doe v Ladapo: 4:23-cv-114

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al.,	)	
Plaintiffs,	)	Case No: 4:23cv114
v.	)	Tallahassee, Florida
	)	June 1, 2023
JOSEPH A. LADAPO, in his official capacity as Florida's Surgeon General of the Florida Department of Health, et al.,	)	
	)	2:00 PM
Defendants.	)	

TRANSCRIPT OF TELEPHONIC PROCEEDING
BEFORE THE HONORABLE ROBERT L. HINKLE
UNITED STATES DISTRICT JUDGE
(Pages 1 through 12)

Court Reporter: MEGAN A. HAGUE, RPR, FCRR, CSR
111 North Adams Street
Tallahassee, Florida 32301
megan.a.hague@gmail.com

Proceedings reported by stenotype reporter.
Transcript produced by Computer-Aided Transcription.

APPEARANCES:

For Plaintiffs:

GLBTQ Legal Advocates & Defenders
By: JENNIFER L. LEVI
CHRISTOPHER M. ERCHULL
Attorney at Law
jlevi@glad.org
cerchull@glad.org
18 Tremont Street
Suite 950
Boston, Massachussets 02108

Southern Legal Counsel
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorneys at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

National Center for Lesbian Rights
By: KELLY J. POPKIN
SHANNON MINTER
CHRIS STOLL
Attorneys at Law
kpopkin@nclrights.org
sminter@nclrights.org
cstoll@nclrights.org
870 Market Street
San Francisco, California 94102

Human Rights Campaign Foundation
By: AMI R. PATEL
CYNTHIA C. WEAVER
Attorney at Law
ami.patel@hrc.org
cynthia.weaver@hrc.org
1640 Rhode Island Avenue NW
Suite 950
Washington, DC 20001

APPEARANCES (cont'd):

For Defendants:
Holtzman Vogel Baren, et al.
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street
Suite 500
Tallahassee, Florida 32301

For Defendant Moody:
Attorney General's Office
By: WILLIAM H. STAFFORD, III
Assistant Attorney General
william.stafford@myfloridalegal.com
The Capitol
400 South Monroe Street
Tallahassee, Florida 32399

For Defendant State Attorneys:

Jacobs, Scholz & Wyler, LLC
By: BUDDY JACOBS
Attorney at Law
961687 Gateway Boulevard
Suite 201-1
Fernandina Beach, Florida 32034

P R O C E E D I N G S

(Call to Order of the Court at 2:22 PM on Thursday, June 01, 2023.)

THE COURT: Good afternoon. This is Judge Hinkle.

Let me start by saying two things: First, thank you for being available on short notice; and, second, thank you for your patience as you waited. I've been in the courtroom in another hearing that ran longer than anticipated, so I apologize for starting late with all of you. I know that's a burden, and I appreciate you bearing it.

The agenda for today, first and foremost, is to take stock of where we are in terms of getting notice to the defendants who were added by the recent amendment to the complaint. Both sides were heard on the preliminary injunction motion and procedures, but, of course, the new defendants were not, and so I wanted to give them a chance to be heard.

Maybe I should start with the plaintiffs and get you to tell me who you've served, gotten notice to, and where things stand, whether you have made any agreements with the defense along the lines of what the parties agreed to before the amendment.

MR. MINTER: Thank you, sir. Shannon Minter for the plaintiffs.

We have served all of the new defendants. They have all been served. And we have been able to reach an agreement

with the state attorneys whereby one of them will remain in the case to defend SB 254, and we've agreed to dismiss the others, the 19 others, in exchange for their agreement that they'll abide by the Court's orders.

MR. JACOBS: Your Honor, if I may just say -- this is Buddy Jacobs. I'm general counsel for the Florida Prosecuting Attorney's Association. We represent the 20 state attorneys.

And what was just said is 99 percent correct. We are still finalizing the stipulation and the conditions. We certainly are optimistic. We've done this before with the ACLU case, which you may have heard about which were similar allegations dealing with House Bill 5. This is dealing with Senate Bill 254.

But what was just said is correct. There are 19 that are going to be dismissed based upon the finalization of the stipulation and the conditions, and one will remain in the case, and that's the Fifth Circuit out of Ocala. Bill Gladson is the state attorney. He is on the call today as well.

So that's kind of where we are, Your Honor, in this situation. We ought to have these conditions and stipulation all presented to the Court within the next few days. And it will be by agreement of the 19 state attorneys and the plaintiffs on the other side.

THE COURT: All right. Thank you. That will make the procedures a little easier for everybody.

Does Mr. Gladson want to -- Mr. Gladson may be on the phone. I don't know who is going to represent Mr. Gladson.

MR. JACOBS: I'm going to do that, Your Honor, Buddy Jacobs. I'll be representing Mr. Gladson as well.

THE COURT: Do you want to be heard today on the motion for TRO or preliminary injunction?

MR. JACOBS: No, sir. We will defer to the folks on the defense side.

THE COURT: All right. Meaning the medical -- what I've called --

MR. JACOBS: Yes, sir, all the medical folks.

THE COURT: -- medical defendants?

MR. JACOBS: Yes, sir.

THE COURT: Okay. And then the other new party is the attorney general. Is somebody on the phone for the attorney general, and tell me where the attorney general stands?

MR. STAFFORD: Yes, Your Honor, this is William Stafford for the attorney general.

We have filed a notice of appearance, and we have also filed a motion to dismiss based on standing and the Eleventh Amendment essentially saying that the attorney general is not a proper party because she has no enforcement authority over this statute, either in her capacity as the legal officer -- the State's legal officer, her superintendence over the state attorneys, nor with respect to her authority with respect to the

statewide prosecutor.

THE COURT: I did see that you had filed that, and I guess at this point I've just glanced at it and haven't gone all the way through it. A couple of the plaintiffs, at least, maybe all three of the plaintiffs, who had moved for a temporary restraining order or preliminary injunction get care in a county different from their own.

Doesn't that make the criminal statute within the jurisdiction of the statewide prosecutor?

MR. STAFFORD: Your Honor, that might otherwise be the case, but the statute that -- the statewide prosecutor is a state officer of -- whose jurisdiction is limited. Not only is it limited to crimes involving more than one jurisdiction, it's also -- there are express statutes and chapters over which the statewide prosecutor is given jurisdiction. This statute is not among them nor is Chapter 456 where this statute is located.

So I think without any express jurisdictional grant, there is no possibility for the statewide prosecutor to prosecute any action under this -- the new criminal statute.

THE COURT: All right. You may have taught me something about the statewide prosecutor. It is not enough to bring something within the statewide prosecutor's jurisdiction for it to be a crime that crosses county lines; it also has to be within a separate listing of specific areas?

MR. STAFFORD: Yes, Your Honor. I would -- I will

point to Section 16.56, which creates the Office of Statewide Prosecution, and Section 1(a) lists the statutes and types of statutes over which the statewide prosecutor has jurisdiction. And with those there is -- it lists the statutes or types of statutes over which there is authority, but also -- it also confirms that it requires a multi-circuit involvement. The list is at least 16, but I can represent that looking at this -- looking at it, either through the crimes that are described or the ones that are specifically referenced by statute number, Chapter 456 or 456.52 are not listed among them.

THE COURT: All right. So in due course the plaintiffs will respond to your motion to dismiss.

Do you wish to be heard in any other respect on the motions for a temporary restraining order or preliminary injunction?

MR. STAFFORD: No, Your Honor. We would agree with the position taken by the health defendants in this case otherwise.

THE COURT: All right. I think that answers my question, but let me ask both you and Mr. Jacobs this more specifically. The medical defendants, the original defendants, in the case agreed that the temporary restraining order and preliminary injunction could be adjudicated based not just on the filings of this case, but also based on the record in the Dekker case, a separate case that involves Medicaid

reimbursement for these same procedures. And the record in that case includes the entire transcript of the bench trial that I have conducted and not yet ruled on.

And, Mr. Stafford, I understand you want to be dismissed entirely, but aside from that, do you agree with the medical defendants and plaintiffs' stipulation that the records from Dekker can be considered?

MR. STAFFORD: Your Honor, I would like just an opportunity to review that record. And the only reason being if there is any -- I didn't know if there was any criminal statute involved there because the -- under the jurisdiction of the statewide prosecutor, there may be some crimes involving fraud that might -- if there was a separate criminal provision might be implicated.

So I would not feel comfortable responding at this point. I just need to do a little more exploration.

THE COURT: Fair enough. I don't think there is any criminal claim in that case. That doesn't mean that criminal statutes weren't talked about at some point during the testimony or whatever, but the case does not involve a -- any crime and wouldn't be any different. At the point that that case was filed, there was a rule, so it started off as a challenge to a rule, and it deals with reimbursement payment by the Medicaid system for the procedures.

MR. STAFFORD: Your Honor, just so I can do my due

diligence, I'd like the opportunity, maybe until Monday to file a notice with the Court, you know, agreeing or not agreeing with the stipulation as to Dekker.

THE COURT: Perfect, and that works.

And then, Mr. Jacobs, same question of you.

MR. JACOBS: All right. Mr. Stafford and I work together on many, many cases, and so I would join him in this effort and would like to review the things that we are discussing here today. And I appreciate the opportunity to join him as we move forward on Monday.

THE COURT: All right. Very good.

I think that's all I needed to ask anybody today.

Let me see from the plaintiffs -- ask the plaintiffs whether there is anything else you'd like to bring up or deal with other than I know you are in a -- you'd like a ruling just as soon as I can get it to you.

MR. MINTER: Yes, sir. Just that we do have the plaintiffs' medical records. They are ready to be submitted under seal. And we are -- have circulated a proposed protective order and HIPAA order to defense counsel, and as soon as there is an agreement on that, we will move forward as quickly as we can to get those records to you.

THE COURT: Very good. And to file them under seal you'd probably need to submit hard copies, and then the clerk's office will get them properly sealed. If you can do that as

soon as you can do that, that would be excellent.

In fact, I can tell you that if you want to go ahead and overnight them or whatever to the clerk's office, I can have them filed under seal, pending your agreements with the other side and how you want to deal with it.

MS. LEVI: Thank you, Your Honor.

THE COURT: And I'll alert the clerk's office to be on the lookout so they can get them on file.

Anything else from the plaintiffs?

MS. LEVI: No, sir.

THE COURT: How about the original defendants? I haven't called on you.

Is there anything you'd like to address today?

MR. JAZIL: No, thank you, Your Honor.

This is Mohammad Jazil.

THE COURT: Then for the -- Mr. Jacobs or Mr. Stafford, anything further?

MR. STAFFORD: No, Your Honor.

MR. JACOBS: No, sir, Your Honor. But thank you very much. And I appreciate you letting us appear by telephone. I look much better over telephone than I do by Zoom.

THE COURT: I look just about as bad either place, but I do understand it saves a lot of effort and not have to travel for somebody as quick as this.

Again, thank you for your patience with me.

We are adjourned.

MR. JACOBS: Thank you, Your Honor.

MR. STAFFORD: Thank you, Judge.

(Proceedings concluded at 2:36 PM on Thursday, June 01, 2023.)

* * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy is noted within the transcript.

/s/ Megan A. Hague 6/2/2023

Megan A. Hague, RPR, FCRR, CSR Date
Official U.S. Court Reporter

Doc. 90

Doe v Ladapo: 4:23-cv-114

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

JANE DOE et al.,

Plaintiffs,

v. CASE NO. 4:23cv114-RH-MAF

JOSEPH A. LADAPO et al.,

Defendants.
_____/

PRELIMINARY INJUNCTION

This action presents a constitutional challenge to a Florida statute and rules that (1) prohibit transgender minors from receiving specific kinds of widely accepted medical care and (2) prohibit doctors from providing it. The treatments at issue are GnRH agonists, colloquially known as "puberty blockers," and cross-sex hormones. This order grants a preliminary injunction.

I. Background: the parties, record, and motions

Each of the seven plaintiffs is the parent of a transgender child on whose behalf this action is brought. Three have moved for a temporary restraining order and preliminary injunction. One child's doctors say she needs GnRH agonists now, without delay; doctors for the other two say they will need GnRH agonists soon.

The needs of the other plaintiffs' children are less immediate, so they have not joined the emergency motions.

The defendants are the Florida Surgeon General, the Florida Board of Medicine and its members, the Florida Board of Osteopathic Medicine and its members, the Florida Attorney General, and each of Florida's 20 State Attorneys. The individuals are defendants only in their official capacities. This order refers to the Surgeon General, the Boards, and their members as the "medical defendants." The order refers to the Attorney General and State Attorneys as the "law-enforcement defendants."

The parties have stipulated to submission of the pending motions based on the written filings in this case and the record compiled in a separate case in this court with overlapping issues, *Dekker v. Weida*, No. 4:22cv325-RH-MAF.[1] A complete bench trial has been conducted in that case.

The plaintiffs and the medical defendants have fully briefed the issues in this case and have presented oral argument. The law-enforcement defendants have chosen to rely on the medical defendants and not to present their own briefs or oral argument. The Attorney General has moved to dismiss on procedural grounds applicable only to her; that motion will be addressed in a separate order.

[1] *See* Trial Tr. in *Dekker v. Weida*, No. 4:22cv325, ECF No. 239 at 174–75. Citations including "*Dekker*" refer to the docket in that case.

The motion for a preliminary injunction is ripe for a decision. This moots any need for separate consideration of a temporary restraining order.

II. Preliminary-injunction standards

As a prerequisite to a preliminary injunction, a plaintiff must establish a substantial likelihood of success on the merits, that the plaintiff will suffer irreparable injury if the injunction does not issue, that the threatened injury outweighs whatever damage the proposed injunction may cause a defendant, and that the injunction will not be adverse to the public interest. *See, e.g.*, *Charles H. Wesley Educ. Found., Inc. v. Cox*, 408 F.3d 1349, 1354 (11th Cir. 2005); *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc).

III. Gender identity is real

With extraordinarily rare exceptions not at issue here, every person is born with external sex characteristics, male or female, and chromosomes that match. As the person goes through life, the person also has a gender identity—a deeply felt internal sense of being male or female.[2] For more than 99% of people, the external sex characteristics and chromosomes—the determinants of what this order calls the person's natal sex—match the person's gender identity.[3]

[2] Trial Tr. in *Dekker*, ECF No. 226 at 23–24; Trial Tr. in *Dekker*, ECF No. 238 at 72–73.

[3] Trial Tr. in *Dekker*, ECF No. 227 at 222.

For less than 1%, the natal sex and gender identity are opposites: a natal male's gender identity is female, or vice versa.[4] This order refers to such a person who identifies as female as a transgender female and to such a person who identifies as male as a transgender male. This order refers to individuals whose gender identity matches their natal sex as cisgender.

The elephant in the room should be noted at the outset. Gender identity is real. The record makes this clear. The medical defendants, speaking through their attorneys, have admitted it. At least one defense expert also has admitted it.[5] That expert is Dr. Stephen B. Levine, the only defense expert who has actually treated a significant number of transgender patients. He addressed the issues conscientiously, on the merits, rather than as a biased advocate.

Despite the defense admissions, there are those who believe that cisgender individuals properly adhere to their natal sex and that transgender individuals have inappropriately *chosen* a contrary gender identity, male or female, just as one might choose whether to read Shakespeare or Grisham. Many people with this view tend to disapprove all things transgender and so oppose medical care that supports a person's transgender existence.[6] In this litigation, the medical

[4] *Id.*; *see also* Trial Tr. in *Dekker*, ECF No. 226 at 23–24; Trial Tr. in *Dekker*, ECF No. 228 at 29–31.
[5] *See* Trial Tr. in *Dekker*, ECF No. 239 at 10–11, 31–32, 80–81.
[6] *See* Trial Tr. in *Dekker*, ECF No. 239 at 129–31.

defendants have explicitly acknowledged that this view is wrong and that pushing individuals away from their transgender identity is not a legitimate state interest.

Still, an unspoken suggestion running just below the surface in some of the proceedings that led to adoption of the statute and rules at issue—and just below the surface in the testimony of some of the defense experts—is that transgender identity is not real, that it is made up.[7] And so, for example, one of the defendants' experts, Dr. Paul Hruz, joined an amicus brief in another proceeding asserting transgender individuals have only a "false belief" in their gender identity—that they are maintaining a "charade" or "delusion."[8] Another defense expert, Dr. Patrick Lappert—a surgeon who has never performed gender-affirming surgery—said in a radio interview that gender-affirming care is a "lie," a "moral violation," a "huge evil," and "diabolical."[9] State employees or consultants suggested treatment of transgender individuals is either a "woke idea" or profiteering by the pharmaceutical industry or doctors.[10]

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[7] *See, e.g.*, Pls.' Exs. 284 & 285 in *Dekker*, ECF Nos. 182-21 & 182-22; *see also* Pls.' Ex. 304 in *Dekker*, ECF No. 183-6.

[8] Trial Tr. in *Dekker*, ECF No. 238 at 194–95. Dr. Hruz fended and parried questions and generally testified as a deeply biased advocate, not as an expert sharing relevant evidence-based information and opinions. I do not credit his testimony. I credit other defense experts only to the extent consistent with this opinion.

[9] Trial Tr. in *Dekker*, ECF No. 239 at 129–31.

[10] Pls.' Ex. 304 in *Dekker*, ECF No. 183-6; Pls.' Exs. 284 & 285 in *Dekker*, ECF Nos. 182-21 & 182-22.

Any proponent of the challenged statute and rules should put up or shut up: do you acknowledge that there are individuals with actual gender identities opposite their natal sex, or do you not? Dog whistles ought not be tolerated.

IV. The challenged statute and rules

The challenged parts of the statute and rules apply to patients under age 18.

The statute prohibits the use of "puberty blockers" to "stop or delay normal puberty in order to affirm a person's perception of his or her sex if that perception is inconsistent with the person's [natal] sex." Fla. Stat. § 456.001(9)(a)1.; *see id.* § 456.52. And the statute prohibits the use of "hormones or hormone antagonists to affirm a person's perception of his or her sex if that perception is inconsistent with the person's [natal] sex." *Id.* § 456.001(9)(a)2. The statute makes violation of these provisions a crime and grounds for terminating a healthcare practitioner's license. *See id.* § 456.52(1) & (5).

The statute has exceptions, including, for example, for use of these products during a transition away from them, but the exceptions are not relevant here. And the statute has other provisions, including a prohibition on transgender surgeries, but those provisions, too, are not at issue here.

The challenged rules were adopted by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine. In identical language, the rules prohibit the Boards' licensed practitioners from treating "gender dysphoria in minors" with

"[p]uberty blocking, hormone, or hormone antagonist therapies." Fla. Admin. Code r. 64B8-9.019(1)(b); Fla. Admin Code r. 64B15-14.014(1)(b).

V. The standards of care

Transgender individuals suffer higher rates of anxiety, depression, suicidal ideation, and suicide than the population at large.[11] Some suffer gender dysphoria, a mental-health condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"). The diagnosis applies when specific criteria are met. Among other things, there must be a marked incongruence between one's experienced gender identity and natal sex for at least six months, manifested in specified ways, and clinically significant distress or impairment.[12]

There are well-established standards of care for treatment of gender dysphoria. These are set out in two publications: first, the Endocrine Society Clinical Practice Guidelines for the Treatment of Gender Dysphoria; and second, the World Professional Association for Transgender Health ("WPATH") Standards of Care, version 8.[13] I credit the abundant testimony in this record that these standards are widely followed by well-trained clinicians.[14] The standards are used

[11] Trial Tr. in *Dekker*, ECF No. 226 at 108.
[12] Pls.' Ex. 33 in *Dekker*, ECF No. 175-33 at 2–3; *see also* Trial Tr. in *Dekker*, ECF No. 226 at 25–26; Trial Tr. in *Dekker*, ECF No. 238 at 71.
[13] Defs.' Exs. 16 & 24 in *Dekker*, ECF Nos. 193-16 & 193-24.
[14] Trial Tr. in *Dekker*, ECF No. 226 at 31 (psychiatrist); *id.* at 198 (pediatric endocrinologist); Trial Tr. in *Dekker*, ECF No. 227 at 50–52 (surgeon); *id.* at 106,

by insurers[15] and have been endorsed by the United States Department of Health and Human Services.[16]

Under the standards, gender-dysphoria treatment begins with a comprehensive biopsychosocial assessment.[17] In addition to any appropriate mental-health therapy, there are three types of possible medical intervention, all available only to adolescents or adults, never younger children.[18]

First, for patients at or near the onset of puberty, medications known as GnRH agonists can delay the onset or continuation of puberty and thus can reduce the development of secondary sex characteristics inconsistent with the patient's gender identity—breasts for transgender males, whiskers for transgender females, changes in body shape, and other physical effects.[19]

Second, cross-sex hormones—testosterone for transgender males, estrogen for transgender females—can promote the development and maintenance of characteristics consistent with the patient's gender identity and can limit the development and maintenance of characteristics consistent with the patient's natal

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112–14 (pediatrician, bioethicist, medical researcher); Trial Tr. in *Dekker*, ECF No. 228 at 15 (physician specializing in pediatrics and adolescent medicine).

[15] Trial Tr. in *Dekker*, ECF No. 227 at 243–44.

[16] *See* Defs.' Ex. 2 in *Dekker*, ECF No. 193-2.

[17] *See* Trial Tr. in *Dekker*, ECF No. 226 at 42–43.

[18] Trial Tr. in *Dekker*, ECF No. 238 at 72 & 74–75; *see also* Trial Tr. in *Dekker*, ECF No. 228 at 14; Trial Tr. in *Dekker*, ECF No. 226 at 36 & 176.

[19] *See* Trial Tr. in *Dekker*, ECF No. 226 at 194–97; Trial Tr. in *Dekker*, ECF No. 228 at 27–28.

sex.[20] For patients treated with GnRH agonists, use of cross-sex hormones typically begins when use of GnRH agonists ends.[21] Cross-sex hormones also can be used later in life, regardless of whether a patient was treated with GnRH agonists.

Third, for some patients, surgery can align physical characteristics with gender identity, to some extent.[22] The most common example: mastectomy can remove a transgender male's breasts. Perhaps 98% of all such surgeries are performed on adults, not minors.[23]

The motions now before the court deal directly only with GnRH agonists. The motions deal indirectly with cross-sex hormones, because to achieve their intended result, GnRH agonists are ordinarily followed by cross-sex hormones. The motions do not present any issue related to surgeries.

VI. General acceptance of the standards of care

The overwhelming weight of medical authority supports treatment of transgender patients with GnRH agonists and cross-sex hormones in appropriate circumstances. Organizations who have formally recognized this include the American Academy of Pediatrics, American Academy of Child and Adolescent

[20] Trial Tr. in *Dekker*, ECF No. 226 at 217–26, 228.
[21] *See* Trial Tr. in *Dekker*, ECF No. 228 at 87–90.
[22] *See* Trial Tr. in *Dekker*, ECF No. 227 at 42.
[23] *See* Trial Tr. in *Dekker*, ECF No. 227 at 43.

Psychiatry, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Psychiatric Association, and at least a dozen more.[24] The record also includes statements from hundreds of professionals supporting this care.[25] At least as shown by this record, not a single reputable medical association has taken a contrary position.

These medications—GnRH agonists, testosterone, and estrogen—have been used for decades to treat other conditions. Their safety records and overall effects are well known. The Food and Drug Administration has approved their use, though not specifically to treat gender dysphoria.[26]

GnRH agonists are routinely used to treat patients with central precocious puberty—children who have begun puberty prematurely—as well as, in some circumstances, endometriosis and prostate cancer.[27] Central precocious puberty presents substantial health risks and ordinarily should be treated. GnRH agonists are an appropriate treatment, even though GnRH agonists have attendant risks.[28]

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[24] *See* Pls.' Exs. 36–43, 45–48 in *Dekker*, ECF Nos. 175-36 through 176-8 (omitting ECF No. 176-4).
[25] *See* Amicus Brief of American Academies and Health Organizations, ECF No. 36-1; Bruggeman et al., *We 300 Florida health care professionals say the state gets transgender guidance wrong* (Apr. 27, 2022), *Dekker* ECF No. 11-1 at 11–32.
[26] *See* Trial Tr. in *Dekker*, ECF No. 226 at 183; *see also* Trial Tr. in *Dekker*, ECF No. 239 at 54–56.
[27] Trial Tr. in *Dekker*, ECF No. 226 at 183–84, 200–02.
[28] *Id.*

So, too, gender dysphoria presents substantial health risks and ordinarily should be treated.[29] For some patients, GnRH agonists are an appropriate treatment, even though, just as with their use to treat central precocious puberty and other conditions, GnRH agonists have attendant risks.[30]

The medical defendants say the risks attendant to use of GnRH agonists to treat central precocious puberty or to treat gender dysphoria are not identical, and that may be so. But it is still true that for gender dysphoria, just as for central precocious puberty, GnRH agonists are an effective treatment whose benefits can outweigh the risks.

The same is true for cross-sex hormones. Testosterone and estrogen are routinely used to treat cisgender patients in appropriate circumstances.[31] The medications are an effective treatment for conditions that should be treated, even though the medications have attendant risks.[32] That is so for cisgender and transgender patients alike. For some transgender patients, cross-sex hormones are an appropriate treatment.

Even the defendants' expert Dr. Levine testified that treatment with GnRH agonists and cross-sex hormones is sometimes appropriate.[33] He would demand

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[29] *Id.*
[30] *Id.* at 201–16.
[31] *Id.* at 216.
[32] *Id.* at 218–29.
[33] Trial Tr. in *Dekker*, ECF No. 239 at 81–83.

appropriate safeguards, as discussed below, but he would not ban the treatments.[34] Nothing in this record suggests these plaintiffs do not qualify for treatment under Dr. Levine's proposed safeguards.

VII. Clinical evidence supporting the standards of care

The record includes testimony of well-qualified doctors who have treated thousands of transgender patients with GnRH agonists and cross-sex hormones over their careers and have achieved excellent results. I credit the testimony of Dr. Dan Karasic (psychiatrist), Dr. Daniel Shumer (pediatric endocrinologist), Dr. Aron Janssen (child and adolescent psychiatrist), Dr. Johanna Olson-Kennedy (specialist in pediatrics and adolescent medicine), and Dr. Armand Antommaria (pediatrician and bioethicist). I credit their testimony that denial of this treatment will cause needless suffering for a substantial number of patients and will increase anxiety, depression, and the risk of suicide.

The clinical evidence would support, though certainly not mandate, a decision by a reasonable patient and parent, in consultation with properly trained practitioners, to use GnRH agonists at or near the onset of puberty and to use cross-sex hormones later, even when fully apprised of the current state of medical knowledge and all attendant risks. There is no rational basis for a state to categorically ban these treatments.

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[34] *Id.* at 91–94.

The record includes no evidence that these treatments have caused substantial adverse clinical results in properly screened and treated patients.

VIII. The plaintiffs

The plaintiffs and their children are proceeding under pseudonyms. The plaintiffs seeking a preliminary injunction are Jane Doe on behalf of Susan Doe, Gloria Goe on behalf of Gavin Goe, and Linda Loe on behalf of Lisa Loe.

A. Susan Doe

Susan Doe is an 11-year-old transgender girl. From a young age, she consistently told her mother she was a girl. She experienced extreme anxiety and distress about wearing boys' clothing.[35] Her mother sought help from a pediatrician, who said Susan should be allowed to dress and play as made her comfortable. Despite fears, her mother allowed her to wear girls' clothes and socially transition. This made Susan a "different child" who was "happy, glowing, [and] secure."[36]

Susan's school peers know her as a girl.[37] They do not know she is transgender. Her legal documentation and government-issued identification say she is female.[38]

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[35] Jane Doe Decl., ECF No. 30-1 at 2–3 ¶ 8.
[36] *Id.* at 3 ¶ 12.
[37] *Id.* at 4 ¶ 14.
[38] *Id.* ¶ 16.

Susan's treating professionals have included the physician at the Pentagon who oversees the United States military's transgender health program[39] and a multidisciplinary team at the University of Florida Health Youth Gender Program.[40] All of Susan's providers have determined GnRH agonists will be medically necessary when she begins puberty—that is, when she reaches the puberty classification denominated Tanner stage II. This could happen any day.[41]

The statute and rules at issue, unless enjoined, will force Susan to go through male puberty. This will "out" her as transgender to her peers and will have devasting physical, emotional, and psychological effects.

B. Gavin Goe

Gloria Goe is the mother of Gavin Goe, an eight-year-old transgender boy. From a very young age, Gavin wanted short hair, masculine clothing, and a boy's name. He experienced distress and asked his mother why no one believed he was a boy.[42] His mother came to understand Gavin was transgender, and she sought to learn how best to support and love her child. She allowed Gavin to socially

[39] *Id.* at 4–5 ¶ 17.
[40] *Id.* at 5 ¶¶ 18–19.
[41] *Id.* at 6 ¶ 20.
[42] Gloria Goe Decl., ECF No. 30-3 at 3 ¶ 10.

transition, including by using a boy's name and wearing boy's clothing.[43] Gavin's teacher, counselor, and principal know Gavin is transgender, but his peers do not.[44]

Gavin's pediatrician referred him to a psychologist for treatment of gender dysphoria, anxiety, and depression.[45] Now, at age eight, Gavin is younger than the average age of puberty onset, but his sister began puberty at age nine, so Gavin, too, may begin puberty early.[46] The pediatrician has referred Gavin to a pediatric endocrinologist at the Johns Hopkins Children's Hospital gender clinic in St. Petersburg, Florida, to assess possible treatment with GnRH agonists.[47] Gavin had an appointment, but it was canceled when the Board of Medicine adopted the rule prohibiting doctors from providing this kind of care.[48]

C. Lisa Loe

Linda Loe is the mother of Lisa Loe, an 11-year-old transgender girl. Lisa has always gravitated toward interests and activities more stereotypically associated with girls. At age 9, Lisa told her mother she was a girl.

Lisa suffered gender dysphoria.[49] Her family sought the care of a psychologist. Lisa was allowed to socially transition, and her happiness and well-

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[43] *Id.* ¶ 11.
[44] *Id.* at 3–4 ¶ 14.
[45] *See* ECF No. 86 at 9.
[46] Gloria Goe Decl., ECF No. 30-3 at 4 ¶ 15; *see id.* at 8.
[47] Gloria Goe Decl., ECF No. 30-3 at 4 ¶ 17; *see also* ECF No. 86 at 9.
[48] Gloria Goe Decl., ECF No. 30-3 at 4 ¶ 17.
[49] Linda Loe Decl., ECF No. 30-2 at 3 ¶ 7.

being improved.[50] But her classmates and teachers continued to treat her as a boy, causing more distress. Her mother eventually decided to move Lisa to a more supportive and inclusive school.

Lisa's pediatrician referred her to a pediatric endocrinologist who specializes in the treatment of gender dysphoria.[51] The endocrinologist in turn referred Lisa to a gender clinic.[52] She has begun puberty and needs GnRH agonists without further delay.[53]

Lisa has become extremely anxious as her puberty progresses.[54]

D. Findings on appropriate treatment

I find, based on the record now before the court, that the plaintiffs are likely to succeed on their claim that they have obtained appropriate medical care for their children to this point, that qualified professionals have properly evaluated the children's medical conditions and needs in accordance with the well-established standards of care, and that the plaintiffs and their children, in consultation with their treating professionals, have determined that the benefits of treatment with GnRH agonists, and eventually with cross-sex hormones, will outweigh the risks. I find that the plaintiffs' ability to evaluate the benefits and risks of treating their

[50] *Id.*
[51] *Id.* at 4 ¶ 10.
[52] ECF No. 86 at 1–2.
[53] Linda Loe Decl., ECF No. 30-2 at 4 ¶ 11; *see also* ECF No. 86 at 2.
[54] Linda Loe Decl., ECF No. 30-2 at 5 ¶ 12.

individual children this way far exceeds the ability of the State of Florida to do so. I find that the plaintiffs' motivation is love for their children and the desire to achieve the best possible treatment for them. This is not the State's motivation.

IX. Equal protection

The plaintiffs assert banning treatment with GnRH agonists and cross-sex hormones violates the Fourteenth Amendment's Equal Protection Clause. The only circuit that has addressed the issue agrees. In *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022), the Eighth Circuit affirmed a preliminary injunction against enforcement of an Arkansas statute identical in relevant respects to the statute at issue here. The decision is on point, well reasoned, and should be followed. But as an Eighth Circuit decision, it is not binding.

A. Introduction to levels of scrutiny

Equal-protection analysis often starts with attention to the appropriate level of scrutiny: strict, intermediate, or rational-basis.

There was a time when the Supreme Court seemed to treat strict scrutiny and rational basis as exhaustive categories of equal-protection review. A leading commentator said that in some situations the first category was "'strict' in theory and fatal in fact" while the second called for "minimal scrutiny in theory and virtually none in fact." Gerald Gunther, *The Supreme Court, 1971 Term—*

Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection, 86 Harv. L. Rev. 1, 8 (1972).

But in the decades since, the Supreme Court has applied *intermediate* scrutiny in many circumstances. And rational-basis review no longer means virtually no review. *See, e.g.*, *Romer v. Evans*, 517 U.S. 620, 632 (1996) (striking down, for lack of a legitimate rational basis, a state law restricting local ordinances protecting gays: "[E]ven in the ordinary equal protection case calling for the most deferential of standards, we insist on knowing the relation between the classification adopted and the object to be attained."); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 447–50 (1985) (striking down, for lack of a legitimate rational basis, an ordinance requiring group-care facilities for the mentally handicapped, but not other facilities with multiple occupants, to obtain land-use permits); *Hooper v. Bernalillo Cnty. Assessor*, 472 U.S. 612, 623 (1985) (striking down, for lack of a legitimate rational basis, a tax exemption for Vietnam War veterans limited to those who resided in the state on May 8, 1976); *United States Dep't of Agric. v. Moreno*, 413 U.S. 528 (1973) (striking down, for lack of a legitimate rational basis, a statute denying food stamps to members of a household with unrelated members).

In short, regardless of the level of scrutiny, there is no substitute for careful, unbiased, intellectually honest analysis. Still, the level of scrutiny matters, so this order addresses it.

B. Intermediate scrutiny applies here

The plaintiffs say the challenged statute and rules discriminate on the basis of sex and transgender status and that either alone would be sufficient to trigger intermediate scrutiny. The defendants say only rational-basis scrutiny applies. The plaintiffs have the better of it.

1. Sex

It is well established that drawing lines based on sex triggers intermediate scrutiny. *See, e.g.*, *United States v. Virginia*, 518 U.S. 515, 533 (1996); *Adams v. St. Johns Cnty.*, 57 F.4th 791 801 (11th Cir. 2022) (en banc). If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex. *See, e.g.*, *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1737 (2020); *Adams*, 57 F.4th at 801. The defendants do not deny this; instead, they say the challenged statute does not draw a line based on sex.

But it does. Consider an adolescent, perhaps age 16, that a physician wishes to treat with testosterone. Under the challenged statute, is the treatment legal or illegal? To know the answer, one must know the adolescent's sex. If the adolescent is a natal male, the treatment is legal. If the adolescent is a natal female, the

treatment is illegal. This is a line drawn on the basis of sex, plain and simple. *See Brandt*, 47 F.4th at 669 ("Because the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law, [the law] discriminates on the basis of sex."); *Adams*, 57 F.4th at 801 (applying intermediate scrutiny to a policy under which entry into a designated bathroom was legal or not depending on the entrant's natal sex).

In asserting the contrary, the defendants note that the reason for the treatment—the diagnosis—is different for the natal male and natal female. Indeed it is. But this does not change the fact that this is differential treatment based on sex. The *reason* for sex-based differential treatment is the purported *justification* for treating the natal male and natal female differently—the justification that must survive intermediate scrutiny. One can survive—but cannot avoid—intermediate scrutiny by saying there is a good reason for treating a male and female differently.

2. Gender nonconformity

Drawing a line based on gender nonconformity—this includes transgender status—also triggers intermediate scrutiny. *See Glenn v. Brumby*, 663 F.3d 1313, 1316 (11th Cir. 2011). Although the defendants deny it, the statute and rules at issue draw lines based on transgender status. *See Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1147 (M.D. Ala. 2022) (citing *Glenn*, 663 F.3d at 1317).

To confirm this, consider a child that a physician wishes to treat with GnRH agonists to delay the onset of puberty. Is the treatment legal or illegal? To know the answer, one must know whether the child is cisgender or transgender. The treatment is legal if the child is cisgender but illegal if the child is transgender, because the statute prohibits GnRH agonists only for transgender children, not for anyone else. The theoretical but remote-to-the-point-of-nonexistent possibility that a child will be identified as transgender before needing GnRH agonists for the treatment of central precocious puberty does not change the essential nature of the distinction.

Adverse treatment of transgender individuals should trigger intermediate scrutiny for another reason, too. In *United States v. Carolene Products Co.*, 304 U.S. 144, 152 n.4 (1938), the Court suggested heightened scrutiny might be appropriate for statutes showing "prejudice against discrete and insular minorities." Courts have continued to apply the discrete-and-insular-minority construct. *See, e.g.*, *Foley v. Connelie*, 435 U.S. 291, 294–95 (1978) (citing *Carolene Products* and noting that "close scrutiny" applies to equal-protection claims of resident aliens, who lack access to the political process); *Estrada v. Becker*, 917 F.3d 1298, 1310 (11th Cir. 2019) (citing *Carolene Products*; recognizing that, under *Foley*, heightened scrutiny applies to resident aliens; but declining to afford the same

treatment to illegal immigrants). Transgender individuals are a discrete and insular minority.

The Supreme Court further explained this basis for heightened scrutiny in *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 447–50 (1985). There the Court declined to extend strict or even intermediate scrutiny to intellectually disabled individuals—those with very limited mental ability. But the Court gave two explanations that support a different result for transgender individuals.

First, *City of Cleburne* noted that strict scrutiny applies when the characteristic at issue is almost never a legitimate reason for governmental action. Race is the paradigm—leaving aside affirmative action as a remedy for prior discrimination, it is almost never appropriate to parcel out government benefits or burdens based on race. Transgender status is much the same. Transgender status is rarely an appropriate basis on which to parcel out government benefits or burdens.

Second, *Carolene Products* and *Foley* both referred to a minority's lack of political voice as a basis for heightened scrutiny. *City of Cleburne* noted that the class of intellectually disabled individuals had garnered considerable public and political support—that this was not a class lacking political access. The same is not true of transgender individuals, who continue to suffer widespread private opprobrium and governmental discrimination, notably in the statute and rules now under review. This is precisely the kind of government action, targeted at a discrete

and insular minority, for which heightened scrutiny is appropriate. *See Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020) (holding transgenders are a quasi-suspect class); *Karnoski v. Trump*, 926 F.3d 1180, 1201 (9th Cir. 2019) (same). *But see Adams*, 57 F.4th at 803 n.5 (noting that whether transgender status is a quasi-suspect class was not at issue there but, in dictum, expressing "grave doubt").

In any event, *City of Cleburne* is important for another reason, too. The Court applied rational-basis scrutiny, but it was *meaningful* rational-basis scrutiny. The Court did not blindly accept a proffered reason for the city's action that did not withstand meaningful analysis. The defendants' proffered reasons here, like those in *City of Cleburne*, do not withstand meaningful analysis. *See Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022) (affirming a preliminary injunction and holding the plaintiffs were likely to prevail on their equal-protection challenge to an Arkansas statute banning gender-affirming care for minors); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131 (M.D. Ala. May 13, 2022) (granting a preliminary injunction and holding plaintiffs were likely to prevail on their equal-protection and parental-rights challenge to Alabama's ban on puberty blockers and cross-sex hormones).

3. Cases involving identical, not different, treatment of classes

In opposing heightened scrutiny, the defendants cite *Geduldig v. Aiello*, 417 U.S. 484 (1974), for the proposition that heightened scrutiny does not apply when there are members of the allegedly disfavored class on both sides of the challenged classification. *Geduldig* held that exclusion of pregnancy from state employees' health coverage was not sex discrimination. Some women become pregnant, some do not. The defendants say this is why the challenged provision did not discriminate based on sex—there were women on both sides. Note, though, that men and women were treated the same: nobody had health coverage for pregnancy. When men and women are treated the same, the Court reasoned, it is not intentional sex discrimination, even if the challenged provision has a disparate impact.

The situation is different here. Transgender and cisgender individuals are not treated the same. Cisgender individuals can be and routinely are treated with GnRH agonists, testosterone, or estrogen, when they and their doctors deem it appropriate. Not so for transgender individuals—the challenged statute and rules prohibit it. To know whether treatment with any of these medications is legal, one must know whether the patient is transgender. And to know whether treatment with testosterone or estrogen is legal, one must know the patient's natal sex.

This is differential treatment based on sex and transgender status. *Geduldig* is not to the contrary. Intermediate scrutiny applies.

C. Applying the proper level of scrutiny

To survive intermediate scrutiny, a state must show that its classification is substantially related to a sufficiently important interest. *Adams*, 57 F.4th at 801 (cleaned up); *see also Glenn*, 663 F.3d at 1316. To survive rational-basis scrutiny, a state must show a rational relationship to a legitimate state interest. *Romer*, 517 U.S. at 631. The challenged statute and rules survive neither level of scrutiny.

The record establishes that for some patients, including the three now at issue, a treatment regimen of mental-health therapy followed by GnRH agonists and eventually by cross-sex hormones is the best available treatment. These patients and their parents, in consultation with their doctors and multidisciplinary teams, have rationally chosen this treatment. The State of Florida's decision to ban the treatment is not rationally related to a legitimate state interest.

Dissuading a person from conforming to the person's gender identity rather than to the person's natal sex is not a legitimate state interest. The medical defendants have acknowledged this.[55] But the state's disapproval of transgender status—of a person's gender identity when it does not match the person's natal

[55] Trial Tr. in *Dekker*, ECF No. 242 at 97–98.

sex—was a substantial motivating factor in enactment of the challenged statute and rules.

Discouraging individuals from pursuing their gender identities, when different from their natal sex, was also a substantial motivating factor. In a "fact sheet," the Florida Department of Health asserted social transitioning, which involves no medical intervention at all, should not be a treatment option for children or adolescents.[56] Nothing could have motivated this remarkable intrusion into parental prerogatives other than opposition to transgender status itself.

State action motivated by purposeful discrimination, even if otherwise lawful, violates the Equal Protection Clause. *See Adams*, 57 F.4th at 810 (recognizing that an otherwise neutral law still violates the Equal Protection Clause when it is "motivated by 'purposeful discrimination'") (citing *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 274 (1979)); *see also Greater Birmingham Ministries v. Sec'y of State for Ala.*, 992 F.3d 1299, 1321–22 (11th Cir. 2021). The statute and rules at issue were motivated in substantial part by the plainly illegitimate purposes of disapproving transgender status and discouraging individuals from pursuing their honest gender identities. This was purposeful discrimination against transgenders.

The plaintiffs are likely to succeed on their equal-protection claim.

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[56] Defs.' Ex. 5 in *Dekker*, ECF No. 193-5 at 1.

X. Parental rights

The plaintiffs also assert a claim under the Due Process Clause, which protects a parent's right to control a child's medical treatment. *See, e.g.*, *Troxel v. Granville*, 530 U.S. 57 (2000) (plurality); *Parham v. J.R.*, 442 U.S. 584, 602–03 (1979); *Maddox v. Stephens*, 727 F.3d 1109, 1118–19 (11th Cir. 2013); *Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990).

The defendants say a parent's right to control a child's medical treatment does not give the parent a right to insist on treatment that is properly prohibited on other grounds. Quite so. If the state could properly prohibit the treatments at issue as unsafe, parents would have no right to override the state's decision. But as set out above, there is no rational basis, let alone a basis that would survive heightened scrutiny, for prohibiting these treatments in appropriate circumstances.

The plaintiffs are likely to prevail on their parental-rights claim.

XI. The pretextual justifications for the statute and rules

In support of their position, the defendants have proffered a laundry list of purported justifications for the statute and rules. The purported justifications are largely pretextual and, in any event, do not call for a different result.

A. "Low quality" evidence

A methodology often used for evaluating medical studies—for evaluating research-generated evidence on the safety and efficacy of any given course of

treatment—is known as Grading of Recommendations, Assessment, Development, and Evaluation ("GRADE"). The defendants stridently assert that the evidence supporting the treatments at issue is "low" or "very low" quality as those terms are used in the GRADE system. But the evidence on the other side—the evidence purportedly showing these treatments are ineffective or unsafe—is far weaker, not just of "low" or "very low" quality. Indeed, evidence suggesting these treatments are ineffective is nonexistent.

The choice these plaintiffs face is binary: to use GnRH agonists and cross-sex hormones, or not. It is no answer to say the evidence on the yes side is weak when the evidence on the no side is weaker or nonexistent. There is substantial and persuasive, though not conclusive, research showing favorable results from these treatments.[57] A decision for the three patients at issue cannot wait for further or better research; the treatment decision must be made now.

Moreover, the fact that research-generated evidence supporting these treatments gets classified as "low" or "very low" quality on the GRADE scale does not mean the evidence is not persuasive, or that it is not the best available research-generated evidence on the question of how to treat gender dysphoria, or that medical treatments should not be provided consistent with the research results and clinical evidence.

[57] *See, e.g.*, Trial Tr. in Dekker, ECF No. 228 at 41–42.

It is commonplace for medical treatments to be provided even when supported only by research producing evidence classified as "low" or "very low" on this scale.[58] The record includes unrebutted testimony that only about 13.5% of accepted medical treatments across all disciplines are supported by "high" quality evidence on the GRADE scale.[59] The defendants' assertion that treatment should be banned based on the supporting research's GRADE score is a misuse of the GRADE system.

We put band-aids on cuts to keep dirt out not because there is "high" quality research-generated evidence supporting the practice but because we know, from clinical experience, that cuts come with a risk of infection and band-aids can reduce the risk.

Gender dysphoria is far more complicated, and one cannot know, with the same level of confidence, how to treat it. But there is now extensive clinical experience showing excellent results from treatment with GnRH agonists and cross-sex hormones. If these treatments are prohibited, many patients will suffer needlessly.[60] The extensive clinical evidence is important and indeed persuasive

[58] *See* Trial Tr. in *Dekker*, ECF No. 227 at 98–101.
[59] Trial Tr. in *Dekker*, ECF No. 226 at 68–69.
[60] Trial Tr. in *Dekker*, ECF No. 226 at 64; Trial Tr. in *Dekker*, ECF No. 238 at 97–98.

evidence, even if the supporting research has produced only "low" or "very low" quality evidence on the GRADE scale.

When facing a binary decision to use or not use GnRH agonists or hormones, a reasonable decisionmaker would consider the evidence on the yes side, as well as the weaker evidence on the no side. Calling the evidence on the yes side "low" or "very low" quality would not rationally control the decision.

B. Risks attendant to treatment

The defendants assert there are risks attendant to treatment with GnRH agonists and cross-sex hormones. Indeed there are. There are legitimate concerns about fertility and sexuality that a child entering puberty is not well-equipped to evaluate and for which parents may be less-than-perfect decisionmakers. There is a risk of misdiagnosis, though the requirement in the standards of care for careful analysis by a multidisciplinary team should minimize the risk. There is a risk that a child later confronted with the bias that is part of our world will come to believe it would have been better to try to pass as cisgender.

There also are studies suggesting not that there *are* but that there *may be* additional medical risks. An unreplicated study found that sheep who took GnRH agonists became worse at negotiating a maze, at least for a time. Another study showed a not-statistically-significant but nonetheless-concerning decrease in IQ among cisgender children treated for central precocious puberty with GnRH

agonists. These and other studies cited by the defendants would surely be rated low or very-low quality on the GRADE scale and, more importantly, are not very persuasive. The latter study has not led to a ban on the use of GnRH agonists to treat central precocious puberty. One cannot know from these studies whether treating transgender adolescents with GnRH agonists will cause comparable adverse results in some patients. But the risk that they will is a risk a decisionmaker should reasonably consider.

That there are risks does not end the inquiry. There are also substantial benefits for the overwhelming majority of patients treated with GnRH agonists and cross-sex hormones. And there are risks attendant to *not* using these treatments, including the risk—in some instances, the near certainty—of anxiety and depression and even suicidal ideation. The challenged statute ignores the benefits that many patients realize from these treatments and the substantial risk posed by foregoing the treatments—the risk from failing to pursue what is, for many, the most effective available treatment of gender dysphoria. One of the *Dekker* plaintiffs attempted suicide four times before beginning successful treatment with cross-sex hormones; he is now thriving.[61]

If the three plaintiffs at issue here do not start GnRH agonists soon, they will go through puberty consistent with their natal sex. They will live with the

[61] Trial Tr. in *Dekker*, ECF No. 228 at 150 & 166–67.

consequences for the rest of their lives. The likelihood is very high that they will suffer attendant adverse mental-health consequences. If, on the other hand, they *do* get GnRH agonists, they will avoid some of the adverse consequences. They also will face attendant risks.

Risks attend many kinds of medical treatment, perhaps most. Ordinarily it is the patient, in consultation with the doctor, who weighs the risks and benefits and chooses a course of treatment. What is remarkable about the challenged statute and rules is not that they address medical treatments with both risks and benefits but that they arrogate to the state the right to make the decision. And worse, the statute and rules make the same decision for everybody, without considering any patient's individual circumstances. The statute and rules do this in contravention of widely accepted standards of care.

That there are risks of the kind presented here is not a rational basis for denying patients the option to choose this treatment.

C. Bias in medical organizations

The defendants say the many professional organizations that have endorsed treatment of gender dysphoria with GnRH agonists and hormones all have it wrong. The defendants say, in effect, that the organizations were dominated by individuals who pursued good politics, not good medicine.

If ever a pot called a kettle black, it is here. The statute and the rules were an exercise in politics, not good medicine.

This is a politically fraught area. There has long been, and still is, substantial bigotry directed at transgender individuals. Common experience confirms this, as does a Florida legislator's remarkable reference to transgender witnesses at a committee hearing as "mutants" and "demons."[62] And even when not based on bigotry, there are those who incorrectly but sincerely believe that gender identity is not real but instead just a choice. This is, as noted above, the elephant in the room.

Where there is bigotry, there are usually—one hopes, always—opponents of bigotry. It is hardly surprising that doctors who understand that transgender identity can be real, not made up—doctors who are willing to provide supportive medical care—oppose anti-transgender bigotry.

It sometimes happens that opponents of bigotry deem opposing viewpoints bigoted even when they are not. And it sometimes happens that those with

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[62] *Hearing on Facility Requirements Based on Sex*, CS/HB 1521 2023 Session (Fla. Apr. 10, 2023), https://www.myfloridahouse.gov/VideoPlayer.aspx?eventID=8804 (time stamp 2:30:35 to 2:34:10). Representative Webster Barnaby said to transgender Florida citizens who spoke at the hearing that they were "mutants living among us on Planet Earth." He raised his voice and said, "[T]his is Planet Earth, where God created men, male and women, female!" He continued: "[T]he Lord rebuke you Satan and all of your demons and imps that come parade before us. That's right I called you demons and imps who come and parade before us and pretend that you are part of this world." Finally, he said, you can "take [him] on" but he "promises [he] will win every time."

opposing viewpoints are slow to speak up, lest they be accused of bigotry. These dynamics could affect a medical association's consideration of transgender treatment. The record suggests these dynamics *have* affected the tone and quality of debate within WPATH. It is entirely possible that the same dynamics could have affected the tone and quality of debate within other associations.

Even so, it is fanciful to believe that all the many medical associations who have endorsed gender-affirming care, or who have spoken out or joined an amicus brief supporting the plaintiffs in this litigation, have so readily sold their patients down the river. The great weight of medical authority supports these treatments. The widely accepted standards of care require competent therapy and careful evaluation by a multidisciplinary team before use of GnRH agonists and cross-sex hormones for treatment of gender dysphoria. But the widely accepted standards of care support their use in appropriate circumstances. The standards have been unanimously endorsed by reputable medical associations, even though not unanimously endorsed by all the members of the associations.

The overwhelming majority of doctors are dedicated professionals whose first goal is the safe and effective treatment of their patients. There is no reason to believe the doctors who adopted these standards were motivated by anything else.

D. International views

The defendants have asserted time and again that Florida now treats GnRH agonists and cross-sex hormones the same as European countries. A heading in the defendants' response to the current motions is typical: "Florida Joins the International Consensus." The assertion is false. And no matter how many times the defendants say it, it will still be false. No country in Europe—or so far as shown by this record, anywhere in the world—entirely bans these treatments.

To be sure, there are countries that ban gays and lesbians and probably transgender individuals, too. One doubts these treatments are available in Iran or other similarly repressive regimes. But the treatments are available in appropriate circumstances in all the countries cited by the defendants, including Finland, Sweden, Norway, Great Britain, France, Australia, and New Zealand.[63] Some or all of these insist on appropriate preconditions and allow care only in approved facilities—just as the Endocrine Society and WPATH standards insist on appropriate preconditions, and just as care in the United States is ordinarily provided through capable facilities. Had Florida truly joined the international consensus—making these treatments available in appropriate circumstances or in

[63] *See* Trial Tr. in *Dekker*, ECF No. 226 at 78–79; *see also* Trial Tr. in *Dekker*, ECF No. 227 at 134; Trial Tr. in *Dekker*, ECF No. 228 at 61–62.

approved facilities—these plaintiffs would qualify, and the instant motions would not be necessary.

E. Malpractice

The defendants assert, with no real evidentiary support, that GnRH agonists and cross-sex hormones have sometimes been provided in Florida without the appropriate mental-health therapy and evaluation by a multidisciplinary team.

If that were true, the solution would be to appropriately regulate these treatments, not to ban them. And there are, of course, remedies already in place in Florida for deficient medical care. There is no evidence that this kind of care is routinely provided so badly that it should be banned outright.

Along the same lines, the defendants say gender dysphoria is difficult to diagnose accurately—that gender identity can be fluid, that there is no objective test to confirm gender identity or gender dysphoria, and that patients treated with GnRH agonists or cross-sex hormones have sometimes come to regret it. But the defendants ignore facts that do not support their narrative. Fluidity is common prior to puberty but not thereafter. Regret is rare; indeed, the defendants have offered no evidence of any Florida resident who regrets being treated with GnRH agonists or cross-sex hormones. And the absence of objective tests to confirm gender dysphoria does not set it apart from many other mental-health conditions

that are routinely diagnosed without objective tests and treated with powerful medications.

The difficulty diagnosing a patient calls for caution. It does not call for a one-size-fits-all refusal to provide widely accepted medical treatment.[64] It does not call for the state to make a binary decision not to provide the treatment even for a properly diagnosed patient.

F. Continuation of treatment

The defendants note that 98% or more of adolescents treated with GnRH agonists progress to cross-sex hormones. That is hardly an indictment of the treatment; it is instead consistent with the view that in 98% or more of the cases, the patient's gender identity did not align with natal sex, this was accurately determined, and the patient was appropriately treated first with GnRH agonists and later with cross-sex hormones. An advocate who denies the existence of genuine transgender identity or who wishes to make everyone cisgender might well fear progression to cross-sex hormones, but the defendants have denied that this is a basis for their current reference to this progression.

The defendants say, instead, that the high rate of progression rebuts an argument in support of GnRH agonists: that GnRH agonists give a patient time to

[64] *See* Trial Tr. in *Dekker*, ECF No. 239 at 91–94 (defense expert Dr. Levine explaining that medical intervention such as puberty blockers and hormones should be carefully prescribed and monitored but not banned).

reflect on the patient's gender identity and, if still convinced of a gender identity opposite the natal sex, to reflect on whether to go forward socially in the gender identity or natal sex. But if that is a goal of treatment with GnRH agonists, it is certainly not the treatment's *primary* goal. The primary goal is to delay and eventually avoid development of secondary sex characteristics inconsistent with the patient's gender identity—and thus to avoid or reduce the attendant anxiety, depression, and possible suicidal ideation.

The high rate of progression from GnRH agonists to cross-sex hormones is not a reason to ban the treatments.

G. Off-label use of FDA-approved drugs

The defendants note that while the Food and Drug Administration has approved GnRH agonists and the hormones at issue as safe and effective, the agency has not addressed their use to treat gender dysphoria. Quite so. Use of these drugs to treat gender dysphoria is "off label."

That the FDA has not approved these drugs for treatment of gender dysphoria says precisely nothing about whether the drugs are safe and effective when used for that purpose. Off-label use of drugs is commonplace and widely accepted across the medical profession. The defendants' contrary implication is divorced from reality.

Obtaining FDA approval of a drug is a burdensome, expensive process.[65] A pharmaceutical provider who wishes to market a new drug must incur the burden and expense because the drug cannot be distributed without FDA approval. Once a drug has been approved, however, the drug can be distributed not just for the approved use but for any other use as well. There ordinarily is little reason to incur the burden and expense of seeking additional FDA approval.

That the FDA approved these drugs at all confirms that, at least for one use, they are safe and effective.[66] This provides some support for the view that they are safe when properly administered and that they effectively produce the intended results—that GnRH agonists delay puberty and that testosterone and estrogen have masculinizing or feminizing effects as expected. The FDA approval goes no further—it does not address one way or the other the question whether using these drugs to treat gender dysphoria is as safe and effective as on-label uses.

That use of GnRH agonists and cross-sex hormones to treat gender dysphoria is "off-label" is not a reason to ban their use for that purpose.

XII. Other prerequisites to a preliminary injunction

The plaintiffs have met the other prerequisites for a preliminary injunction. The plaintiffs' adolescent children will suffer irreparable harm—the unwanted and

[65] Trial Tr. in *Dekker*, No. 226 at 182–84; Trial Tr. in *Dekker* No. 227 at 120–23; Trial Tr. in *Dekker*, ECF No. 239 at 54–55.
[66] Trial Tr. in *Dekker*, No. 226 at 182–84; Trial Tr. in *Dekker* No. 227 at 120–23.

irreversible onset and progression of puberty in their natal sex—if they do not promptly begin treatment with GnRH agonists. The treatment will affect the patients themselves, nobody else, and will cause the defendants no harm. The preliminary injunction will be consistent with, not adverse to, the public interest. Adherence to the Constitution is always in the public interest.

XIII. Improper defendants

The plaintiffs seek prospective relief under 42 U.S.C. § 1983. They are entitled to such relief against appropriate state officials in their official capacity. *See Ex parte Young*, 209 U.S. 123 (1908).

The Attorney General's motion asserts she is not an appropriate defendant—that she has no authority to enforce, and no other involvement with, the challenged statute and rules. That may be correct. The preliminary injunction will not run against the Attorney General, at least pending a ruling on her motion to dismiss.

A state itself is not a "person" who may be held liable under § 1983, and in any event a state has Eleventh Amendment immunity from a § 1983 claim in federal court. *See, e.g., Will v. Mich. Dep't of State Police*, 491 U.S. 58, 64 (1989) (holding that a state is not a "person" within the meaning of § 1983); *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44 (1996) (holding that a state sued in its own name has Eleventh Amendment immunity, regardless of the relief sought, unless

the immunity has been waived or validly abrogated by Congress under the Fourteenth Amendment).

The defendants Florida Board of Medicine and Florida Board of Osteopathic Medicine are agencies of the state—the jurisdictional equivalent of the state itself. Their presence in the case may be, in any event, merely redundant to that of their individual members, acting in their official capacities. *Cf. Busby v. City of Orlando*, 931 F.2d 764, 776 (11th Cir. 1991) (approving the dismissal of official-capacity defendants whose presence was merely redundant to the naming of an institutional defendant).

This order does not resolve the question whether the Boards will stay in the case. But the preliminary injunction will run against the Board members, not the Boards themselves. A broader preliminary injunction is not needed.

XIV. Conclusion

Gender identity is real. Those whose gender identity does not match their natal sex often suffer gender dysphoria. The widely accepted standard of care calls for evaluation and treatment by a multidisciplinary team. Proper treatment begins with mental-health therapy and is followed in appropriate cases by GnRH agonists and cross-sex hormones. Florida has adopted a statute and rules that prohibit these treatments even when medically appropriate. The plaintiffs are likely to prevail on

their claim that the prohibition is unconstitutional. And they have met the other prerequisites to a preliminary injunction.

The plaintiffs thus are entitled to a preliminary injunction of appropriate scope. Federal Rule of Civil Procedure 65(c) requires a party who obtains a preliminary injunction to "give[] security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined." This order requires the plaintiffs to give security for costs in a modest amount. Any party may move at any time to adjust the amount of security.

IT IS ORDERED:

1. The motion for a preliminary injunction, ECF Nos. 30 and 57, is granted in part.

2. The motion for a temporary restraining order, ECF No. 57, is denied as moot.

3. A preliminary injunction is entered against these defendants: Joseph Ladapo, in his capacity as the Surgeon General of the Florida Department of Health; Scot Ackerman, Nicholas W. Romanello, Wael Barsoum, Matthew R. Benson, Gregory Coffman, Amy Derick, David Diamond, Patrick Hunter, Luz Marina Pages, Eleonor Pimentel, Hector Vila, Michael Wasylik, Zachariah P. Zachariah, Maria Garcia, and Nicole Justice, in their official capacities as members

of the Florida Board of Medicine; Watson Ducatel, Tiffany Sizemore Di Pietro, Gregory Williams, Monica Mortensen, Valerie Jackson, Chris Creegan, and William D. Kirsh, in their official capacities as members of the Florida Board of Osteopathic Medicine; and State Attorneys Ginger Bowen Madden, Jack Campbell, John Durrett, Melissa Nelson, William Gladson, Bruce Bartlett, R.J. Larizza, Brian S. Kramer, Monique H. Worrell, Brian Haas, Kathern Fernandez Rundle, Ed Brodsky, Susan S. Lopez, Larry Basford, Dave Aronberg, Dennis Ward, Harold F. Pryor, Phil Archer, Thomas Bakkedahl, and Amira D. Fox, in their official capacities.

4. The preliminarily enjoined parties must not take any steps to prevent the administration of GnRH agonists or cross-sex hormones to Susan Doe, Gavin Goe, or Lisa Loe in accordance with professional standards that would apply to use of the same substances to treat patients with other medical conditions.

5. The preliminarily enjoined parties must not take any steps to enforce against Susan Doe, Gavin Goe, or Lisa Loe, or their parents or healthcare providers, Florida Statutes § 456.52(1) & (5) or Florida Administrative Code rules 64B8-9.019(1)(b) or 64B15-14.014(1)(b).

6. This preliminary injunction will take effect upon the posting of security in the amount of $100 for costs and damages sustained by a defendant found to have

been wrongfully enjoined. Security may be posted by a cash deposit with the Clerk of Court.

7. This preliminary injunction will terminate upon entry of a final judgment or when otherwise ordered.

8. This preliminary injunction binds the defendants and their officers, agents, servants, employees, and attorneys—and others in active concert or participation with any of them—who receive actual notice of this injunction by personal service or otherwise.

SO ORDERED on June 6, 2023.

s/Robert L. Hinkle
United States District Judge

Doc. 107

Doe v Ladapo: 4:23-cv-114

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

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al.,

Plaintiffs,

v. Case No. 4:23-cv-001114-RH-MAF

JOSEPH A. LADAPO, in his official capacity as Florida's Surgeon General of the Florida Department of Health, et al.,

Defendants.
_____/

CORRECTED, CONSOLIDATED ANSWER BY ALL DEFENDANTS TO PLAINTIFFS' SECOND AMENDED COMPLAINT[1]

Surgeon General Ladapo, the Florida Board of Medicine, and the Florida Board of Osteopathic Medicine (the "State Medical Defendants"), and State Attorney Gladson respond to Plaintiffs' second amended complaint. Any allegation not specifically admitted is denied.

Preliminary Statement

1. Denied that the agency rules and legislation are "bans"; otherwise, admitted.

[1] This Corrected, Consolidated Answer adds State Attorney Gladson to the prefatory paragraph that follows the title.

2. Denied.

3. Denied.

4. Denied.

5. Admitted that Plaintiffs seek declaratory and injunctive relief; denied that Plaintiffs are entitled to that relief, and denied that Plaintiffs will suffer injury without such relief.

Parties

I.

6. Without knowledge; therefore, denied.

7. Without knowledge; therefore, denied.

8. Without knowledge; therefore, denied.

9. Without knowledge; therefore, denied.

10. Without knowledge; therefore, denied.

11. Without knowledge; therefore, denied.

12. Without knowledge; therefore, denied.

II.

13. Denied that the agency rules are "bans"; otherwise, admitted.

14. Admitted.

15. Admitted.

16. Admitted.

17. Admitted.

18. Admitted.

19. Admitted.

20. Admitted.

21. Admitted.

22. Admitted.

23. Admitted.

24. Admitted.

25. Admitted.

26. Admitted.

27. Admitted.

28. Admitted.

29. Admitted.

30. Admitted.

31. Admitted.

32. Admitted.

33. Admitted.

34. Admitted.

35. Admitted.

36. Denied that board members can individually promulgate rules and individually take disciplinary actions. *See* Fla. Stat. § 456.011; Fla. Stat. § 456.073. Otherwise, admitted.

37. Denied that board members can individually promulgate rules and individually take disciplinary actions. *See* Fla. Stat. § 456.011; Fla. Stat. § 456.073. Otherwise, admitted.

38. Admitted.

39. Admitted.

40. Admitted.

41. Admitted.

42. Admitted.

43. Admitted.

44. Admitted.

45. Admitted.

46. Admitted.

47. Admitted.

48. Admitted.

49. Admitted.

50. Admitted.

51. Admitted.

52. Admitted.

53. Admitted.

54. Admitted.

55. Admitted.

56. Admitted.

57. Admitted.

58. Admitted.

Jurisdiction and Venue

59. Admitted to the extent that paragraph 59 states the relief Plaintiffs seek; denied that Plaintiffs are entitled to the relief; denied that federal law has been violated; denied that the agency rules and legislation are "transgender medical bans."

60. Admitted.

61. Denied that Plaintiffs' federal rights have been violated; otherwise, admitted.

62. Admitted.

63. Admitted that venue is proper; otherwise, denied.

64. Admitted.

65. Admitted.

Factual Allegations

I.

66. Denied.

67. Admitted to the extent that gender dysphoria is a medical diagnosis that arises from an incongruence between an individual's sex and gender identity; admitted that the incongruence can cause clinical distress; admitted that the DSM-5 contains diagnosing criteria for gender dysphoria; otherwise, denied.

68. Without knowledge; therefore, denied.

69. Denied.

70. Admitted that certain organizations promulgated, and that certain individuals in medical organizations approved, recommendations on the treatments for gender dysphoria; otherwise, denied.

71. Admitted that WPATH promulgated recommendations on the treatments for gender dysphoria; otherwise, denied.

72. Admitted that the Endocrine Society promulgated recommendations on the treatments for gender dysphoria; otherwise, denied.

73. Admitted to the extent that certain individuals who are in the referenced medical organizations approve of WPATH's and the Endocrine Society's recommendations on treatments for gender dysphoria; otherwise, denied.

74. Admitted that there are treatments for gender dysphoria and that the treatments have several components; otherwise, denied.

75. Denied.

76. Admitted that certain medical professionals support social transition, as described in paragraph 76; otherwise, denied.

77. Admitted that certain medical professionals support the treatments for gender dysphoria described in paragraph 76; otherwise, denied.

78. Admitted.

79. Admitted to the extent that certain medical professionals and WPATH support puberty-blocking treatments for gender dysphoria, as described in paragraph 79; otherwise, denied.

80. Admitted that certain medical professionals support cross-sex-hormone treatments for gender dysphoria; otherwise, denied.

81. Denied.

II.

82. Admitted to the extent that Surgeon General Ladapo sent a letter to the State medical boards in June 2022 regarding standards of care for treatments for gender dysphoria; otherwise, denied.

83. Denied that the rules are "categorical ban[s] on all treatment of gender dysphoria"; otherwise, admitted.

84. Admitted.

85. Admitted.

86. Admitted.

87. Admitted.

88. Admitted.

89. Admitted.

90. Denied that the rules are "transgender medical bans"; otherwise, admitted.

91. Admitted.

92. Admitted.

93. Denied that the rules are "bans"; otherwise, admitted.

94. Denied that the rules are "bans"; denied that the use of hormones or puberty blockers for purposes of treating gender dysphoria is medically necessary for minors; otherwise, admitted.

95. Denied.

96. Denied.

III.

97. Admitted.

98. Admitted.

99. Admitted.

100. Admitted.

101. Admitted.

102. Admitted.

103. Admitted.

104. Admitted.

105. Admitted.

106. Admitted.

IV.

107. Without knowledge; therefore, denied.

108. Without knowledge; therefore, denied.

109. Without knowledge; therefore, denied.

110. Without knowledge; therefore, denied.

111. Without knowledge; therefore, denied.

112. Without knowledge; therefore, denied.

113. Without knowledge; therefore, denied.

114. Without knowledge; therefore, denied.

115. Without knowledge; therefore, denied.

116. Without knowledge; therefore, denied.

117. Without knowledge; therefore, denied.

118. Without knowledge; therefore, denied.

119. Without knowledge; therefore, denied.

120. Without knowledge; therefore, denied.

121. Without knowledge; therefore, denied.

122. Without knowledge; therefore, denied.

123. Without knowledge; therefore, denied.

124. Without knowledge; therefore, denied.

125. Without knowledge; therefore, denied.

126. Without knowledge; therefore, denied.

127. Without knowledge; therefore, denied.

128. Without knowledge; therefore, denied.

129. Without knowledge; therefore, denied.

130. Without knowledge; therefore, denied.

131. Without knowledge; therefore, denied.

132. Without knowledge; therefore, denied.

133. Without knowledge; therefore, denied.

134. Without knowledge; therefore, denied.

135. Without knowledge; therefore, denied.

136. Without knowledge; therefore, denied.

137. Without knowledge; therefore, denied.

138. Without knowledge; therefore, denied.

139. Without knowledge; therefore, denied.

140. Without knowledge; therefore, denied.

141. Without knowledge; therefore, denied.

142. Without knowledge; therefore, denied.

143. Without knowledge; therefore, denied.

144. Without knowledge; therefore, denied.

145. Without knowledge; therefore, denied.

146. Without knowledge; therefore, denied.

147. Without knowledge; therefore, denied.

Claims for Relief

Count I

148. The State Medical Defendants incorporate paragraphs 1-147 in this answer.

149. Admitted that Plaintiffs bring Count I against all Defendants; denied that relief under Count I is warranted.

150. Admitted that the Fourteenth Amendment protects certain rights; admitted that the quotation in paragraph 150 comes from *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality); otherwise, denied.

151. Denied.

152. Denied.

153. Denied.

Count II

154. The State Medical Defendants incorporate paragraphs 1-147 in this answer.

155. Admitted that Plaintiffs bring Count I against all Defendants; denied that relief under Count II is warranted.

156. Admitted.

157. Denied.

158. Denied.

159. Denied.

160. Denied.

161. Denied.

162. Denied.

163. Denied.

Relief Requested by Plaintiffs

Wherefore,

(1) Denied that such relief is warranted.

(2) Denied that such relief is warranted.

(3) Denied that such relief is warranted.

(4) Denied that such relief is warranted.

(5) Denied that such relief is warranted.

Dated: June 23, 2023

Ashley Moody
ATTORNEY GENERAL

/s/ James H. Percival
James H. Percival (FBN 1016188)
CHIEF OF STAFF

/s/ Henry C. Whitaker
Henry C. Whitaker (FBN 1031175)
SOLICITOR GENERAL

/s/ Daniel William Bell
Daniel William Bell (FBN 1008587)
CHIEF DEPUTY SOLICITOR GENERAL

/s/ Joseph E. Hart
Joseph E. Hart (FBN 0124720)
COUNSELOR TO THE ATTORNEY GENERAL

Office of the Attorney General
The Capitol, Pl-01
Tallahassee, Florida 32399-1050
(850) 414-3300
(850) 410-2672 (fax)

Respectfully submitted by:

/s/ Mohammad O. Jazil
Mohammad O. Jazil (FBN 72556)
Gary V. Perko (FBN 855898)
Michael Beato (FBN 1017715)
Holtzman Vogel Baran
Torchinsky & Josefiak PLLC
119 S. Monroe St., Suite 500
Tallahassee, FL 32301
(850) 270-5938
mjazil@holtzmanvogel.com
gperko@holtzmanvogel.com
mbeato@holtzmanvogel.com

Counsel for the Surgeon General, the Department of Health, the Boards of Medicine, and the individual Board Members

Joseph.Hart@myfloridalegal.com

Counsel for the Surgeon General, the Department of Health, and State Attorney Gladson

CERTIFICATE OF SERVICE

I certify that, on June 23, 2023, this answer was filed through the Court's CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/ Mohammad O. Jazil
Mohammad O. Jazil

Doc. 108

Doe v Ladapo: 4:23-cv-114

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

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al.,

Plaintiffs,

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

JOSEPH A. LADAPO, in his official capacity as Florida's Surgeon General of the Florida Department of Health, et al.,

Defendants.
_____/

NOTICE OF APPEAL

Defendants Surgeon General Ladapo, the Florida Board of Medicine, the Florida Board of Osteopathic Medicine, the individual Board Members, and State Attorney Gladson, appeal the order for preliminary injunction, Doc. 90, which was entered on June 6, 2023, to the U.S. Court of Appeals for the Eleventh Circuit.

Dated: June 26, 2023

/s/ James H. Percival
James H. Percival (FBN 1016188)
OFFICE OF THE ATTORNEY GENERAL
The Capitol, Pl-01
Tallahassee, Florida 32399-1050
(850) 414-3300
(850) 410-2672 (fax)
James.Percival@myfloridalegal.com

Respectfully submitted by:

/s/ Mohammad O. Jazil
Mohammad O. Jazil (FBN 72556)
Gary V. Perko (FBN 855898)
Michael Beato (FBN 1017715)
Holtzman Vogel Baran
Torchinsky & Josefiak PLLC
119 S. Monroe St., Suite 500
Tallahassee, FL 32301
(850) 270-5938

Counsel for the Surgeon General, the Department of Health, and State Attorney Gladson
mjazil@holtzmanvogel.com
gperko@holtzmanvogel.com
mbeato@holtzmanvogel.com

Counsel for the Surgeon General, the Department of Health, the Boards of Medicine, and the individual Board Members

CERTIFICATE OF SERVICE

I certify that, on June 26, 2023, this answer was filed through the Court's CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/ Mohammad O. Jazil
Mohammad O. Jazil

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

JANE DOE et al.,

Plaintiffs,

v. CASE NO. 4:23cv114-RH-MAF

JOSEPH A. LADAPO et al.,

Defendants.
_____/

PRELIMINARY INJUNCTION

This action presents a constitutional challenge to a Florida statute and rules that (1) prohibit transgender minors from receiving specific kinds of widely accepted medical care and (2) prohibit doctors from providing it. The treatments at issue are GnRH agonists, colloquially known as "puberty blockers," and cross-sex hormones. This order grants a preliminary injunction.

I. Background: the parties, record, and motions

Each of the seven plaintiffs is the parent of a transgender child on whose behalf this action is brought. Three have moved for a temporary restraining order and preliminary injunction. One child's doctors say she needs GnRH agonists now, without delay; doctors for the other two say they will need GnRH agonists soon.

The needs of the other plaintiffs' children are less immediate, so they have not joined the emergency motions.

The defendants are the Florida Surgeon General, the Florida Board of Medicine and its members, the Florida Board of Osteopathic Medicine and its members, the Florida Attorney General, and each of Florida's 20 State Attorneys. The individuals are defendants only in their official capacities. This order refers to the Surgeon General, the Boards, and their members as the "medical defendants." The order refers to the Attorney General and State Attorneys as the "law-enforcement defendants."

The parties have stipulated to submission of the pending motions based on the written filings in this case and the record compiled in a separate case in this court with overlapping issues, *Dekker v. Weida*, No. 4:22cv325-RH-MAF.[1] A complete bench trial has been conducted in that case.

The plaintiffs and the medical defendants have fully briefed the issues in this case and have presented oral argument. The law-enforcement defendants have chosen to rely on the medical defendants and not to present their own briefs or oral argument. The Attorney General has moved to dismiss on procedural grounds applicable only to her; that motion will be addressed in a separate order.

[1] *See* Trial Tr. in *Dekker v. Weida*, No. 4:22cv325, ECF No. 239 at 174–75. Citations including "*Dekker*" refer to the docket in that case.

The motion for a preliminary injunction is ripe for a decision. This moots any need for separate consideration of a temporary restraining order.

II. Preliminary-injunction standards

As a prerequisite to a preliminary injunction, a plaintiff must establish a substantial likelihood of success on the merits, that the plaintiff will suffer irreparable injury if the injunction does not issue, that the threatened injury outweighs whatever damage the proposed injunction may cause a defendant, and that the injunction will not be adverse to the public interest. *See, e.g.*, *Charles H. Wesley Educ. Found., Inc. v. Cox*, 408 F.3d 1349, 1354 (11th Cir. 2005); *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc).

III. Gender identity is real

With extraordinarily rare exceptions not at issue here, every person is born with external sex characteristics, male or female, and chromosomes that match. As the person goes through life, the person also has a gender identity—a deeply felt internal sense of being male or female.[2] For more than 99% of people, the external sex characteristics and chromosomes—the determinants of what this order calls the person's natal sex—match the person's gender identity.[3]

[2] Trial Tr. in *Dekker*, ECF No. 226 at 23–24; Trial Tr. in *Dekker*, ECF No. 238 at 72–73.

[3] Trial Tr. in *Dekker*, ECF No. 227 at 222.

For less than 1%, the natal sex and gender identity are opposites: a natal male's gender identity is female, or vice versa.[4] This order refers to such a person who identifies as female as a transgender female and to such a person who identifies as male as a transgender male. This order refers to individuals whose gender identity matches their natal sex as cisgender.

The elephant in the room should be noted at the outset. Gender identity is real. The record makes this clear. The medical defendants, speaking through their attorneys, have admitted it. At least one defense expert also has admitted it.[5] That expert is Dr. Stephen B. Levine, the only defense expert who has actually treated a significant number of transgender patients. He addressed the issues conscientiously, on the merits, rather than as a biased advocate.

Despite the defense admissions, there are those who believe that cisgender individuals properly adhere to their natal sex and that transgender individuals have inappropriately *chosen* a contrary gender identity, male or female, just as one might choose whether to read Shakespeare or Grisham. Many people with this view tend to disapprove all things transgender and so oppose medical care that supports a person's transgender existence.[6] In this litigation, the medical

[4] *Id.*; *see also* Trial Tr. in *Dekker*, ECF No. 226 at 23–24; Trial Tr. in *Dekker*, ECF No. 228 at 29–31.
[5] *See* Trial Tr. in *Dekker*, ECF No. 239 at 10–11, 31–32, 80–81.
[6] *See* Trial Tr. in *Dekker*, ECF No. 239 at 129–31.

defendants have explicitly acknowledged that this view is wrong and that pushing individuals away from their transgender identity is not a legitimate state interest.

Still, an unspoken suggestion running just below the surface in some of the proceedings that led to adoption of the statute and rules at issue—and just below the surface in the testimony of some of the defense experts—is that transgender identity is not real, that it is made up.[7] And so, for example, one of the defendants' experts, Dr. Paul Hruz, joined an amicus brief in another proceeding asserting transgender individuals have only a "false belief" in their gender identity—that they are maintaining a "charade" or "delusion."[8] Another defense expert, Dr. Patrick Lappert—a surgeon who has never performed gender-affirming surgery—said in a radio interview that gender-affirming care is a "lie," a "moral violation," a "huge evil," and "diabolical."[9] State employees or consultants suggested treatment of transgender individuals is either a "woke idea" or profiteering by the pharmaceutical industry or doctors.[10]

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[7] *See, e.g.*, Pls.' Exs. 284 & 285 in *Dekker*, ECF Nos. 182-21 & 182-22; *see also* Pls.' Ex. 304 in *Dekker*, ECF No. 183-6.

[8] Trial Tr. in *Dekker*, ECF No. 238 at 194–95. Dr. Hruz fended and parried questions and generally testified as a deeply biased advocate, not as an expert sharing relevant evidence-based information and opinions. I do not credit his testimony. I credit other defense experts only to the extent consistent with this opinion.

[9] Trial Tr. in *Dekker*, ECF No. 239 at 129–31.

[10] Pls.' Ex. 304 in *Dekker*, ECF No. 183-6; Pls.' Exs. 284 & 285 in *Dekker*, ECF Nos. 182-21 & 182-22.

Any proponent of the challenged statute and rules should put up or shut up: do you acknowledge that there are individuals with actual gender identities opposite their natal sex, or do you not? Dog whistles ought not be tolerated.

IV. The challenged statute and rules

The challenged parts of the statute and rules apply to patients under age 18.

The statute prohibits the use of "puberty blockers" to "stop or delay normal puberty in order to affirm a person's perception of his or her sex if that perception is inconsistent with the person's [natal] sex." Fla. Stat. § 456.001(9)(a)1.; *see id.* § 456.52. And the statute prohibits the use of "hormones or hormone antagonists to affirm a person's perception of his or her sex if that perception is inconsistent with the person's [natal] sex." *Id.* § 456.001(9)(a)2. The statute makes violation of these provisions a crime and grounds for terminating a healthcare practitioner's license. *See id.* § 456.52(1) & (5).

The statute has exceptions, including, for example, for use of these products during a transition away from them, but the exceptions are not relevant here. And the statute has other provisions, including a prohibition on transgender surgeries, but those provisions, too, are not at issue here.

The challenged rules were adopted by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine. In identical language, the rules prohibit the Boards' licensed practitioners from treating "gender dysphoria in minors" with

"[p]uberty blocking, hormone, or hormone antagonist therapies." Fla. Admin. Code r. 64B8-9.019(1)(b); Fla. Admin Code r. 64B15-14.014(1)(b).

V. The standards of care

Transgender individuals suffer higher rates of anxiety, depression, suicidal ideation, and suicide than the population at large.[11] Some suffer gender dysphoria, a mental-health condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"). The diagnosis applies when specific criteria are met. Among other things, there must be a marked incongruence between one's experienced gender identity and natal sex for at least six months, manifested in specified ways, and clinically significant distress or impairment.[12]

There are well-established standards of care for treatment of gender dysphoria. These are set out in two publications: first, the Endocrine Society Clinical Practice Guidelines for the Treatment of Gender Dysphoria; and second, the World Professional Association for Transgender Health ("WPATH") Standards of Care, version 8.[13] I credit the abundant testimony in this record that these standards are widely followed by well-trained clinicians.[14] The standards are used

[11] Trial Tr. in *Dekker*, ECF No. 226 at 108.
[12] Pls.' Ex. 33 in *Dekker*, ECF No. 175-33 at 2–3; *see also* Trial Tr. in *Dekker*, ECF No. 226 at 25–26; Trial Tr. in *Dekker*, ECF No. 238 at 71.
[13] Defs.' Exs. 16 & 24 in *Dekker*, ECF Nos. 193-16 & 193-24.
[14] Trial Tr. in *Dekker*, ECF No. 226 at 31 (psychiatrist); *id.* at 198 (pediatric endocrinologist); Trial Tr. in *Dekker*, ECF No. 227 at 50–52 (surgeon); *id.* at 106,

by insurers[15] and have been endorsed by the United States Department of Health and Human Services.[16]

Under the standards, gender-dysphoria treatment begins with a comprehensive biopsychosocial assessment.[17] In addition to any appropriate mental-health therapy, there are three types of possible medical intervention, all available only to adolescents or adults, never younger children.[18]

First, for patients at or near the onset of puberty, medications known as GnRH agonists can delay the onset or continuation of puberty and thus can reduce the development of secondary sex characteristics inconsistent with the patient's gender identity—breasts for transgender males, whiskers for transgender females, changes in body shape, and other physical effects.[19]

Second, cross-sex hormones—testosterone for transgender males, estrogen for transgender females—can promote the development and maintenance of characteristics consistent with the patient's gender identity and can limit the development and maintenance of characteristics consistent with the patient's natal

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112–14 (pediatrician, bioethicist, medical researcher); Trial Tr. in *Dekker*, ECF No. 228 at 15 (physician specializing in pediatrics and adolescent medicine).

[15] Trial Tr. in *Dekker*, ECF No. 227 at 243–44.

[16] *See* Defs.' Ex. 2 in *Dekker*, ECF No. 193-2.

[17] *See* Trial Tr. in *Dekker*, ECF No. 226 at 42–43.

[18] Trial Tr. in *Dekker*, ECF No. 238 at 72 & 74–75; *see also* Trial Tr. in *Dekker*, ECF No. 228 at 14; Trial Tr. in *Dekker*, ECF No. 226 at 36 & 176.

[19] *See* Trial Tr. in *Dekker*, ECF No. 226 at 194–97; Trial Tr. in *Dekker*, ECF No. 228 at 27–28.

sex.[20] For patients treated with GnRH agonists, use of cross-sex hormones typically begins when use of GnRH agonists ends.[21] Cross-sex hormones also can be used later in life, regardless of whether a patient was treated with GnRH agonists.

Third, for some patients, surgery can align physical characteristics with gender identity, to some extent.[22] The most common example: mastectomy can remove a transgender male's breasts. Perhaps 98% of all such surgeries are performed on adults, not minors.[23]

The motions now before the court deal directly only with GnRH agonists. The motions deal indirectly with cross-sex hormones, because to achieve their intended result, GnRH agonists are ordinarily followed by cross-sex hormones. The motions do not present any issue related to surgeries.

VI. General acceptance of the standards of care

The overwhelming weight of medical authority supports treatment of transgender patients with GnRH agonists and cross-sex hormones in appropriate circumstances. Organizations who have formally recognized this include the American Academy of Pediatrics, American Academy of Child and Adolescent

[20] Trial Tr. in *Dekker*, ECF No. 226 at 217–26, 228.
[21] *See* Trial Tr. in *Dekker*, ECF No. 228 at 87–90.
[22] *See* Trial Tr. in *Dekker*, ECF No. 227 at 42.
[23] *See* Trial Tr. in *Dekker*, ECF No. 227 at 43.

Psychiatry, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Psychiatric Association, and at least a dozen more.[24] The record also includes statements from hundreds of professionals supporting this care.[25] At least as shown by this record, not a single reputable medical association has taken a contrary position.

These medications—GnRH agonists, testosterone, and estrogen—have been used for decades to treat other conditions. Their safety records and overall effects are well known. The Food and Drug Administration has approved their use, though not specifically to treat gender dysphoria.[26]

GnRH agonists are routinely used to treat patients with central precocious puberty—children who have begun puberty prematurely—as well as, in some circumstances, endometriosis and prostate cancer.[27] Central precocious puberty presents substantial health risks and ordinarily should be treated. GnRH agonists are an appropriate treatment, even though GnRH agonists have attendant risks.[28]

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[24] *See* Pls.' Exs. 36–43, 45–48 in *Dekker*, ECF Nos. 175-36 through 176-8 (omitting ECF No. 176-4).
[25] *See* Amicus Brief of American Academies and Health Organizations, ECF No. 36-1; Bruggeman et al., *We 300 Florida health care professionals say the state gets transgender guidance wrong* (Apr. 27, 2022), *Dekker* ECF No. 11-1 at 11–32.
[26] *See* Trial Tr. in *Dekker*, ECF No. 226 at 183; *see also* Trial Tr. in *Dekker*, ECF No. 239 at 54–56.
[27] Trial Tr. in *Dekker*, ECF No. 226 at 183–84, 200–02.
[28] *Id.*

So, too, gender dysphoria presents substantial health risks and ordinarily should be treated.[29] For some patients, GnRH agonists are an appropriate treatment, even though, just as with their use to treat central precocious puberty and other conditions, GnRH agonists have attendant risks.[30]

The medical defendants say the risks attendant to use of GnRH agonists to treat central precocious puberty or to treat gender dysphoria are not identical, and that may be so. But it is still true that for gender dysphoria, just as for central precocious puberty, GnRH agonists are an effective treatment whose benefits can outweigh the risks.

The same is true for cross-sex hormones. Testosterone and estrogen are routinely used to treat cisgender patients in appropriate circumstances.[31] The medications are an effective treatment for conditions that should be treated, even though the medications have attendant risks.[32] That is so for cisgender and transgender patients alike. For some transgender patients, cross-sex hormones are an appropriate treatment.

Even the defendants' expert Dr. Levine testified that treatment with GnRH agonists and cross-sex hormones is sometimes appropriate.[33] He would demand

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[29] *Id.*
[30] *Id.* at 201–16.
[31] *Id.* at 216.
[32] *Id.* at 218–29.
[33] Trial Tr. in *Dekker*, ECF No. 239 at 81–83.

appropriate safeguards, as discussed below, but he would not ban the treatments.[34] Nothing in this record suggests these plaintiffs do not qualify for treatment under Dr. Levine's proposed safeguards.

VII. Clinical evidence supporting the standards of care

The record includes testimony of well-qualified doctors who have treated thousands of transgender patients with GnRH agonists and cross-sex hormones over their careers and have achieved excellent results. I credit the testimony of Dr. Dan Karasic (psychiatrist), Dr. Daniel Shumer (pediatric endocrinologist), Dr. Aron Janssen (child and adolescent psychiatrist), Dr. Johanna Olson-Kennedy (specialist in pediatrics and adolescent medicine), and Dr. Armand Antommaria (pediatrician and bioethicist). I credit their testimony that denial of this treatment will cause needless suffering for a substantial number of patients and will increase anxiety, depression, and the risk of suicide.

The clinical evidence would support, though certainly not mandate, a decision by a reasonable patient and parent, in consultation with properly trained practitioners, to use GnRH agonists at or near the onset of puberty and to use cross-sex hormones later, even when fully apprised of the current state of medical knowledge and all attendant risks. There is no rational basis for a state to categorically ban these treatments.

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[34] *Id.* at 91–94.

The record includes no evidence that these treatments have caused substantial adverse clinical results in properly screened and treated patients.

VIII. The plaintiffs

The plaintiffs and their children are proceeding under pseudonyms. The plaintiffs seeking a preliminary injunction are Jane Doe on behalf of Susan Doe, Gloria Goe on behalf of Gavin Goe, and Linda Loe on behalf of Lisa Loe.

A. Susan Doe

Susan Doe is an 11-year-old transgender girl. From a young age, she consistently told her mother she was a girl. She experienced extreme anxiety and distress about wearing boys' clothing.[35] Her mother sought help from a pediatrician, who said Susan should be allowed to dress and play as made her comfortable. Despite fears, her mother allowed her to wear girls' clothes and socially transition. This made Susan a "different child" who was "happy, glowing, [and] secure."[36]

Susan's school peers know her as a girl.[37] They do not know she is transgender. Her legal documentation and government-issued identification say she is female.[38]

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[35] Jane Doe Decl., ECF No. 30-1 at 2–3 ¶ 8.
[36] *Id.* at 3 ¶ 12.
[37] *Id.* at 4 ¶ 14.
[38] *Id.* ¶ 16.

Susan's treating professionals have included the physician at the Pentagon who oversees the United States military's transgender health program[39] and a multidisciplinary team at the University of Florida Health Youth Gender Program.[40] All of Susan's providers have determined GnRH agonists will be medically necessary when she begins puberty—that is, when she reaches the puberty classification denominated Tanner stage II. This could happen any day.[41]

The statute and rules at issue, unless enjoined, will force Susan to go through male puberty. This will "out" her as transgender to her peers and will have devasting physical, emotional, and psychological effects.

B. Gavin Goe

Gloria Goe is the mother of Gavin Goe, an eight-year-old transgender boy. From a very young age, Gavin wanted short hair, masculine clothing, and a boy's name. He experienced distress and asked his mother why no one believed he was a boy.[42] His mother came to understand Gavin was transgender, and she sought to learn how best to support and love her child. She allowed Gavin to socially

[39] *Id.* at 4–5 ¶ 17.
[40] *Id.* at 5 ¶¶ 18–19.
[41] *Id.* at 6 ¶ 20.
[42] Gloria Goe Decl., ECF No. 30-3 at 3 ¶ 10.

transition, including by using a boy's name and wearing boy's clothing.[43] Gavin's teacher, counselor, and principal know Gavin is transgender, but his peers do not.[44]

Gavin's pediatrician referred him to a psychologist for treatment of gender dysphoria, anxiety, and depression.[45] Now, at age eight, Gavin is younger than the average age of puberty onset, but his sister began puberty at age nine, so Gavin, too, may begin puberty early.[46] The pediatrician has referred Gavin to a pediatric endocrinologist at the Johns Hopkins Children's Hospital gender clinic in St. Petersburg, Florida, to assess possible treatment with GnRH agonists.[47] Gavin had an appointment, but it was canceled when the Board of Medicine adopted the rule prohibiting doctors from providing this kind of care.[48]

C. Lisa Loe

Linda Loe is the mother of Lisa Loe, an 11-year-old transgender girl. Lisa has always gravitated toward interests and activities more stereotypically associated with girls. At age 9, Lisa told her mother she was a girl.

Lisa suffered gender dysphoria.[49] Her family sought the care of a psychologist. Lisa was allowed to socially transition, and her happiness and well-

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[43] *Id.* ¶ 11.
[44] *Id.* at 3–4 ¶ 14.
[45] *See* ECF No. 86 at 9.
[46] Gloria Goe Decl., ECF No. 30-3 at 4 ¶ 15; *see id.* at 8.
[47] Gloria Goe Decl., ECF No. 30-3 at 4 ¶ 17; *see also* ECF No. 86 at 9.
[48] Gloria Goe Decl., ECF No. 30-3 at 4 ¶ 17.
[49] Linda Loe Decl., ECF No. 30-2 at 3 ¶ 7.

being improved.[50] But her classmates and teachers continued to treat her as a boy, causing more distress. Her mother eventually decided to move Lisa to a more supportive and inclusive school.

Lisa's pediatrician referred her to a pediatric endocrinologist who specializes in the treatment of gender dysphoria.[51] The endocrinologist in turn referred Lisa to a gender clinic.[52] She has begun puberty and needs GnRH agonists without further delay.[53]

Lisa has become extremely anxious as her puberty progresses.[54]

D. Findings on appropriate treatment

I find, based on the record now before the court, that the plaintiffs are likely to succeed on their claim that they have obtained appropriate medical care for their children to this point, that qualified professionals have properly evaluated the children's medical conditions and needs in accordance with the well-established standards of care, and that the plaintiffs and their children, in consultation with their treating professionals, have determined that the benefits of treatment with GnRH agonists, and eventually with cross-sex hormones, will outweigh the risks. I find that the plaintiffs' ability to evaluate the benefits and risks of treating their

[50] *Id.*
[51] *Id.* at 4 ¶ 10.
[52] ECF No. 86 at 1–2.
[53] Linda Loe Decl., ECF No. 30-2 at 4 ¶ 11; *see also* ECF No. 86 at 2.
[54] Linda Loe Decl., ECF No. 30-2 at 5 ¶ 12.

individual children this way far exceeds the ability of the State of Florida to do so. I find that the plaintiffs' motivation is love for their children and the desire to achieve the best possible treatment for them. This is not the State's motivation.

IX. Equal protection

The plaintiffs assert banning treatment with GnRH agonists and cross-sex hormones violates the Fourteenth Amendment's Equal Protection Clause. The only circuit that has addressed the issue agrees. In *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022), the Eighth Circuit affirmed a preliminary injunction against enforcement of an Arkansas statute identical in relevant respects to the statute at issue here. The decision is on point, well reasoned, and should be followed. But as an Eighth Circuit decision, it is not binding.

A. Introduction to levels of scrutiny

Equal-protection analysis often starts with attention to the appropriate level of scrutiny: strict, intermediate, or rational-basis.

There was a time when the Supreme Court seemed to treat strict scrutiny and rational basis as exhaustive categories of equal-protection review. A leading commentator said that in some situations the first category was "'strict' in theory and fatal in fact" while the second called for "minimal scrutiny in theory and virtually none in fact." Gerald Gunther, *The Supreme Court, 1971 Term—*

Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection, 86 Harv. L. Rev. 1, 8 (1972).

But in the decades since, the Supreme Court has applied *intermediate* scrutiny in many circumstances. And rational-basis review no longer means virtually no review. *See, e.g.*, *Romer v. Evans*, 517 U.S. 620, 632 (1996) (striking down, for lack of a legitimate rational basis, a state law restricting local ordinances protecting gays: "[E]ven in the ordinary equal protection case calling for the most deferential of standards, we insist on knowing the relation between the classification adopted and the object to be attained."); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 447–50 (1985) (striking down, for lack of a legitimate rational basis, an ordinance requiring group-care facilities for the mentally handicapped, but not other facilities with multiple occupants, to obtain land-use permits); *Hooper v. Bernalillo Cnty. Assessor*, 472 U.S. 612, 623 (1985) (striking down, for lack of a legitimate rational basis, a tax exemption for Vietnam War veterans limited to those who resided in the state on May 8, 1976); *United States Dep't of Agric. v. Moreno*, 413 U.S. 528 (1973) (striking down, for lack of a legitimate rational basis, a statute denying food stamps to members of a household with unrelated members).

In short, regardless of the level of scrutiny, there is no substitute for careful, unbiased, intellectually honest analysis. Still, the level of scrutiny matters, so this order addresses it.

B. Intermediate scrutiny applies here

The plaintiffs say the challenged statute and rules discriminate on the basis of sex and transgender status and that either alone would be sufficient to trigger intermediate scrutiny. The defendants say only rational-basis scrutiny applies. The plaintiffs have the better of it.

1. Sex

It is well established that drawing lines based on sex triggers intermediate scrutiny. *See, e.g.*, *United States v. Virginia*, 518 U.S. 515, 533 (1996); *Adams v. St. Johns Cnty.*, 57 F.4th 791 801 (11th Cir. 2022) (en banc). If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex. *See, e.g.*, *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1737 (2020); *Adams*, 57 F.4th at 801. The defendants do not deny this; instead, they say the challenged statute does not draw a line based on sex.

But it does. Consider an adolescent, perhaps age 16, that a physician wishes to treat with testosterone. Under the challenged statute, is the treatment legal or illegal? To know the answer, one must know the adolescent's sex. If the adolescent is a natal male, the treatment is legal. If the adolescent is a natal female, the

treatment is illegal. This is a line drawn on the basis of sex, plain and simple. *See Brandt*, 47 F.4th at 669 ("Because the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law, [the law] discriminates on the basis of sex."); *Adams*, 57 F.4th at 801 (applying intermediate scrutiny to a policy under which entry into a designated bathroom was legal or not depending on the entrant's natal sex).

In asserting the contrary, the defendants note that the reason for the treatment—the diagnosis—is different for the natal male and natal female. Indeed it is. But this does not change the fact that this is differential treatment based on sex. The *reason* for sex-based differential treatment is the purported *justification* for treating the natal male and natal female differently—the justification that must survive intermediate scrutiny. One can survive—but cannot avoid—intermediate scrutiny by saying there is a good reason for treating a male and female differently.

2. Gender nonconformity

Drawing a line based on gender nonconformity—this includes transgender status—also triggers intermediate scrutiny. *See Glenn v. Brumby*, 663 F.3d 1313, 1316 (11th Cir. 2011). Although the defendants deny it, the statute and rules at issue draw lines based on transgender status. *See Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1147 (M.D. Ala. 2022) (citing *Glenn*, 663 F.3d at 1317).

To confirm this, consider a child that a physician wishes to treat with GnRH agonists to delay the onset of puberty. Is the treatment legal or illegal? To know the answer, one must know whether the child is cisgender or transgender. The treatment is legal if the child is cisgender but illegal if the child is transgender, because the statute prohibits GnRH agonists only for transgender children, not for anyone else. The theoretical but remote-to-the-point-of-nonexistent possibility that a child will be identified as transgender before needing GnRH agonists for the treatment of central precocious puberty does not change the essential nature of the distinction.

Adverse treatment of transgender individuals should trigger intermediate scrutiny for another reason, too. In *United States v. Carolene Products Co.*, 304 U.S. 144, 152 n.4 (1938), the Court suggested heightened scrutiny might be appropriate for statutes showing "prejudice against discrete and insular minorities." Courts have continued to apply the discrete-and-insular-minority construct. *See, e.g.*, *Foley v. Connelie*, 435 U.S. 291, 294–95 (1978) (citing *Carolene Products* and noting that "close scrutiny" applies to equal-protection claims of resident aliens, who lack access to the political process); *Estrada v. Becker*, 917 F.3d 1298, 1310 (11th Cir. 2019) (citing *Carolene Products*; recognizing that, under *Foley*, heightened scrutiny applies to resident aliens; but declining to afford the same

treatment to illegal immigrants). Transgender individuals are a discrete and insular minority.

The Supreme Court further explained this basis for heightened scrutiny in *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 447–50 (1985). There the Court declined to extend strict or even intermediate scrutiny to intellectually disabled individuals—those with very limited mental ability. But the Court gave two explanations that support a different result for transgender individuals.

First, *City of Cleburne* noted that strict scrutiny applies when the characteristic at issue is almost never a legitimate reason for governmental action. Race is the paradigm—leaving aside affirmative action as a remedy for prior discrimination, it is almost never appropriate to parcel out government benefits or burdens based on race. Transgender status is much the same. Transgender status is rarely an appropriate basis on which to parcel out government benefits or burdens.

Second, *Carolene Products* and *Foley* both referred to a minority's lack of political voice as a basis for heightened scrutiny. *City of Cleburne* noted that the class of intellectually disabled individuals had garnered considerable public and political support—that this was not a class lacking political access. The same is not true of transgender individuals, who continue to suffer widespread private opprobrium and governmental discrimination, notably in the statute and rules now under review. This is precisely the kind of government action, targeted at a discrete

and insular minority, for which heightened scrutiny is appropriate. *See Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020) (holding transgenders are a quasi-suspect class); *Karnoski v. Trump*, 926 F.3d 1180, 1201 (9th Cir. 2019) (same). *But see Adams*, 57 F.4th at 803 n.5 (noting that whether transgender status is a quasi-suspect class was not at issue there but, in dictum, expressing "grave doubt").

In any event, *City of Cleburne* is important for another reason, too. The Court applied rational-basis scrutiny, but it was *meaningful* rational-basis scrutiny. The Court did not blindly accept a proffered reason for the city's action that did not withstand meaningful analysis. The defendants' proffered reasons here, like those in *City of Cleburne*, do not withstand meaningful analysis. *See Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022) (affirming a preliminary injunction and holding the plaintiffs were likely to prevail on their equal-protection challenge to an Arkansas statute banning gender-affirming care for minors); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131 (M.D. Ala. May 13, 2022) (granting a preliminary injunction and holding plaintiffs were likely to prevail on their equal-protection and parental-rights challenge to Alabama's ban on puberty blockers and cross-sex hormones).

3. Cases involving identical, not different, treatment of classes

In opposing heightened scrutiny, the defendants cite *Geduldig v. Aiello*, 417 U.S. 484 (1974), for the proposition that heightened scrutiny does not apply when there are members of the allegedly disfavored class on both sides of the challenged classification. *Geduldig* held that exclusion of pregnancy from state employees' health coverage was not sex discrimination. Some women become pregnant, some do not. The defendants say this is why the challenged provision did not discriminate based on sex—there were women on both sides. Note, though, that men and women were treated the same: nobody had health coverage for pregnancy. When men and women are treated the same, the Court reasoned, it is not intentional sex discrimination, even if the challenged provision has a disparate impact.

The situation is different here. Transgender and cisgender individuals are not treated the same. Cisgender individuals can be and routinely are treated with GnRH agonists, testosterone, or estrogen, when they and their doctors deem it appropriate. Not so for transgender individuals—the challenged statute and rules prohibit it. To know whether treatment with any of these medications is legal, one must know whether the patient is transgender. And to know whether treatment with testosterone or estrogen is legal, one must know the patient's natal sex.

This is differential treatment based on sex and transgender status. *Geduldig* is not to the contrary. Intermediate scrutiny applies.

C. Applying the proper level of scrutiny

To survive intermediate scrutiny, a state must show that its classification is substantially related to a sufficiently important interest. *Adams*, 57 F.4th at 801 (cleaned up); *see also Glenn*, 663 F.3d at 1316. To survive rational-basis scrutiny, a state must show a rational relationship to a legitimate state interest. *Romer*, 517 U.S. at 631. The challenged statute and rules survive neither level of scrutiny.

The record establishes that for some patients, including the three now at issue, a treatment regimen of mental-health therapy followed by GnRH agonists and eventually by cross-sex hormones is the best available treatment. These patients and their parents, in consultation with their doctors and multidisciplinary teams, have rationally chosen this treatment. The State of Florida's decision to ban the treatment is not rationally related to a legitimate state interest.

Dissuading a person from conforming to the person's gender identity rather than to the person's natal sex is not a legitimate state interest. The medical defendants have acknowledged this.[55] But the state's disapproval of transgender status—of a person's gender identity when it does not match the person's natal

[55] Trial Tr. in *Dekker*, ECF No. 242 at 97–98.

sex—was a substantial motivating factor in enactment of the challenged statute and rules.

Discouraging individuals from pursuing their gender identities, when different from their natal sex, was also a substantial motivating factor. In a "fact sheet," the Florida Department of Health asserted social transitioning, which involves no medical intervention at all, should not be a treatment option for children or adolescents.[56] Nothing could have motivated this remarkable intrusion into parental prerogatives other than opposition to transgender status itself.

State action motivated by purposeful discrimination, even if otherwise lawful, violates the Equal Protection Clause. *See Adams*, 57 F.4th at 810 (recognizing that an otherwise neutral law still violates the Equal Protection Clause when it is "motivated by 'purposeful discrimination'") (citing *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 274 (1979)); *see also Greater Birmingham Ministries v. Sec'y of State for Ala.*, 992 F.3d 1299, 1321–22 (11th Cir. 2021). The statute and rules at issue were motivated in substantial part by the plainly illegitimate purposes of disapproving transgender status and discouraging individuals from pursuing their honest gender identities. This was purposeful discrimination against transgenders.

The plaintiffs are likely to succeed on their equal-protection claim.

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[56] Defs.' Ex. 5 in *Dekker*, ECF No. 193-5 at 1.

X. Parental rights

The plaintiffs also assert a claim under the Due Process Clause, which protects a parent's right to control a child's medical treatment. *See, e.g.*, *Troxel v. Granville*, 530 U.S. 57 (2000) (plurality); *Parham v. J.R.*, 442 U.S. 584, 602–03 (1979); *Maddox v. Stephens*, 727 F.3d 1109, 1118–19 (11th Cir. 2013); *Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990).

The defendants say a parent's right to control a child's medical treatment does not give the parent a right to insist on treatment that is properly prohibited on other grounds. Quite so. If the state could properly prohibit the treatments at issue as unsafe, parents would have no right to override the state's decision. But as set out above, there is no rational basis, let alone a basis that would survive heightened scrutiny, for prohibiting these treatments in appropriate circumstances.

The plaintiffs are likely to prevail on their parental-rights claim.

XI. The pretextual justifications for the statute and rules

In support of their position, the defendants have proffered a laundry list of purported justifications for the statute and rules. The purported justifications are largely pretextual and, in any event, do not call for a different result.

A. "Low quality" evidence

A methodology often used for evaluating medical studies—for evaluating research-generated evidence on the safety and efficacy of any given course of

treatment—is known as Grading of Recommendations, Assessment, Development, and Evaluation ("GRADE"). The defendants stridently assert that the evidence supporting the treatments at issue is "low" or "very low" quality as those terms are used in the GRADE system. But the evidence on the other side—the evidence purportedly showing these treatments are ineffective or unsafe—is far weaker, not just of "low" or "very low" quality. Indeed, evidence suggesting these treatments are ineffective is nonexistent.

The choice these plaintiffs face is binary: to use GnRH agonists and cross-sex hormones, or not. It is no answer to say the evidence on the yes side is weak when the evidence on the no side is weaker or nonexistent. There is substantial and persuasive, though not conclusive, research showing favorable results from these treatments.[57] A decision for the three patients at issue cannot wait for further or better research; the treatment decision must be made now.

Moreover, the fact that research-generated evidence supporting these treatments gets classified as "low" or "very low" quality on the GRADE scale does not mean the evidence is not persuasive, or that it is not the best available research-generated evidence on the question of how to treat gender dysphoria, or that medical treatments should not be provided consistent with the research results and clinical evidence.

[57] *See, e.g.*, Trial Tr. in Dekker, ECF No. 228 at 41–42.

It is commonplace for medical treatments to be provided even when supported only by research producing evidence classified as "low" or "very low" on this scale.[58] The record includes unrebutted testimony that only about 13.5% of accepted medical treatments across all disciplines are supported by "high" quality evidence on the GRADE scale.[59] The defendants' assertion that treatment should be banned based on the supporting research's GRADE score is a misuse of the GRADE system.

We put band-aids on cuts to keep dirt out not because there is "high" quality research-generated evidence supporting the practice but because we know, from clinical experience, that cuts come with a risk of infection and band-aids can reduce the risk.

Gender dysphoria is far more complicated, and one cannot know, with the same level of confidence, how to treat it. But there is now extensive clinical experience showing excellent results from treatment with GnRH agonists and cross-sex hormones. If these treatments are prohibited, many patients will suffer needlessly.[60] The extensive clinical evidence is important and indeed persuasive

[58] *See* Trial Tr. in *Dekker*, ECF No. 227 at 98–101.
[59] Trial Tr. in *Dekker*, ECF No. 226 at 68–69.
[60] Trial Tr. in *Dekker*, ECF No. 226 at 64; Trial Tr. in *Dekker*, ECF No. 238 at 97–98.

evidence, even if the supporting research has produced only "low" or "very low" quality evidence on the GRADE scale.

When facing a binary decision to use or not use GnRH agonists or hormones, a reasonable decisionmaker would consider the evidence on the yes side, as well as the weaker evidence on the no side. Calling the evidence on the yes side "low" or "very low" quality would not rationally control the decision.

B. Risks attendant to treatment

The defendants assert there are risks attendant to treatment with GnRH agonists and cross-sex hormones. Indeed there are. There are legitimate concerns about fertility and sexuality that a child entering puberty is not well-equipped to evaluate and for which parents may be less-than-perfect decisionmakers. There is a risk of misdiagnosis, though the requirement in the standards of care for careful analysis by a multidisciplinary team should minimize the risk. There is a risk that a child later confronted with the bias that is part of our world will come to believe it would have been better to try to pass as cisgender.

There also are studies suggesting not that there *are* but that there *may be* additional medical risks. An unreplicated study found that sheep who took GnRH agonists became worse at negotiating a maze, at least for a time. Another study showed a not-statistically-significant but nonetheless-concerning decrease in IQ among cisgender children treated for central precocious puberty with GnRH

agonists. These and other studies cited by the defendants would surely be rated low or very-low quality on the GRADE scale and, more importantly, are not very persuasive. The latter study has not led to a ban on the use of GnRH agonists to treat central precocious puberty. One cannot know from these studies whether treating transgender adolescents with GnRH agonists will cause comparable adverse results in some patients. But the risk that they will is a risk a decisionmaker should reasonably consider.

That there are risks does not end the inquiry. There are also substantial benefits for the overwhelming majority of patients treated with GnRH agonists and cross-sex hormones. And there are risks attendant to *not* using these treatments, including the risk—in some instances, the near certainty—of anxiety and depression and even suicidal ideation. The challenged statute ignores the benefits that many patients realize from these treatments and the substantial risk posed by foregoing the treatments—the risk from failing to pursue what is, for many, the most effective available treatment of gender dysphoria. One of the *Dekker* plaintiffs attempted suicide four times before beginning successful treatment with cross-sex hormones; he is now thriving.[61]

If the three plaintiffs at issue here do not start GnRH agonists soon, they will go through puberty consistent with their natal sex. They will live with the

[61] Trial Tr. in *Dekker*, ECF No. 228 at 150 & 166–67.

consequences for the rest of their lives. The likelihood is very high that they will suffer attendant adverse mental-health consequences. If, on the other hand, they *do* get GnRH agonists, they will avoid some of the adverse consequences. They also will face attendant risks.

Risks attend many kinds of medical treatment, perhaps most. Ordinarily it is the patient, in consultation with the doctor, who weighs the risks and benefits and chooses a course of treatment. What is remarkable about the challenged statute and rules is not that they address medical treatments with both risks and benefits but that they arrogate to the state the right to make the decision. And worse, the statute and rules make the same decision for everybody, without considering any patient's individual circumstances. The statute and rules do this in contravention of widely accepted standards of care.

That there are risks of the kind presented here is not a rational basis for denying patients the option to choose this treatment.

C. Bias in medical organizations

The defendants say the many professional organizations that have endorsed treatment of gender dysphoria with GnRH agonists and hormones all have it wrong. The defendants say, in effect, that the organizations were dominated by individuals who pursued good politics, not good medicine.

If ever a pot called a kettle black, it is here. The statute and the rules were an exercise in politics, not good medicine.

This is a politically fraught area. There has long been, and still is, substantial bigotry directed at transgender individuals. Common experience confirms this, as does a Florida legislator's remarkable reference to transgender witnesses at a committee hearing as "mutants" and "demons."[62] And even when not based on bigotry, there are those who incorrectly but sincerely believe that gender identity is not real but instead just a choice. This is, as noted above, the elephant in the room.

Where there is bigotry, there are usually—one hopes, always—opponents of bigotry. It is hardly surprising that doctors who understand that transgender identity can be real, not made up—doctors who are willing to provide supportive medical care—oppose anti-transgender bigotry.

It sometimes happens that opponents of bigotry deem opposing viewpoints bigoted even when they are not. And it sometimes happens that those with

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[62] *Hearing on Facility Requirements Based on Sex*, CS/HB 1521 2023 Session (Fla. Apr. 10, 2023), https://www.myfloridahouse.gov/VideoPlayer.aspx?eventID=8804 (time stamp 2:30:35 to 2:34:10). Representative Webster Barnaby said to transgender Florida citizens who spoke at the hearing that they were "mutants living among us on Planet Earth." He raised his voice and said, "[T]his is Planet Earth, where God created men, male and women, female!" He continued: "[T]he Lord rebuke you Satan and all of your demons and imps that come parade before us. That's right I called you demons and imps who come and parade before us and pretend that you are part of this world." Finally, he said, you can "take [him] on" but he "promises [he] will win every time."

opposing viewpoints are slow to speak up, lest they be accused of bigotry. These dynamics could affect a medical association's consideration of transgender treatment. The record suggests these dynamics *have* affected the tone and quality of debate within WPATH. It is entirely possible that the same dynamics could have affected the tone and quality of debate within other associations.

Even so, it is fanciful to believe that all the many medical associations who have endorsed gender-affirming care, or who have spoken out or joined an amicus brief supporting the plaintiffs in this litigation, have so readily sold their patients down the river. The great weight of medical authority supports these treatments. The widely accepted standards of care require competent therapy and careful evaluation by a multidisciplinary team before use of GnRH agonists and cross-sex hormones for treatment of gender dysphoria. But the widely accepted standards of care support their use in appropriate circumstances. The standards have been unanimously endorsed by reputable medical associations, even though not unanimously endorsed by all the members of the associations.

The overwhelming majority of doctors are dedicated professionals whose first goal is the safe and effective treatment of their patients. There is no reason to believe the doctors who adopted these standards were motivated by anything else.

D. International views

The defendants have asserted time and again that Florida now treats GnRH agonists and cross-sex hormones the same as European countries. A heading in the defendants' response to the current motions is typical: "Florida Joins the International Consensus." The assertion is false. And no matter how many times the defendants say it, it will still be false. No country in Europe—or so far as shown by this record, anywhere in the world—entirely bans these treatments.

To be sure, there are countries that ban gays and lesbians and probably transgender individuals, too. One doubts these treatments are available in Iran or other similarly repressive regimes. But the treatments are available in appropriate circumstances in all the countries cited by the defendants, including Finland, Sweden, Norway, Great Britain, France, Australia, and New Zealand.[63] Some or all of these insist on appropriate preconditions and allow care only in approved facilities—just as the Endocrine Society and WPATH standards insist on appropriate preconditions, and just as care in the United States is ordinarily provided through capable facilities. Had Florida truly joined the international consensus—making these treatments available in appropriate circumstances or in

[63] *See* Trial Tr. in *Dekker*, ECF No. 226 at 78–79; *see also* Trial Tr. in *Dekker*, ECF No. 227 at 134; Trial Tr. in *Dekker*, ECF No. 228 at 61–62.

approved facilities—these plaintiffs would qualify, and the instant motions would not be necessary.

E. Malpractice

The defendants assert, with no real evidentiary support, that GnRH agonists and cross-sex hormones have sometimes been provided in Florida without the appropriate mental-health therapy and evaluation by a multidisciplinary team.

If that were true, the solution would be to appropriately regulate these treatments, not to ban them. And there are, of course, remedies already in place in Florida for deficient medical care. There is no evidence that this kind of care is routinely provided so badly that it should be banned outright.

Along the same lines, the defendants say gender dysphoria is difficult to diagnose accurately—that gender identity can be fluid, that there is no objective test to confirm gender identity or gender dysphoria, and that patients treated with GnRH agonists or cross-sex hormones have sometimes come to regret it. But the defendants ignore facts that do not support their narrative. Fluidity is common prior to puberty but not thereafter. Regret is rare; indeed, the defendants have offered no evidence of any Florida resident who regrets being treated with GnRH agonists or cross-sex hormones. And the absence of objective tests to confirm gender dysphoria does not set it apart from many other mental-health conditions

that are routinely diagnosed without objective tests and treated with powerful medications.

The difficulty diagnosing a patient calls for caution. It does not call for a one-size-fits-all refusal to provide widely accepted medical treatment.[64] It does not call for the state to make a binary decision not to provide the treatment even for a properly diagnosed patient.

F. Continuation of treatment

The defendants note that 98% or more of adolescents treated with GnRH agonists progress to cross-sex hormones. That is hardly an indictment of the treatment; it is instead consistent with the view that in 98% or more of the cases, the patient's gender identity did not align with natal sex, this was accurately determined, and the patient was appropriately treated first with GnRH agonists and later with cross-sex hormones. An advocate who denies the existence of genuine transgender identity or who wishes to make everyone cisgender might well fear progression to cross-sex hormones, but the defendants have denied that this is a basis for their current reference to this progression.

The defendants say, instead, that the high rate of progression rebuts an argument in support of GnRH agonists: that GnRH agonists give a patient time to

[64] *See* Trial Tr. in *Dekker*, ECF No. 239 at 91–94 (defense expert Dr. Levine explaining that medical intervention such as puberty blockers and hormones should be carefully prescribed and monitored but not banned).

reflect on the patient's gender identity and, if still convinced of a gender identity opposite the natal sex, to reflect on whether to go forward socially in the gender identity or natal sex. But if that is a goal of treatment with GnRH agonists, it is certainly not the treatment's *primary* goal. The primary goal is to delay and eventually avoid development of secondary sex characteristics inconsistent with the patient's gender identity—and thus to avoid or reduce the attendant anxiety, depression, and possible suicidal ideation.

The high rate of progression from GnRH agonists to cross-sex hormones is not a reason to ban the treatments.

G. Off-label use of FDA-approved drugs

The defendants note that while the Food and Drug Administration has approved GnRH agonists and the hormones at issue as safe and effective, the agency has not addressed their use to treat gender dysphoria. Quite so. Use of these drugs to treat gender dysphoria is "off label."

That the FDA has not approved these drugs for treatment of gender dysphoria says precisely nothing about whether the drugs are safe and effective when used for that purpose. Off-label use of drugs is commonplace and widely accepted across the medical profession. The defendants' contrary implication is divorced from reality.

Obtaining FDA approval of a drug is a burdensome, expensive process.[65] A pharmaceutical provider who wishes to market a new drug must incur the burden and expense because the drug cannot be distributed without FDA approval. Once a drug has been approved, however, the drug can be distributed not just for the approved use but for any other use as well. There ordinarily is little reason to incur the burden and expense of seeking additional FDA approval.

That the FDA approved these drugs at all confirms that, at least for one use, they are safe and effective.[66] This provides some support for the view that they are safe when properly administered and that they effectively produce the intended results—that GnRH agonists delay puberty and that testosterone and estrogen have masculinizing or feminizing effects as expected. The FDA approval goes no further—it does not address one way or the other the question whether using these drugs to treat gender dysphoria is as safe and effective as on-label uses.

That use of GnRH agonists and cross-sex hormones to treat gender dysphoria is "off-label" is not a reason to ban their use for that purpose.

XII. Other prerequisites to a preliminary injunction

The plaintiffs have met the other prerequisites for a preliminary injunction. The plaintiffs' adolescent children will suffer irreparable harm—the unwanted and

[65] Trial Tr. in *Dekker*, No. 226 at 182–84; Trial Tr. in *Dekker* No. 227 at 120–23; Trial Tr. in *Dekker*, ECF No. 239 at 54–55.
[66] Trial Tr. in *Dekker*, No. 226 at 182–84; Trial Tr. in *Dekker* No. 227 at 120–23.

irreversible onset and progression of puberty in their natal sex—if they do not promptly begin treatment with GnRH agonists. The treatment will affect the patients themselves, nobody else, and will cause the defendants no harm. The preliminary injunction will be consistent with, not adverse to, the public interest. Adherence to the Constitution is always in the public interest.

XIII. Improper defendants

The plaintiffs seek prospective relief under 42 U.S.C. § 1983. They are entitled to such relief against appropriate state officials in their official capacity. *See Ex parte Young*, 209 U.S. 123 (1908).

The Attorney General's motion asserts she is not an appropriate defendant—that she has no authority to enforce, and no other involvement with, the challenged statute and rules. That may be correct. The preliminary injunction will not run against the Attorney General, at least pending a ruling on her motion to dismiss.

A state itself is not a "person" who may be held liable under § 1983, and in any event a state has Eleventh Amendment immunity from a § 1983 claim in federal court. *See, e.g.*, *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 64 (1989) (holding that a state is not a "person" within the meaning of § 1983); *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44 (1996) (holding that a state sued in its own name has Eleventh Amendment immunity, regardless of the relief sought, unless

the immunity has been waived or validly abrogated by Congress under the Fourteenth Amendment).

The defendants Florida Board of Medicine and Florida Board of Osteopathic Medicine are agencies of the state—the jurisdictional equivalent of the state itself. Their presence in the case may be, in any event, merely redundant to that of their individual members, acting in their official capacities. *Cf. Busby v. City of Orlando*, 931 F.2d 764, 776 (11th Cir. 1991) (approving the dismissal of official-capacity defendants whose presence was merely redundant to the naming of an institutional defendant).

This order does not resolve the question whether the Boards will stay in the case. But the preliminary injunction will run against the Board members, not the Boards themselves. A broader preliminary injunction is not needed.

XIV. Conclusion

Gender identity is real. Those whose gender identity does not match their natal sex often suffer gender dysphoria. The widely accepted standard of care calls for evaluation and treatment by a multidisciplinary team. Proper treatment begins with mental-health therapy and is followed in appropriate cases by GnRH agonists and cross-sex hormones. Florida has adopted a statute and rules that prohibit these treatments even when medically appropriate. The plaintiffs are likely to prevail on

their claim that the prohibition is unconstitutional. And they have met the other prerequisites to a preliminary injunction.

The plaintiffs thus are entitled to a preliminary injunction of appropriate scope. Federal Rule of Civil Procedure 65(c) requires a party who obtains a preliminary injunction to "give[] security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined." This order requires the plaintiffs to give security for costs in a modest amount. Any party may move at any time to adjust the amount of security.

IT IS ORDERED:

1. The motion for a preliminary injunction, ECF Nos. 30 and 57, is granted in part.

2. The motion for a temporary restraining order, ECF No. 57, is denied as moot.

3. A preliminary injunction is entered against these defendants: Joseph Ladapo, in his capacity as the Surgeon General of the Florida Department of Health; Scot Ackerman, Nicholas W. Romanello, Wael Barsoum, Matthew R. Benson, Gregory Coffman, Amy Derick, David Diamond, Patrick Hunter, Luz Marina Pages, Eleonor Pimentel, Hector Vila, Michael Wasylik, Zachariah P. Zachariah, Maria Garcia, and Nicole Justice, in their official capacities as members

of the Florida Board of Medicine; Watson Ducatel, Tiffany Sizemore Di Pietro, Gregory Williams, Monica Mortensen, Valerie Jackson, Chris Creegan, and William D. Kirsh, in their official capacities as members of the Florida Board of Osteopathic Medicine; and State Attorneys Ginger Bowen Madden, Jack Campbell, John Durrett, Melissa Nelson, William Gladson, Bruce Bartlett, R.J. Larizza, Brian S. Kramer, Monique H. Worrell, Brian Haas, Kathern Fernandez Rundle, Ed Brodsky, Susan S. Lopez, Larry Basford, Dave Aronberg, Dennis Ward, Harold F. Pryor, Phil Archer, Thomas Bakkedahl, and Amira D. Fox, in their official capacities.

4. The preliminarily enjoined parties must not take any steps to prevent the administration of GnRH agonists or cross-sex hormones to Susan Doe, Gavin Goe, or Lisa Loe in accordance with professional standards that would apply to use of the same substances to treat patients with other medical conditions.

5. The preliminarily enjoined parties must not take any steps to enforce against Susan Doe, Gavin Goe, or Lisa Loe, or their parents or healthcare providers, Florida Statutes § 456.52(1) & (5) or Florida Administrative Code rules 64B8-9.019(1)(b) or 64B15-14.014(1)(b).

6. This preliminary injunction will take effect upon the posting of security in the amount of $100 for costs and damages sustained by a defendant found to have

been wrongfully enjoined. Security may be posted by a cash deposit with the Clerk of Court.

7. This preliminary injunction will terminate upon entry of a final judgment or when otherwise ordered.

8. This preliminary injunction binds the defendants and their officers, agents, servants, employees, and attorneys—and others in active concert or participation with any of them—who receive actual notice of this injunction by personal service or otherwise.

SO ORDERED on June 6, 2023.

s/Robert L. Hinkle
United States District Judge

Doc. 61

Dekker v Weida: 4:22-cv-325

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
v.	)	Tallahassee, Florida
	)	October 12, 2022
SIMONE MARSTILLER, et al.,	)	
	)	9:33 AM
Defendants.	)	
_____	)	

TRANSCRIPT OF PRELIMINARY INJUNCTION PROCEEDINGS
BEFORE THE HONORABLE ROBERT L. HINKLE
UNITED STATES CHIEF DISTRICT JUDGE
(Pages 1 through 120)

Court Reporter: MEGAN A. HAGUE, RPR, FCRR, CSR
111 North Adams Street
Tallahassee, Florida 32301
megan.a.hague@gmail.com

Proceedings reported by stenotype reporter.
Transcript produced by Computer-Aided Transcription.

APPEARANCES:

For Plaintiffs:

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.com
120 Wall Street
19th Floor
New York, New York 10005

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JENNIFER ALTMAN
Attorney at Law
jennifer.altman@pillsburylaw.com
600 Brickell Avenue
Suite 3100
Miami, Florida 33131

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorney at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DEBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

National Health Law Program
By: CATHERINE ANNE MCKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

APPEARANCES (continued):

For Defendants: Holtzman Vogel Baren, et al.
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street
Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(Call to Order of the Court at 9:33 AM on Wednesday, October 12, 2022.)

THE COURT: Good morning. Please be seated.

We're here on the plaintiffs' motion for a preliminary injunction. I've read all of the papers. I've read the record. I think I'm up to speed.

The plaintiffs submitted evidence but did not indicate they wish to call any live witnesses. Defense has indicated it wishes to call live witnesses. Unless either side has something you want to tell me first, we can go straight to the witnesses.

Is there anything on the plaintiffs' side you want to tell me before we do that?

MR. GONZALEZ-PAGAN: No, Your Honor. We're ready to proceed with the witnesses if defendants are.

THE COURT: All right. And for the defense?

MR. GONZALEZ-PAGAN: Your Honor, we would just note that we would have a standing objection regarding the relevance regarding the lay witnesses, and we filed a motion to that effect as well.

THE COURT: And I read the motion and the response. I'm not going to exclude the witnesses wholesale. The -- if the testimony is relevant, it's not a very high standard.

Yes.

MR. PERKO: May it please the Court, the defense would

like to call Dr. Michael K. Laidlaw --

THE COURT: All right.

MR. PERKO: -- by remote -- or video.

THE COURT: All right. And for what it's worth, I've read Dr. Laidlaw's declaration, so I've seen some of what he has to say.

MR. PERKO: Good morning, Dr. Laidlaw. Can you hear me?

THE WITNESS: I can hear you okay.

THE COURT: I need to speak with him first.

Dr. Laidlaw, are you there in a room by yourself?

THE WITNESS: I am.

THE COURT: All right. You should be by yourself while you're testifying. If anyone else comes into the room where you are, if you'd stop and let me know, we'll address it.

If you would, please, raise your right hand.

DR. MICHAEL K. LAIDLAW, DEFENSE WITNESS, DULY SWORN

THE COURT: Please tell us your full name, and spell your last name for the record for our record.

THE WITNESS: Michael K. Laidlaw. That's spelled L-a-i-d, as in David, L-a-w.

THE COURT: All right. And the lawyers will have some questions for you.

MR. PERKO: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Laidlaw, could you please briefly describe your educational background?

A. Sure. I got a bachelor's degree of science in biology, concentration in molecular cell biology, at San José State University. I received a medical doctor degree from University of Southern California in 2001. I went on to train in an internal medical residency at the same location and did a -- for three years and did a two-year fellowship afterwards in endocrinology, diabetes and metabolism, and took and passed board certifications in both of those areas.

Q. Could you briefly describe your professional experiences in obtaining your degrees?

A. Yes. Since that time, since 2006, I've been in private practice in endocrinology, primarily outpatient but some inpatient work, in Rocklin, California.

Q. Can you describe us -- or tell us what endocrinology entails?

A. Yeah. Endocrinology involves the study of disorders of glands and hormones, structural gland disorders such as cancer or tumors, and then hormonal imbalances such as high hormone levels of, say, the thyroid or testosterone or estrogen or low levels of these hormones and the consequences -- physical and mental consequences that occur from these hormones. And so I diagnosis and treat these conditions.

Q. Are you a member of any professional associations?
A. I am a member of the Endocrine Society.
MR. PERKO: Your Honor, at this time we'd proffer Dr. Laidlaw as an expert in endocrinology.
MR. CHARLES: Objection, Your Honor. I'd like to voir dire the witness.
THE COURT: You may certainly voir dire the witness.
MR. CHARLES: May it please the Court, Your Honor. My name is Carl Charles for the plaintiffs.

VOIR DIRE EXAMINATION

BY MR. CHARLES:
Q. Dr. Laidlaw, can you hear me?
A. Yes.
Q. Okay. Dr. Laidlaw, you wrote a declaration that was filed in this case; correct?
A. Correct.
Q. And as a part of that declaration, you submitted a CV entitled "Exhibit A"?
A. Yes.
Q. And you're not a practicing psychiatrist; is that correct, Dr. Laidlaw?
A. That is correct.
Q. You are not a licensed mental health care provider; is that correct?
A. That's correct.

Q. And you're not a psychologist; is that correct?
A. That is correct.
Q. And, Dr. Laidlaw, you're not an obstetrician; is that correct?
A. That is correct.
Q. And, Dr. Laidlaw, you're not a gynecologist; is that correct?
A. That is correct.
Q. And you're not a surgeon, Dr. Laidlaw; is that correct?
A. That's correct.
Q. And you're not a pediatric endocrinologist; is that correct?
A. That is correct.
Q. Less than 5 percent of your patients are under the age of 18; is that correct?
A. Yes.
Q. And you're not a bioethicist; is that correct?
A. I have no formal training other than an IRB certification many years ago.
Q. Okay. So you don't practice as a bioethicist; is that correct?
A. That's correct.
Q. And you haven't done any primary research on fertility; is that correct?
A. No primary research on fertility; that's correct.

Q. And you haven't done any primary research on sterility; is that correct?
A. That is correct.
Q. And you haven't written any articles which have been subjected to a confirmed peer-review process about fertility; is that correct?
A. I -- specifically about fertility -- I don't know what the peer review -- I had a paper in *The American Journal of Bioethics.* I don't know what the peer-review process was.
Q. Okay. So you -- again, you have not written any articles which have been subjected to a peer review for process which you can confirm about fertility; is that correct?
A. Not that I can confirm.
Q. And you haven't written any articles that have been subjected to a confirmed peer-review process about sterility; is that correct?
A. Correct.
Q. And you haven't performed any primary research about medical ethics; is that correct?
A. That's correct.
Q. And you haven't written any confirmed peer-reviewed publications about medical ethics; is that correct?
A. I have not independent -- there is the article that I mentioned. I have not independently confirmed the peer-review process.

Q. Okay. You cannot confirm that that article has been peer reviewed?
A. I cannot confirm.
Q. And you have not performed any primary research about informed consent; is that correct?
A. That's correct.
Q. And you have not written any articles confirmed to be peer reviewed regarding parents' ability to consent for treatment for their minor children; is that correct?
A. I have not written a peer reviewed article on that topic.
Q. And none of the publications listed in your CV attached to your declaration are based on original primary research; is that correct?
A. That's correct.
Q. And you haven't done any primary research about transgender people; is that correct?
A. Just to clarify, when you say "primary research," you're talking about using human subjects in the research -- as part of the research rather than a review of the literature; is that correct?
Q. You haven't done any original primary research about transgender people; is that correct?
A. In the context of working with human subjects, that is correct.
Q. And that includes any research about children and

adolescents; isn't that correct?
A. Yes. With regard to human subjects, that is correct.
Q. And you haven't received any grants to support research into endocrine treatments for gender dysphoria; is that correct?
A. That is correct.
Q. And you have not done any original primary research about the treatment of gender dysphoria; is that correct?
A. Not with human subjects; that's correct.
Q. And you haven't performed any original primary research into the frequency of gender -- into how frequently gender dysphoria occurs; is that correct?
A. I have not done primary research involving which -- human subjects on that matter.
Q. And you haven't -- and you have not done any original primary research about the phenomenon of desistance; is that correct?
A. I have not done primary research with human subjects on that condition -- for that condition.
Q. And you've never diagnosed anyone with gender dysphoria; is that correct?
A. That is correct.
Q. And you've previously testified under oath that you've only provided care to one transgender patient related to the treatment of gender dysphoria; is that correct?
A. I have worked with patients with gender incongruence in the

context of my practice, but as far as providing hormones, there was -- someone with gender dysphoria, there was one.

Q. And it was only to provide that patient with a refill of estrogen; is that correct?

A. There was an evaluation. There was an office visit, and there was necessity for a refill of estrogen in that case.

Q. Okay. And so you did not deny the patient the refill of the estrogen?

A. That's correct.

Q. So you have utilized the Endocrine Society guidelines for the treatment of gender dysphoria once; is that correct?

A. This was -- this preceded the Endocrine Society guidelines.

Q. What year was the treatment of that patient?

A. It was in the early 2000s. It was prior to -- it was prior to 2009, which is when the first Endocrine Society guidelines were published.

Q. In your private practice, Dr. Laidlaw, you do not contract with California Medicaid insurance; is that correct?

A. That's correct.

Q. And you have not spoken with any transgender Florida Medicaid beneficiaries; is that correct?

A. Yeah, not that I'm aware of.

Q. And that would include the plaintiffs in this matter; is that correct?

A. That's correct.

Q. And that would also include the parents of the minor plaintiffs in this case; is that correct?
A. Yeah, I have not spoken directly with them. That is correct.
Q. And you have not evaluated any transgender Florida Medicaid beneficiaries for any endocrine issues; is that correct?
A. That's correct.
Q. And you have not evaluated any of the plaintiffs for issues related to the endocrine treatment they are receiving for their gender dysphoria; is that correct?
A. I have evaluated medical records that were provided to me.
Q. Right. But you have not evaluated those individuals for the purposes of the endocrine treatment they are receiving as treatment for their gender dysphoria?
A. When you say "evaluate," I presume you mean a direct history and physical evaluation. I have not done that.
Q. And you have not spoken with any of the plaintiffs' current treating medical providers; is that correct?
A. That's correct.
Q. So you have not spoken with their qualified mental health care professionals; is that correct?
A. That's correct.
Q. And you have not spoken with any of their primary care physicians; is that correct?
A. That's correct.

Q. And you have not spoken with any of the plaintiffs' current treating endocrinologists; is that correct?
A. That's correct.
Q. And you have not reviewed the entirety of these individuals' medical records; is that correct?
A. That is correct.
MR. CHARLES: Your Honor, if I may have just one moment to confer with counsel?
THE COURT: You may.
(Discussion was held.)
MR. CHARLES: Your Honor, I would make a proffer at this time that due to Dr. Laidlaw's lack of experience treating gender dysphoria or writing or publishing in this area, due to his lack of evaluation of the plaintiffs or the complete review of their medical records, that he not be able to testify further as to the contents of his declaration at this time.
THE COURT: The objection is overruled. There are subjects on which he may be able to testify. If you have objections to individual questions, you may object as they arise.
MR. CHARLES: Thank you, Your Honor.
THE COURT: Mr. Perko, you may proceed.
MR. PERKO: Thank you, Your Honor.

CONTINUED DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Laidlaw, you submitted a declaration in this matter, didn't you?

A. I did.

Q. And have you reviewed the declarations -- rebuttal declarations that the plaintiffs submitted in response to your declaration?

A. Yes.

Q. And do you stand by the opinions in your declaration, notwithstanding those rebuttal reports?

A. Yes, I do stand by those opinions.

Q. What were your opinions expressed in your declaration based on?

A. My opinions are based on my education and clinical experience in endocrinology, my work with gender incongruent patients in the context of my practice, including a detransitioner, my extensive evaluation of the scientific literature regarding the treatment of gender dysphoria, gender incongruence for adults and minors, and also my review of all the plaintiffs' declarations and the medical records provided to me.

Q. Dr. Laidlaw, you stated that you had limited experience with gender dysphoria. But have you reviewed the literature with regard to gender dysphoria in the gender-affirming care?

A. I have reviewed the literature extensively over the last at least four years.
Q. And why is that?
A. Well, for a few reasons. One is that these treatments that they advocate for involve hormones and raising hormone levels to sometimes very high levels or very low levels. So I've taken an interest in the risk-and-benefit ratio of these types of treatments, and this is something I do every day in endocrinology.

Furthermore, before my colleagues and I are to follow any sort of treatment protocol, I think it's essential that these studies and so forth are evaluated to determine the risk-benefit profile before any of us use these treatments.

Q. And, Dr. Laidlaw, what exactly is gender dysphoria?
A. Gender dysphoria is -- well, there's a couple of terms that would be helpful. Gender identity is a person's internal or mental sense of being male or female or perhaps some other designation, and there's an incongruence or mismatch in these cases with their physical body. For example, a person may identify as a female but have been born with a male body, and so there is resulting distress and impairment of function. There's different definitions from there on as to how long it lasts and slight differences for adults versus children and adolescents.
Q. And is gender dysphoria an endocrine disorder?
A. It's not an endocrine disorder. It's a disorder found in

the DSM-V, *Diagnostic and Statistical Manual of Mental Disorders.*

Q. Are there any objective tests for diagnosing gender dysphoria?

A. There are no objective tests insofar as you can't do a scan or -- a brain scan, for example, or a blood test, a genetic test, or other biomarkers cannot test and confirm gender dysphoria.

Q. Dr. Laidlaw, what is desistance?

A. Desistance is a condition where someone had -- once had gender dysphoria or gender incongruence and then over time lost or changed that condition such that some go on to fully identify their internal sense of gender identity that is equivalent with their physical body that they were born with.

Q. And what is detransition?

A. Detransition is a further step that one may take who has desisted or is in the process of desisting such that they are -- you might think of it as reserving the process that they went through in transition. So they may stop the hormones that they were taking. They may dress in a manner more typical of the sex of their nation. They may opt to reverse surgeries and so forth to align their identity with their physical body and their perception in society.

Q. So, Dr. Laidlaw, would you consider gender identity to be immutable?

A. No.
Q. And why is that?
A. Well, I think that it's proved by the desistance, particularly with young people. Children have high desistance rates. There are many detransitioners who are adults, including one patient of mine, which proves that this gender identity is not immutable.
Q. Doctor, switching gears a little bit, you say in your declaration that hormone treatment for gender dysphoria can lead to infertility.
Is that always the case?
MR. CHARLES: Objection, Your Honor.
The witness has already stated he's not qualified to opine about this subject.
MR. PERKO: I don't believe that's the case, Your Honor. He's talking about hormone therapy, and he's an endocrinologist.
THE COURT: I'll overrule the objection. I'm going to be the finder of fact.
When Dr. Laidlaw has knowledge because of his actual medical practice, as opposed to having read some stuff over the last four years, you might want to point it out, because he's not going to persuade me very much -- he may persuade me, but he's less likely to persuade me when all he is telling me is what he has read and not what he has applied in his practice.

MR. PERKO: Yes, Your Honor.
BY MR. PERKO:
Q. Can you answer the question, Dr. Laidlaw?
A. Could you repeat the question, please?
Q. You state in your declaration that hormone treatment for gender dysphoria can lead to infertility. Is that always the case?
A. That is not always the case. It depends at what stage of puberty the gender dysphoria treatment was initiated. For example, in late stages of puberty or adulthood, a person may take hormones of the opposite sex, for example, and then withdraw those hormones and then later regain fertility, where they were once infertile while taking those hormones. But if puberty is stopped in a very early stage, say before ovulation takes place for a female or sperm production takes place for a male, then while they're taking these hormones they will remain in an infertile state.
Q. Dr. Laidlaw --
THE COURT: That -- for example, how does he know that?
BY MR. PERKO:
Q. How do you know that, Doctor?
A. Well, that's based on -- I mean, part of endocrinology is sexual development. We deal with gonads -- male/female gonads, reproductive issues, infertility issues. For example, I see

woman with polycystic ovarian syndrome who have high testosterone levels which leads to infertility that in some cases I treat with Metformin. So infertility is part of our, you know, daily workup.

And understanding what happens to children, as they get older, they could develop infertility as children and present as adults, for example, because of their endocrine disorders. The thing with the treatment that they're advising is that they're inducing the infertility through their hormones that they're prescribing rather than it developing natally in the body, but the situation is the same.

Q. Dr. Laidlaw, are you familiar with the standards of care for gender dysphoria developed by the World Professional Association for Transgender Health, or WPATH?

A. Yes.

Q. And why are you familiar with those?

A. For a couple of reasons. This is -- there's a recently published "Standards of Care 8" by WPATH. These relate to our Endocrine Society guidelines last published in 2017 that were created with mainly WPATH authors. So I've studied these documents in order to understand what the effects of these treatments would be on any of my patients before I were to endeavor to follow their recommendations.

Q. And do you follow the WPATH standards of care?

A. I do not.

Q. Why not?
A. Could you repeat?
Q. Why not?
A. Why not was the question?
Well, for -- one thing is that they're not standards of care. They're standards of care that exist within their own organization, but they're not widely accepted standards of care. In fact, the Endocrine Society, which worked with WPATH on their own set of guidelines, says explicitly that they're not standards of care. So these -- I see these as an opinion on what should be done with these patients but not the exclusive rule.
Q. And you mentioned the Endocrine Society's guidelines. Do you follow the Endocrine Society guidelines?
A. I have read the guidelines extensively. They have ratings for the quality of evidence which you can read, which are low, very low quality, or absent evidence. There are some useful facts in those guidelines, but again, I think their determination to use high doses of hormones and block normal puberty has more risks than benefits. So I do not follow the recommendations of those guidelines.
Q. Dr. Laidlaw, switching gears again, in your report, you talked about your review of medical records for the plaintiffs.
What specifically did you review?
A. I was provided case notes for two patients. There was an

Excel spreadsheet with dates of service, diagnostic and procedure codes. And then for two other patients there were medical records provided in association with authorizations for medications and, I think, procedures.

Q. Dr. Laidlaw, the plaintiffs' expert rebuttal reports criticize you for making conclusions based on your review of the medical records.

Could you please respond to those criticisms?

A. Well, as I said, I've spent quite a bit of time evaluating guidelines and papers on gender dysphoria to make a determination if the risks exceed the benefits for these patients. So going into it, I believe already that the risks exceed the benefits.

However, when reviewing the records, I can also see medications, whether it be contraindications or concerns. I can see diagnoses where the application of high doses of hormones are blocking puberty could compound the patient's problems. So the risk level I determined was heightened for these plaintiffs based on that limited review.

Q. And did you rely on your professional experience in making those conclusions?

A. Yes, I relied on my professional experience in endocrinology to make those decisions.

Q. Without getting into specifics, Dr. Laidlaw, what did you conclude based on your review of the medical records?

A. I concluded that the risks outweighed the benefits for hormone social transition and surgery for the plaintiffs or minors.

MR. PERKO: May I confer with Counsel, Your Honor?

THE COURT: You may.

(Discussion was held.)

MR. PERKO: We have no further questions, Your Honor.

THE COURT: Cross-examine.

MR. CHARLES: Yes, Your Honor.

If I may just have a moment.

(Pause in proceedings.)

CROSS-EXAMINATION

BY MR. CHARLES:

Q. Okay. Dr. Laidlaw, can you hear me?

A. Yes.

Q. You testified that you have determined that based on a review of incomplete medical records that gender-affirming care for the plaintiffs could compound their problems; is that right?

A. Yes.

Q. You're not referring to endocrine problems, are you?

A. Endocrine problems are a part of it, yes.

Q. Okay. So what is the endocrine problem you're referring to?

A. Issues of hypogonadotropic hypogonadism, hyperandrogenism, hyperestrogenemia, and consequential infertility growth

abnormalities that occur from those.
Q. You said that was part of it; is that correct?
A. Yes.
Q. And the other part of it is nonendocrine problems. What are you referring to?
A. Referring to issues with patients' underlying psychological conditions that could be worsened by hormone manipulation.
Q. But you not a psychiatrist; is that correct?
A. No, but I have to make these evaluations every day to determine if my hormone prescription --
Q. Dr. Laidlaw, I understand --
THE COURT: Wait. Wait. Wait. When he's answering, you have to let him answer the question.
MR. CHARLES: Yes, Your Honor.
THE WITNESS: I have to assess if the hormones that I'm providing are going to exacerbate or cause psychological conditions.
BY MR. CHARLES:
Q. But as a nonpsychiatrist, you don't know if those hormones are going to exacerbate any psychiatric conditions?
A. They can affect -- I mean, there's warnings on the medications themselves that they can affect psychiatric conditions.
Q. And you're not a psychologist, right, Dr. Laidlaw?
A. That's correct.

Q. Psychological conditions?
A. I do not make diagnoses, but we're trained in psychology and psychiatry. It's part of our medical licensing.
Q. Okay. But you are not a practicing psychologist?
A. That's correct.
Q. And you're not a practicing psychiatrist?
A. That's correct.
Q. And you have not met with any of the plaintiffs in this matter --
THE COURT: Mr. Charles, I sat through the voir dire. I'm not going to sit through it again on cross. You get one chance to ask some questions. You've asked those. Let's ask some new ones.
MR. CHARLES: Thank you, Your Honor.
BY MR. CHARLES:
Q. Dr. Laidlaw, you stated you don't follow the WPATH standards of care; is that right?
A. Yes.
Q. But you testified earlier you don't treat gender dysphoria; is that correct?
A. I don't treat gender dysphoria with hormones and surgeries.
Q. Dr. Laidlaw, are you aware that your opposition to gender-affirming care for the treatment of gender dysphoria in youth and adults is contrary to the vast majority of medical associations' recommendations?

A. Yes.
Q. Dr. Laidlaw, can you see the screen share that I've just enabled?
A. Yes, I can.
MR. CHARLES: Your Honor, can you see that as well?
THE COURT: I can. It's hiding under the table up here, but I've got it.
MR. CHARLES: Okay.
BY MR. CHARLES:
Q. Dr. Laidlaw, are you aware that the American Academy of Child and Adolescent Psychiatry supports gender-affirming care for youth?
A. I haven't looked at that specifically.
Q. Okay. And looking at the document here, I'll --
MR. CHARLES: Let me ensure -- Defense Counsel, can you view this document?
MR. PERKO: Yes.
MR. CHARLES: Okay. So I'd like to enter this as Exhibit P1.
BY MR. CHARLES:
Q. This is the -- Dr. Laidlaw, this is the "American Academy of Child and Adolescent Psychiatry Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender-Diverse Youth."
Do you see that?

A. Yes.
Q. And it's dated November 8, 2019?
A. Yes.
Q. And if you could, just read aloud for me that highlighted portion, please.
A. Sure.

Many reputable professional organizations, including the American Psychological Association, the American Psychiatric Association, the American Academy of Pediatrics, and the Endocrine Society, which represent tens of thousands of professionals across the United States, recognize natural variations in gender identity and expression and have published clinical guidance that promotes nondiscriminatory, supportive interventions for gender-diverse youth based on the current evidence base. These interventions may include, and are not limited to, social gender transition, hormone-blocking agents, hormone treatment, and affirmative psychotherapeutic modalities.

The American Academy of Child and Adolescent Psychiatry supports the use of current evidence-based clinical care with minors. AACAP strongly opposes any efforts -- legal, legislative, and otherwise -- to block access to these recognized interventions.

Q. Thank you.

THE COURT: You apparently asked to have this admitted into evidence. I don't think I've seen this, so this may not

have been in the record previously.

MR. CHARLES: Just one moment, Your Honor.

It wasn't, Your Honor, but I do have copies I can provide to the Court to so enter.

THE COURT: Didn't I require disclosures before today? If I didn't, it would certainly depart from the standard of care for judges.

MR. CHARLES: I apologize, Your Honor. I wasn't -- I didn't see that designation so -- in your order.

THE COURT: I may not have.

Do you object to the admission of this?

MR. PERKO: Yes, Your Honor, for the reasons you just stated.

Also, I would suggest that it's really irrelevant to this witness's testimony because it talks about the American Psychological Association. He's already testified he's not a psychologist.

THE COURT: You can't have it both ways.

I'll admit it subject to going back and looking at the scheduling orders and --

(Discussion was held.)

BY MR. CHARLES:

Q. Dr. Laidlaw, is what you just read consistent with your understanding of the position of these organizations?

A. Are you talking about the AACAP?

Q. Yes, let's start with that one.
A. Well, I'm just reading it now for the first time, so it must be -- it was 2019 -- unless they have changed their opinion.
Q. Okay. But you don't have any --
THE COURT: Let me just back up. I'm going to exclude the exhibit. I did require things to be disclosed, and you can't come up to the hearing and bring up a new exhibit that you didn't timely disclose.
MR. CHARLES: Okay.
THE COURT: So Plaintiffs' 1 is excluded.
The scheduling order is ECF No. 32.
MR. CHARLES: Okay. Thank you, Your Honor.
Ms. Markley, you can unpublish, please. Thank you.
BY MR. CHARLES:
Q. Dr. Laidlaw, are you aware that the American Academy of Family Physicians supports gender-affirming care for youth and adults?
A. Supports gender-affirming care for youth and adults?
Q. Yes. Do you need to me to repeat? Did you hear that?
A. They probably do. I don't know their exact statement.
Q. Okay. Are you aware that the American Academy of Family Physicians published a policy statement in July of 2022, approved by their board of directors, entitled "Care for the Transgender and Gender Nonbinary Patient"?

A. I have not read that particular document -- Family Practice Document.
Q. Okay. Are you aware that the American Academy of Family Physicians supports gender-affirming care as an evidence-informed intervention that can promote permanent health equity for gender-diverse individuals?
MR. PERKO: Your Honor, I would object for the same reasons. He's essentially reading from an exhibit that was not disclosed.
THE COURT: He's now exploring the witness's knowledge of the situation in the field. The objection is overruled.
BY MR. CHARLES:
Q. Dr. Laidlaw --
A. I'm not a family practice physician, so I don't keep up with --
Q. Just a moment. Sorry. Let me start over.
A. -- the literature of that organization.
Q. I'm sorry. Can you please repeat that?
A. I said I'm not a family practice physician; I'm an endocrinologist, so I don't keep up with whatever they're publishing.
Q. Okay. So I -- let me just ask you one more question about that brief -- or policy statement. Excuse me.
Are you aware that the American Academy of Family Physicians asserts the full spectrum of gender-affirming health

care should be legal and should remain a treatment decision between a physician and their patient?
A. I'm not surprised.
Q. Can -- so does that mean you are or are not aware?
A. I don't read the Family Practice documents, unless they are provided to me.
Q. Dr. Laidlaw, are you aware the American Academy of Pediatrics supports gender-affirming care for youth?
A. Yes.
Q. Dr. Laidlaw, are you aware that the American College of Obstetricians and Gynecologists has recommendations and conclusions that support gender-affirming care for youth and adults?
A. I'm not -- again, I'm not surprised, but I don't read their literature regularly for that purpose.
Q. Okay. Are you aware that the American College of Obstetricians and Gynecologists has conclusions that gender-affirming hormone therapy is not effective contraception?
A. That gender-affirming therapy is not effective contraception?
Q. Correct.
A. I have read that. I'm not sure if it was theirs or someone else who is publishing that. I'm aware of that concept.
Q. Can you repeat your answer? I didn't understand you.
A. I said I haven't read their statements specifically, but

I'm aware of the concept or proposition that gender-affirming hormones are not effective contraception.

Q. Okay. So you're not aware of the American College of Obstetricians and Gynecologists conclusion that it is not effective contraception?

A. I have not read their particular conclusion.

Q. Are you aware that the American College of Physicians, the largest medical specialty society in the world with 160,000 internal medicine and subspecialty members, supports public and private health care coverage of gender-affirming care?

A. I'm not aware that all 160,000 members voted to approve such a thing, but I'm aware that they have issued a statement like that.

Q. You are aware they issued such a statement?

A. Yes.

Q. Are you aware that in 2022, the American College of Physicians issued a brief supporting access to gender-affirming care and opposing discriminatory policies enforced against LGBTQ people and objected, in particular, to the interference with the physician-patient relationship and the penalization of evidence-based care?

A. I may have read that particular statement from that organization.

Q. Are you aware that the American Medical Association supports gender-affirming medical care for youth and adults?

A. Yes.
Q. Are you aware that in April of 2021, the American Medical Association wrote a letter to the National Governors Association objecting to the interference with health care of transgender children?
A. I believe I had come across that headline.
Q. Are you aware that the American Medical Association, in conjunction with GLMA, has issued a brief in support of public and private insurance coverage of gender-affirming care?
A. I'm not a member of the American Medical Association. I think only 20 percent of physicians in the nation are even a member. So I don't follow everything they say, but I do believe I read that document.
Q. Do you have evidence to support your assertion that only 20 percent of medical practitioners in the United States are members of the AMA?
A. I don't have a piece of paper with evidence, but that's my general understanding. I'm not a member.
Q. But you don't have any evidence today to point to to support that assertion?
A. No.
Q. Are you aware that in 2022, the American Medical Association reaffirmed it's resolution in support of private and public health care coverage for the treatment of gender dysphoria as recommended by a patient's physician in Resolution

Number 158.950?
A. I have not read that resolution.
Q. Are you aware, Dr. Laidlaw, that the American Psychological Association has guidelines that support access to gender-affirming care for youth and adults?
A. Yes.
Q. Are you aware that the American Psychological Association opposes gender-identity change efforts as a broad practice described as a range of techniques used by mental health professionals and nonprofessionals with the goal of changing gender identity, gender expression, or associated components of these, to be in alignment with gender role behaviors stereotypically associated with their sex assigned at birth?
A. Yes, I am aware.
Q. Are you aware that the American Psychiatric Association supports gender-affirming medical care for youth specifically?
A. Yes.
Q. Are you aware that the American Psychiatric Association has a position statement from 2018, supporting access to care for transgender and gender-variant individuals broadly?
A. Yes, I believe so.
Q. Are you aware that the Endocrine Society and the Pediatric Endocrine Society take the position that there is a durable biological underpinning to gender identity that should be considered in policy determinations?

A. I would have to read -- I have not read that particular statement from the Endocrine Society. I would like to see that before I make a -- conclude anything.
Q. Okay. Are you aware this determination was included in a position statement published in December of 2020?
A. I have read that position statement.
Q. And are you aware that the Endocrine Society and the Pediatric Endocrine Society take the position that medical intervention for transgender youth and adults is effective, relatively safe when appropriately monitored, and has been established as the standard of care?
A. Well, they wrote that it was not the standard of care in 2017, so they're contradicting themselves.
Q. Dr. Laidlaw, are you aware that that statement is contained in the transgender health position statement issued December 2020?
A. I believe I read that.
Q. And are you aware that the Endocrine Society and the Pediatric Endocrine Society take the position that federal and private insurers should cover such interventions as prescribed by a physician, as well as the appropriate medical screenings that are recommended for all body tissues that a person may have?
A. I believe I read something along those lines.
Q. Are you aware that the Pediatric Endocrine Society supports

gender-affirming care for youth?
A. Yes.
Q. Are you aware they published a position statement to that effect in April of 2021?
A. Yes. I wrote an article describing why their conclusions are false or incorrect.
Q. Are you aware the Pediatric Endocrine Society recommends an affirmative model of care that supports one's gender identity and follows a multidisciplinary approach that includes involvement of mental health professionals, patients and their families. Puberty suppression and/or gender-affirming hormone therapy is recommended within this evidence-based approach on a case-by-case basis as medically necessary and potentially lifesaving.

Are you aware that was contained in the Pediatric Endocrine Society statement?
A. I am aware that it's contained. I don't agree with it, but, yes, I'm aware.

THE COURT: If we're leading up to something, you can go ahead with all of this. If all you're doing is publishing stuff I've already read --

MR. CHARLES: No, Your Honor.

THE COURT: You're welcome to make a closing argument later and to go through all of this, but if -- this is an incredibly inefficient way to publish material.

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023 /s/ Mohammad O. Jazil

No. 23-12159

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME IV OF XIII

Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
(850) 274-1690

Counsel for Defendants-Appellants Florida Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

Ashley Moody
Attorney General of Florida

Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
(850) 414-3300

Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

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10	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
10-11	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
11	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
11	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
11	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
11-12	Doc.193-16, DX16	WPATH Standards of Care, Version 8
12-13	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
13	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: September 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
Phone: (850) 391-0503
Facsimile: (850) 741-1023
mjazil@holtzmanvogel.com
mbeato@holtzmanvogel.com
Counsel for Defendants-Appellants Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

/s/Joseph E. Hart
Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
Phone: (850) 414-3300
henry.whitaker@myfloridalegal.com
joseph.hart@myfloridalegal.com
Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

MR. CHARLES: Your Honor --

THE COURT: So if that's all we are doing, let's move on.

MR. CHARLES: Thank you, Your Honor. I'm -- I do have a final comment for Dr. Laidlaw related to --

THE COURT: I've been patient through all that, and if you're setting up another question, that's fine.

MR. CHARLES: Okay. Thank you, Your Honor.

Just two more documents. I appreciate your patience.

BY MR. CHARLES:

Q. Dr. Laidlaw, are you aware the Society for Adolescent Health and Medicine supports gender-affirming care for youth?

A. No.

Q. Are you aware the Society for Adolescent Health and Medicine issued a statement in opposition to state legislation barring evidence-based treatment?

A. No.

Q. And, Dr. Laidlaw, are you aware that the World Medical Association, which includes 115 national medical associations, supports gender-affirming care?

A. No.

Q. So, Dr. Laidlaw, you're aware that your opinions related to gender-affirming care are in contrast to all of those medical associations' statements that we just reviewed?

MR. PERKO: Objection, Your Honor.

THE COURT: Overruled.

THE WITNESS: Yeah. Sorry. Could you repeat the question?

BY MR. CHARLES:

Q. You are aware that your opinions against gender-affirming care for the treatment of gender dysphoria are contrary to the positions of the medical associations' statements we just reviewed?

A. Yes.

MR. CHARLES: Just one moment, Your Honor.

(Discussion was held.)

MR. CHARLES: No further questions, Your Honor.

THE COURT: Redirect?

MR. PERKO: Very briefly, Your Honor.

May it please the Court.

REDIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Laidlaw, you testified that you consider mental health effects of hormone therapy in your practice; is that correct?

A. That is correct.

Q. Okay. And why do you consider the potential mental health effects of hormone therapy in your practice?

MR. CHARLES: Objection, Your Honor.

THE COURT: Overruled.

THE WITNESS: To give you maybe a more concrete

example, the thyroid is a gland that makes thyroid hormone. When people have very high levels of thyroid hormone, we call that hyperthyroidism. They can have physical effects like fast heart rates, heart palpitations, tremors, but they can also have mental effects like anxiety and even psychosis. This can occur because their body develops too much thyroid hormone, or they may be taking too high of a dose of thyroid hormone.

So I have to distinguish if a mental health condition is related to a hormone imbalance versus a native psychological condition, or both sometimes.

BY MR. PERKO:

Q. Dr. Laidlaw, one final question.

How many patients a year do you treat with hormone treatments?

A. For hormone treatments?

Q. Yes.

A. Well, all of them, for the most part. I'd have to make an estimate. I see about 50 patient visits a week 50 weeks or so out of the year.

MR. PERKO: Thank you, Your Honor. No further questions.

THE COURT: Dr. Laidlaw, I want to ask you a question, and to do it, I need to define a couple of terms. These may not be the best definitions. They are my definition for purposes of my question.

I'm going to refer to natal identity as the identity at birth, and then I'm going to refer to gender identity as a person's perceived identity, the identity the person believes is the correct identity for the person.

Here's my question. In your opinion, is it ever appropriate for any medical professional in any specialty to support a person's decision to live in the person's gender identity instead of in the person's natal identity?

THE WITNESS: Ever under any circumstances, is that what you are saying?

I think my determination is that, in general, the risks of the hormones that are required and surgeries outweigh the benefits for the majority of people. I recognize there's some small degree of adults, perhaps, who are living this way. There are risks to mental health and things like that. So I'm not opposed to personal autonomy, but I am concerned about risks versus benefits, particularly for minors and youth.

THE COURT: So is the answer no?

THE WITNESS: I guess no.

THE COURT: Questions to follow up on mine?

MR. PERKO: No, Your Honor.

MR. CHARLES: No, Your Honor.

THE COURT: Thank you, Dr. Laidlaw. That concludes your testimony.

THE WITNESS: Thank you.

(Dr. Laidlaw exited the Zoom video conference.)

THE COURT: Please call your next witness.

MR. BEATO: Your Honor, we call Zoe Hawes as our next witness.

MR. PERKO: Your Honor, we don't have any additional witnesses remotely.

THE COURT: We are trying to turn it off.

(Ms. Hawes entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

ZOE HAWES, DEFENSE WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name, and spell your last name for the record.

THE WITNESS: Zoe Hawes, H-a-w-e-s.

DIRECT EXAMINATION

BY MR. BEATO:

Q. Good morning, Ms. Hawes. Michael Beato on behalf of the defendants.

Did you submit a declaration in this case?

A. Yes.

(Pause in proceedings.)

MR. BEATO: Your Honor, may I approach the witness to give her her declaration?

THE COURT: No. Just ask her a question before you

show her her declaration.

MR. BEATO: Of course, Your Honor.

BY MR. BEATO:

Q. Ms. Hawes, your declaration states that you suffered from many mental health issues as a teenager. What were those issues?

A. Yes. So by the age of 15, I was diagnosed with anxiety and major depressive disorder. I was later diagnosed with gender dysphoria, PTSD, and OCD.

Q. You state in your declaration that you met with people.

THE COURT: Look, if a general statement and -- we'll have a trial later in the case, and so here's my statement to both sides -- and some of the lawyers have heard me say this before -- I'm the finder of fact. If you want me to believe what a witness says, your chances are much better if you ask a nonleading question and the witness testifies. If you tell the witness what to say and the witness says yes, it's rarely persuasive.

So you can do it any way you want, but let me just tell you that to the extent that you're just going to read her what she said before -- first, I'll sustain an objection to that question, if there is one, and if there's not, it's not very likely to persuade me.

MR. BEATO: Yes, Your Honor.

BY MR. BEATO:

Q. Ms. Hawes, what gender-affirming treatments did you receive?

A. I started testosterone at the age of 16.

Q. For how long did you receive this treatment?

A. About four years.

Q. What are the physical effects of receiving this treatment?

A. I -- first my menstrual cycle stopped, and then gradually my body started to change, facial hair growth, my voice lowered.

Q. How was your mental health at this time?

A. Not great. I -- anxiety became debilitating to where I dropped out of school. I was unable to keep a job, and I was very -- still very suicidal and was in and out of the hospital six times.

Q. Did you seek any other treatments for gender dysphoria at this time?

A. I was planning and hoping to get a double mastectomy and hysterectomy.

Q. When did you stop taking testosterone?

A. At the age of 20.

Q. And why did you stop taking testosterone?

A. I -- after a suicide attempt, I realized that my peace was not going to come from changing my body, and I began to work on my inner self and not trying to fix the physical.

Q. What happened after you stopped taking testosterone?

A. Gradually my body started to refeminize. I started to have more peace.
Q. And can you describe your mental and physical health now?
A. Much, much better. I've been able to keep a job and -- yeah.
Q. Have you experienced any significant life incidents stopping taking testosterone?
A. Can you repeat the question?
Q. Sure. Or let me rephrase.
Your declaration says that you're married and are expecting a son?
MR. GONZALEZ-PAGAN: Objection. Leading.
THE WITNESS: Yes.
THE COURT: That much is okay. Overruled.
BY MR. BEATO:
Q. How long have you been married?
A. Almost two years.
Q. And when are you expecting a son?
A. At the end of January.
Q. Congratulations.
A. Thank you.
Q. My final question is why did you not receive the gender transition surgeries?
A. I -- at the time we could not afford it. I really, really wanted it and thought it would bring lasting peace. But I

couldn't afford it, and my insurance would not pay for it.

MS. CHRISS: Objection. Calls for speculation.

THE COURT: Overruled.

MR. BEATO: One moment, Your Honor.

No further questions.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MS. CHRISS:

Q. Good afternoon, Ms. Hawes.

THE COURT: Introduce yourself to me. I didn't take appearances to begin with, and so I apologize. But tell me --

MS. CHRISS: I apologize, Your Honor. Thank you.

My name is Simone Chriss, and I represent the plaintiffs in this matter.

BY MS. CHRISS:

Q. Thank you for being here, Ms. Hawes.

In order to keep this succinct and sufficient for the Court, most of the questions that I'm going to ask you are being -- will be in yes or -- can be answered by yes or no; okay?

A. Okay.

Q. Great. Ms. Hawes, you don't live in the state of Florida; correct?

A. Correct.

Q. And you don't receive health insurance through Florida's

Medicaid program; correct?
A. Correct.
Q. You've never received health insurance through Florida Medicaid?
A. Correct.
Q. And you've never received any treatment in the state of Florida?
A. Correct.
Q. Are you aware that this case concerns a rule related to Florida's Medicaid program?
A. Yes.
Q. Were you contacted by anyone, Ms. Hawes, to provide testimony in this case?
A. Yes.
Q. And who were you contacted by?
A. Vernadette (phonetic). I don't know the last name. I'm sorry.
Q. Who is that person?
A. I know she's an attorney.
Q. And what were you asked to do in this case?
A. I was invited to share my story.
Q. And you filed a declaration in this case; correct?
A. Yes, ma'am.
Q. Who prepared the initial draft of that declaration?
A. I am not sure. I think Vernadette, but I'm not positive.

Q. Were you compensated for your time in this case?
A. No.
Q. Ms. Hawes, you stated that you were on testosterone for almost four years; is that correct?
A. Yes.
Q. And you're now an expectant mother?
A. Yes.
Q. You're are not a mental health provider; is that correct?
A. Correct.
Q. And you're not a health care provider?
A. Correct.
Q. And you don't have a medical degree?
A. Correct.
Q. And you don't know any of the plaintiffs in this case?
A. Correct.
Q. So you can only speak to your personal experience with accessing medical care outside of Florida; correct?
A. Yes.
Q. You don't know whether the plaintiffs in this case have benefited from the treatment that they received; is that correct?
A. I don't know them, so correct.
MS. CHRISS: Your Honor, may I have a moment to confer?
THE COURT: You may.

(Discussion held.)

MS. CHRISS: No further questions, Your Honor.

Thank you.

THE COURT: Redirect?

MR. BEATO: No further questions, Your Honor.

THE COURT: Ms. Hawes, before you started testosterone treatment, tell me what kind of medical care you got for the gender dysphoria issues or gender-related issues. What kind of doctor? Where? How much time?

THE WITNESS: I saw a therapist in Norman, Oklahoma, and she was some kind of certified gender therapist. I'm not sure of the precise title on that. But she was qualified to do what she was doing, and I saw her about three, four months. We went over childhood history, everything that led me to believe that I was male, and she was agreeing with what I was saying and feeling, and so after three or four months she signed off on starting testosterone.

THE COURT: The therapist, do you know if it was a medical doctor?

THE WITNESS: The one who signed the document saying I was ready to start testosterone was a therapist, but I was referred to an endocrinologist that had handled that before.

THE COURT: And the therapist is a licensed social worker? Do you know what education level --

THE WITNESS: She was licensed. I'm not sure what

degree or anything like that.

THE COURT: You don't know if she was a medical doctor?

THE WITNESS: Correct. I don't think she was, like, a doctor.

THE COURT: How much time did you spend with the endocrinologist?

THE WITNESS: I had one consultation visit before starting testosterone.

THE COURT: And did you talk to the endocrinologist about the gender-identity issues --

THE WITNESS: Yes.

THE COURT: -- or just about the drug and the treatment?

THE WITNESS: She knew what I was coming in with and asked me brief questions about if I'm sure, and I had to sign a paper saying I understood, like, what I was getting into.

THE COURT: So brief questions. What? 15 minutes? 30 minutes? Two hours? How long?

THE WITNESS: Maybe, like, 45 minutes of just sharing.

THE COURT: Some of that included what testosterone does?

THE WITNESS: Yeah.

THE COURT: I take it some discussion of risks --

THE WITNESS: Yeah.

THE COURT: -- and so forth?

Questions just to follow up on mine?

MR. BEATO: No, Your Honor.

MS. CHRISS: No, Your Honor. Thank you.

THE COURT: All right. Thank you, Ms. Hawes. You may step down.

(Ms. Hawes exited the courtroom.)

THE COURT: Please call your next witness.

MR. JAZIL: Your Honor, Yaacov Sheinfeld is the final witness.

(Mr. Sheinfeld entered the witness stand.)

THE COURT: Right up here, sir.

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

YAACOV SHEINFELD, DEFENSE WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state and spell your full name for the record.

THE WITNESS: Yaacov Sheinfeld.

THE COURTROOM DEPUTY: Could you spell it, please?

THE WITNESS: Y-a-a-c-o-v S-h-e-i-n-f-e-l-d.

DIRECT EXAMINATION

BY MR. JAZIL:

Q. Good morning, Mr. Sheinfeld.

You submitted a declaration in this case --

A. Yes.

Q. -- is that correct?

And your declaration talks about the experience of you and your daughter dealing with transition; is that correct?

A. Yes, I did.

Q. Did your daughter see a therapist?

A. Yes, about since the age of 14, 15.

Q. Why did she start seeking therapy at the age of 14, 15?

A. It was evident that she had issues relating to anxiety and depression.

Q. When did she tell you that she wanted to transition?

A. She was about 17 and a half, 17 and 10 months. I'm sorry about the exact time because it's been about ten years ago.

Q. Was she still suffering with the depression, anxiety that you mentioned at that time?

A. Absolutely.

Q. Did your daughter take any testosterone hormones?

A. Yes. After seeing a therapist in North Hampton where she went to college, she was put on a regimen of testosterone and medication.

Q. What was her age when she started taking the testosterone?

A. I submitted your firm a printout from CVS which contains hundreds of -- hundreds of drugs.

MS. ALTMAN: Your Honor, I would object. It's hearsay at this point.

THE COURT: Well, it probably is. If he doesn't

remember, he doesn't remember.

THE WITNESS: Thank you.

As a father --

THE COURT: Wait. He's going to ask you another question.

THE WITNESS: Okay.

Go ahead.

BY MR. JAZIL:

Q. So the question was do you just remember the age she was?

A. Yes.

Q. What was her age when she started taking the testosterone?

A. Probably 18, 18 and a half.

Q. Now, in your declaration, you also discuss a meeting with a social worker.

Can you briefly tell us what happened at that meeting?

A. Okay. This is in North Hampton. And in a 45-minute time span it was clear to me that the social worker would not consider my total objection to this journey. She dismissed my concerns. She disregarded them, told me to join this journey and just accept my daughter and love her, and everything would be okay.

Q. What happened after that meeting?

A. I was very angry. Could you specify the question, please?

Q. Did she -- did your daughter get any other gender-affirming treatments after that meeting?

A. I'm sure she did.

MS. ALTMAN: Your Honor, objection. I believe it's hearsay.

THE COURT: It probably is.

Sustained.

BY MR. JAZIL:

Q. Do you know whether your daughter got any surgeries after that?

A. Of course she did. The exact date is unknown to me, but she did. She had a double mastectomy. I think it was around the age of 18 and a half. And the reason why I think is because all her medical treatment was kept away from me. Nobody told me anything.

Q. So after the surgery, from your perspective, was there -- what was your daughter's mental health from your perspective after the surgery?

MS. ALTMAN: Your Honor, objection. He just testified that all of the mental health was kept away from him.

THE COURT: Overruled.

BY MR. JAZIL:

Q. So after the surgery, from your perspective, what effect did the surgery and the other treatments have on your daughter's mental health?

THE COURT: Well, I'll sustain an objection to that question. You can ask what he observed, what he saw, what he

heard her say about her mental situation. But he's not going to give a diagnosis.

MR. JAZIL: Yes, Your Honor.

BY MR. JAZIL:

Q. What did you observe?

A. I observed a -- my daughter -- rest her soul -- I saw no improvement. I saw deterioration of her soul and body, her mental health. Her body went through all these changes. They were very difficult for me to accept. And her depression was still evident. All the drugs she took, hundreds of them, had side effects of -- all kinds of effects on her body, her voice, her demeanor, and she wasn't any happier. I can tell you that. There was no improvement in her accepting who she is.

Q. Mr. Yaacov, reading your declaration, it announced your daughter passed away. When did she pass away?

A. October 6, 2021.

Q. Briefly tell us the circumstances of her death.

A. She was found dead in a hotel room alone at the Best Western in West Orange with fentanyl in her system.

THE COURT: He has some.

A. She committed suicide.

BY MR. JAZIL:

Q. Mr. Sheinfeld, I'm sorry for your loss.

MR. JAZIL: I have no further questions. Thank you.

THE COURT: Cross-examine.

MS. ALTMAN: Good morning, Your Honor. May it please the Court, my name is Jennifer Altman.

CROSS-EXAMINATION

BY MS. ALTMAN:

Q. Sir, whenever you're ready.

A. I'm ready.

Q. First of all, on behalf of the plaintiffs, we all certainly do apologize for your loss. It is certainly unfathomable.

I'm going to ask you some questions, and I apologize if they are indelicate under the circumstances, but you have submitted a declaration here.

Virtually all, if not all of them, are yes-or-no questions, and for efficiency, I would ask that you try and answer in that manner.

Are you transgender?

A. No.

Q. Have you ever been diagnosed with gender dysphoria?

A. No.

Q. Have you ever been treated for gender dysphoria?

A. No.

Q. Is it fair to assume you've never been denied treatment for gender dysphoria?

A. No.

Q. Have you ever spoken with any of the treating physicians for the transgender plaintiffs in this action?

A. No.
Q. Do you have a medical degree?
A. No.
Q. Do you have a master's degree in behavioral health?
A. No.
Q. Do you have a doctorate in any specialty relating to psychology?
A. No.
Q. Do you have a bachelor of science or any other degree in psychology?
A. No, but I do have another degree. I have a degree in architectural -- in architecture.
Q. Have you ever treated an individual with gender dysphoria?
A. No.
Q. Would you agree with me, sir, that you have no clinical, educational, or academic training on the treatment of gender dysphoria?
THE WITNESS: Your Honor, can I elaborate on that?
THE COURT: Well, just answer the question she asked.
THE WITNESS: Well, it can't be just yes or no. I have to elaborate on that.
BY MS. ALTMAN:
Q. Do you need me to repeat the question?
A. Yes, please.
Q. You would agree with me, sir, that you have no clinical,

educational, or academic training on the treatment of gender dysphoria?
A. Yes, but it doesn't render me as somebody who is incompetent or somebody without logic to render my decision.
Q. Do you understand my question?
THE COURT: Well, look, you asked an argumentive question; he gets to give an argumentive answer.
BY MS. ALTMAN:
Q. Do you understand the question, sir?
A. I do understand the question.
Q. Do you have any clinical, educational, or academic experience?
A. Educational, yes.
Q. Okay. Can you describe for the Court what your educational experience is in the treatment of gender dysphoria?
A. I think that we are dealing with a genuine feeling of certain individuals who do not agree with their assigned birth assignment, quote/unquote, but I think there is huge underlying issues of these individuals that --
Q. Sir, did you understand the question?
THE COURT: Wait, wait. Let him finish his answer.
When you ask an argumentive question for no reason other than to make your argument, he gets to make his argument in response. If you want to just ask factual questions, I'll make him give you the factual answer, but it has to be something

that has some factual purpose in the case.

MS. ALTMAN: Understood, Your Honor, but my question was his educational experience.

THE COURT: And you asked that solely for the reason of making an argument. He has a degree in architecture. He has no degree in any mental health area. When the only reason to ask a question is to make an argument, you have to listen to the argument that comes back.

MS. ALTMAN: Fair enough, Your Honor.

THE COURT: You may finish your answer, Mr. Sheinfeld.

THE WITNESS: Thank you, Your Honor.

So I'm not here to render any decisions about other individuals who may have genuine feelings of discomfort with their body. All I know is -- what's your name, please?

BY MS. ALTMAN:

Q. Ms. Altman.

A. Ms. Altman.

Q. Yes, sir.

A. All I know is that the system -- and I call the system, you know, the world, the Internet, her friends -- influenced her into a journey that killed her. She's dead. I buried her a year ago, and I'm very angry, because they all failed her. My daughter did not deserve this. So that's my educational, quote/unquote, answer to you.

Q. Understood.

Your daughter died of an overdose of fentanyl and alcohol; correct?

A. Yes, yes.

Q. Sir, were you involved in any of the meetings, discussions, or analysis performed by AHCA that led to the drafting and implementation of Rule 59G-1.050?

A. I don't even know what that is.

Q. Have you reviewed Florida's rule banning gender-affirming care?

A. No, I've not.

Q. Do you believe someone can be transgender?

A. I think that in rare medical cases of maybe biological organs of some individual who may have both organs -- in some rare cases I could see the need for medical intervention that is basically taking care of that issue.

But for the most part, I see it as a contagion of -- of -- it's hard to explain, and I don't have enough time to explain myself. But I feel like this is a social -- why do we have 7,000 percent increase in the last ten years of transgender population to feel discomfort with their body? 7,000 percent. We need to ask ourself why this is happening.

Q. Do you believe someone can have gender dysphoria?

A. I believe in rare cases maybe, yes.

Q. Were you contacted by anyone to prepare or, rather, to provide testimony in this case?

A. Yes.
Q. Who were you contacted by?
A. I was contacted by the firm that is representing the State of Florida.
Q. And who prepared your draft declaration that you submitted in this case?
A. Well, I submitted my verbal, through the phone, testimony, and I was just told about the proceeding, what's going to happen here in this courtroom, today. I am not indoctrinized or was told what to do, if this is what you're after.
Q. Sir, if I understood your testimony correctly, you said your daughter was 18 and a half when she was put on testosterone; is that correct?
A. Yes.
Q. So she was an adult?
A. Yes. By legal term, yes.
Q. And she was also an adult when she made the decision -- when your child made the decision to transition; is that correct?
A. When you call someone an adult, you assume that they are. You think that they are, but she was not an adult.
Q. Was your child --
A. Of legal age?
Q. -- of legal age?
A. Yes.

Q. And how often did you see your child from, let's say, 18 to the point at which she died, annually?
A. My dear child did not speak to me for two years because I had a very hard time accepting her decision and what happened. It was of his choice not to talk to me. So this is part of the whole journey. So it wasn't my choice not to talk to Sophia. It was her choice.
Q. Understood.
When was that period of time, from what year to what year?
A. I would say --
Q. 18 to 20?
A. 18 to 20, yeah.
Q. After that, from age 20 going forward, did you see your daughter?
A. Oh, yeah. We reconciled, thank God. My other daughter was instrumental in that. And we had a loving relationship, and I accepted Sophia to the degree that I could call her Sam, and to the best of my ability, I conformed to what she wanted me to do because my choice was either have no relationship with her or have the relationship according to what Sam wanted. So as a parent, I had no choice in the matter.
Q. And if my question wasn't clear -- I'm trying to understand how frequently you saw your child once you reconciled.
A. I would say it was random because she was in college on and off between Rutgers University and her own life. She moved

quite a bit. At that point she was Sam. So when I say "she," I mean Sam.

I would say every two weeks she would come to my house. In the whole COVID time of 2020, she was in my house for three or four months.

Q. Did you know your child was using fentanyl?

A. I had no idea. That was at the very end, I assume.

If I may elaborate?

Go ahead.

Q. Sir, do you recall -- in paragraph 3 of your declaration, you state: *Florida's Rule will prevent manipulation and coercion on the part of health care providers and from that their own distressed and confused children to comply with demands for medical and surgical intervention aimed at 'affirming' a young person's professed discordant gender identity under threats of alienation or loss of a child to suicide.*

Did I read that portion of your declaration correctly?

A. Say it again and slower. Excuse me. I can't hear you very well.

Q. Yeah.

In paragraph 3 of your declaration, you state: *Florida's Rule will prevent manipulation and coercion on the part of health care providers and from that of their own distressed and confused children to comply with demands for medical and*

surgical intervention aimed at 'affirming' a young person's professed discordant gender identity under threats of alienation or loss of a child to suicide.

Do you recall making that statement in your declaration?

A. No, I don't recall making that declaration. I'm not aware of all the Florida law regarding this sublaw or declaration.

Q. Did you review your declaration before you signed it?

A. Yes.

Q. Sir, your child never stopped identifying as male; correct?

A. I don't know how to answer that.

Q. You don't know how to answer the question?

A. No.

Q. At the time of your child's death, was your child going by the name Sam?

A. Yes.

MS. ALTMAN: I have no further questions, Your Honor.

THE COURT: Redirect?

MR. JAZIL: No, Your Honor. Thank you.

THE COURT: Thank you, Mr. Sheinfeld. You may step down. You are free to go about your business. Thank you, sir.

THE WITNESS: Thank you.

(Mr. Sheinfeld exited the courtroom.)

THE COURT: Further evidence for the defense?

MR. JAZIL: No, Your Honor. Thank you.

THE COURT: Rebuttal evidence for the plaintiffs?

MR. GONZALEZ-PAGAN: Nothing beyond what's in the record, Your Honor.

THE COURT: All right. We can probably take a break before we have argument. Let's take 15.

How long do you want for argument?

MR. GONZALEZ-PAGAN: Your Honor, I think -- I leave it to the Court, depending on the Court's questions, but I think I can present in less than 30 minutes, I'm sure.

MR. JAZIL: Your Honor, 30 minutes is fine for the defense as well.

THE COURT: Let's shoot for 30 minutes a side.

Let's take a 15-minute break. We'll start back at 11:25 by that clock.

(Recess taken at 11:11 AM.)

(Resumed at 11:27 AM.)

THE COURT: Please be seated.

I'll hear from the plaintiffs.

MR. GONZALEZ-PAGAN: Good morning.

THE COURT: Tell me how you want to split up your time.

MR. GONZALEZ-PAGAN: Your Honor, if I could reserve, like, five minutes for rebuttal.

THE COURT: All right. So we'll set the timer at 25 minutes.

MR. GONZALEZ-PAGAN: Thank you, your Honor.

Good morning, Your Honor. Omar Gonzalez-Pagan for the plaintiffs, and may it please the Court.

Central both to the idea of the rule of law and to our own Constitution's guarantee of equal protection is the principle that government and each of its parts remain open on impartial terms to all who seek its assistance. Your Honor, that is *Romer v. Evans.*

We are in court today representing four transgender Medicaid beneficiaries, two of them through their parents, seeking to stop the limitation of a rule that denies Medicaid coverage to a population simply because of who they are. The rule with an incredibly broad brush, categorically excludes from coverage medical care for the treatment of gender dysphoria which only transgender people suffer, and any care that purports to be for, quote, "sex reassignment," close quote, or, quote, alters sexual characteristics," close quote. This rule does not target or specify any particular medication or procedure as experimental, because they are not, but, rather, it deems all gender-affirming care when used to treat gender dysphoria to be experimental because the State does not like the outcome of that care, that being the alignment between a transgender person's body characteristics and their identity.

The reason the rule does not target any particular procedure or treatment as experimental is because these are common services and procedures used to treat other conditions.

Their side effects and risks are well known, and the physical changes that the State complaint of are, in most instances, the desired outcome of the treatment, the masculinization of the body for a transgender male and the feminization of the body for a transgender female.

The exclusion, Your Honor, is unlawful, and unconstitutional. We're asking that it be preliminarily enjoined on the basis that it violates the Equal Protection Clause of the Fourteenth Amendment and Section 1557 of the Affordable Care Act. It facially discriminates on the basis of sex. On its face it speaks purely in sex terms. This is one of the many reasons why *Geduldig* is not applicable here, Your Honor.

The regulation speaks of gender dysphoria, which is charactered by the distress arising from an encumbrance between one's sex assigned at birth and one's gender identity. It targets procedures that lead to sex reassignment or alter sexual characteristics. It seeks to impose sex stereotypes. The exclusion is based on the notion that only those assigned male at birth can and should have access to masculinizing hormones or procedures and only those assigned female at birth can and should have access to feminizing hormones and procedures.

THE COURT: Let me back up and put this in a framework here.

You start by saying this is not experimental, and I

understand the vast majority of medical associations certainly take your side of the equation. There are some doctors who take the opposite view.

But let's try to frame the issue. If this is experimental -- and we can talk about what that means in more detail, but some things are experimental. If this is experimental, you lose; right?

MR. GONZALEZ-PAGAN: Not necessarily, Your Honor.

THE COURT: Well, explain to me how you get around *Rush versus Parham,* a binding circuit decision. Didn't it say in just so many terms -- I mean, it deals with gender surgery in that case, but gender-affirming care, and it says, Vacate the district court's decision in favor of the plaintiff. Remand. The question on remand: Is this experimental and is it medically necessary for this plaintiff?

MR. GONZALEZ-PAGAN: Correct, Your Honor.

THE COURT: So -- and there was an equal protection claim in that case. So plainly the circuit said, If it's experimental, the plaintiffs lose. Now, why isn't that controlling here; if this is experimental, you lose?

MR. GONZALEZ-PAGAN: For a couple of reasons, Your Honor.

Rush v. Parham specifically stands for the unremarkable proposition that a state Medicaid program can, according -- following the criteria of the statute and their own

regulations, not cover experimental services or procedures.

Why *Rush v. Parham* doesn't apply here, there's a few reasons. A, this doesn't target specific services or procedures, Your Honor. This actually allows those services and procedures to be provided for and be covered under the state's Medicaid program in other circumstances, and that was --

THE COURT: The same is true in *Rush versus Parham*. It was a mastectomy, for God's sake. It was plainly covered -- I think it was Georgia. It was plainly covered under the Medicaid statute in Georgia, and the only question was is it covered for a transgender person.

MR. GONZALEZ-PAGAN: Yes, Your Honor. But at that point in time, also *Rush* -- what *Rush v. Parham* stands for is the actual -- it's the guiding -- the guiding -- the guidance necessary for the Court to adjudicate whether it's experimental, that being on Footnote 11 of *Rush v. Parham*, Your Honor, where that Fifth Circuit at the time specifically noted that the clearest articulation of the considerations that go into determining whether a particular service is experimental is whether the service has come to be generally accepted by the professional medical community as an effective, proven treatment for the condition for which it is being used.

THE COURT: Absolutely. But I started off by saying there's a question in the case whether it's experimental, and as *Rush* says, that's a factual question. So today, or in due

course, I'll make a determination whether it is reasonable for the State to decide this is experimental.

MR. GONZALEZ-PAGAN: Correct.

THE COURT: That's what that case says.

But my question is something else. My question is not did the State reasonably decide this was experimental. My question is this: If the State reasonably decided it was experimental, don't you lose? And it seems to me this is a very easy question, and the answer is yes. But if you've got an argument to the contrary, I need you to tell me it, but don't jump back and say it's not experimental.

MR. GONZALEZ-PAGAN: Absolutely, your Honor.

THE COURT: You've got to come to grips with this question.

MR. GONZALEZ-PAGAN: Yes. And the answer is no.

Rush v. -- the Affordable Care Act, which this Court needs to give both enforcement and implementation to all of the statutory provisions both of the Social Security Act as it pertains to the Medicaid Act and the Affordable Care Act -- the Affordable Care Act specifically prohibits the design -- the benefit design of coverage plans, health plans in a manner that is discriminatory on the basis of sex.

So even if it were to be experimental, it cannot be done with --

THE COURT: Wait.

MR. GONZALEZ-PAGAN: -- reference to sex.

THE COURT: You think the Affordable Care Act says a state must cover an experimental procedure for transgenders even though it does not have to cover experimental treatments for anyone else?

MR. GONZALEZ-PAGAN: No, Your Honor, I won't go that far. What I would say is that the Affordable Care Act says that in the design of the health plan, and here the regulation, the plan is not allowed to use sex as a criteria that has a discriminatory effect.

And here their regulation at issue is -- which is, again, categorically with a broad brush, as to all care -- medical care for a condition. This is not a particular treatment or procedure that is being deemed to be experimental; it's all care for a condition. It is designed exclusively on the basis of sex. If they were to say and have gone through the analysis of, like, X procedure doesn't apply, X medication doesn't apply, that's a different question, Your Honor.

THE COURT: I thought --

MR. GONZALEZ-PAGAN: That would fit within *Rush v. Parham*, but not --

THE COURT: Maybe I don't understand it, but I thought that's exactly what they did do.

MR. GONZALEZ-PAGAN: No, Your Honor.

THE COURT: Well, let me ask you this. If someone

presents to a mental health professional, a psychiatrist, for treatment of gender dysphoria, is that covered?

MR. GONZALEZ-PAGAN: The mental health care is covered, Your Honor.

THE COURT: Okay. So the State hasn't said you can't get treatment for gender dysphoria. What the statement has said is you can't get hormone treatment, puberty blockers, or sex reassignment surgery, particular kinds of surgery.

So, what, they didn't list them carefully enough? Instead of listing a few things, they needed to make it a longer list?

MR. GONZALEZ-PAGAN: Well, Your Honor, I think because it goes to the question of how it was drafted and the outcome that was already preordained, there is a conflation of risk and side effects of all of these treatments, and it painted with a broad brush all of this care. And I think if you were to parse them all out, it is a house of cards that falls. Right? They speak of infertility and sterility as a side effect, but that doesn't apply to hormones or puberty blockers and most surgeries.

THE COURT: We're back to the factual question of whether this decision is reasonable.

MR. GONZALEZ-PAGAN: Yes.

THE COURT: But here's what I want to get to for today. And I tell both sides, I'm a

follow-the-circuit-decisions guy. I mean, the circuit has a prior panel rule. When the prior panel makes a decision, a later panel has to follow it. And that's even more true for district judges.

So when there is a binding Eleventh Circuit decision or a Fifth Circuit pre-*Bonner* decision dealing with an issue and it's right on the issue, I'm going to follow it, maybe more than the subsequent panel does.

MR. GONZALEZ-PAGAN: Understood, Your Honor.

THE COURT: So I'm going to follow *Rush v. Parham*.

But here's the question as it applies to today. So if the law of the circuit is the State doesn't have to cover experimental treatments, if the State refuses to pay for a treatment and it's not experimental, then under *Rush*, I can enter an injunction and say, Pay for the treatment. But if the State reasonably concludes that the treatment is experimental, then I can't. And it's not an equal protection violation, because it wasn't an equal protection violation in *Rush v. Parham.*

MR. GONZALEZ-PAGAN: Well, your Honor, I would quibble with that in that the Fifth Circuit in no point actually dealt with the equal protection claim in *Rush v. Parham.*

THE COURT: Well, let's push on that a little bit. There was an equal protection claim. It says so right in the decision.

MR. GONZALEZ-PAGAN: Correct.

THE COURT: They reversed the decision in the plaintiff's favor and remanded for a determination of whether the State reasonably decided this was experimental.

MR. GONZALEZ-PAGAN: Correct.

THE COURT: How can that not be a holding that if it's experimental, the plaintiff loses? Basically that's what the circuit told the district court: You make a fact-finding whether this is a reasonable determination that it's experimental, and if it was a reasonable determination, the plaintiff loses.

MR. GONZALEZ-PAGAN: Your Honor, I would go to page 1153 of *Rush v. Parham* -- just before 1154, so at the end of 1153 -- and note the issues that were decided on summary judgment and which were dealt with with the -- by the circuit court on appeal.

Those were, first, whether the state Medicaid program could categorically deny funding of a medically necessary service because it was decided purely on the statutory grounds at that point in time; and, B, whether the Department of Medical Assistance abused its discretion in finding that the surgery was not indicated for *Rush*.

Those were the issues that were decided by the district court that went up on appeal, because it was decided purely on statutory grounds.

The Fifth Circuit did not weigh in on the protection claim that was in the complaint because it wasn't decided at that point in time. And once the circuit court said, Under the Medicaid Act, the State is allowed to not provide coverage for experimental care, then that is a factual question that goes down to the district court.

That is separate and apart from the confines of the Constitution that was not decided by the Fifth Circuit in *Rush v. Parham.* And it was touched on by the district court thereafter because it not only had guidance on how to deal with the statutory claim, but the Constitution has limits as to -- that supplant and are supreme over these federal statutes.

And here the way that the regulation was drafted, the way that it classifies it is purely a sex-based classification, and the question of whether the care is experimental then goes to the justifications of tailoring, but not as to whether it is presumptively unconstitutional under the Equal Protection Clause. And I would argue the same under the ACA.

THE COURT: Well, here's where -- I take your answer -- and I'll go back and read *Rush* yet again. I've read it a number of times already.

Here's where I'm going. I told you I'm a follow-the-prior-panel guy. I also believe in *Ashwander*, the Brandeis concurrence, I guess it is. When I don't need to get to a constitutional question, I don't get to the constitutional

question; I just apply the statute.

So here's the premise -- and I get it from what you tell me that you disagree with part of this. But here's the premise. If it's constitutional for a state to exclude experimental treatments under Medicaid -- and I know you say it's not, but assume for me for a minute that I rule that it's -- that I would think it's constitutional to exclude experimental treatments. Then it seems to me that if you win this case under the Medicaid statute because this is not experimental, then you win this case, and there's no reason to get to the constitutional question.

On the other hand, if you lose this case under the Medicaid statute because the treatment is experimental, then you also lose under the Constitution.

So the Medicaid decision is going to control the outcome every time. And if that's so, there's no reason for me to get to the constitutional question and I've just got a Medicaid question, my difficulty today is you didn't ask for a preliminary injunction under the statute.

So I guess what's wrong with that analysis and why not? And if the answer is -- and this is the only answer I can imagine -- you don't want an answer today under the Medicaid statute, you're going for the home run. You don't want the single. You want the home run. And the home run is to tell the legislature, Don't go banning this because it's

unconstitutional.

But that's not my question. I've got these four people and payment under Medicaid. And so are you just trying to make me get to the constitutional issue, or why else would you not have moved under the Medicaid statute?

MR. GONZALEZ-PAGAN: Your Honor, I believe some of the Medicaid claims that we brought -- and I'll be honest, in *Rush v. Parham* and the subsequent caption of *Rush v. Johnson* is somewhat unclear as to what were -- the claims under Medicaid that were being brought, but the comparability and EPSDT claims that we brought we believe probably would benefit from some more factual development.

But that is separate and apart from the question of whether an injunction can be entered today, because Your Honor's question, just assuming for the sake of this conversation that we are having, the premise about experimental or not under the Medicaid Act because there is no -- the question then becomes one of tailoring; right. We know here -- and that can be done also with regards to the ACA claim and not have to reach the constitutional claim; right. We have a statutory claim that permits the Court to reach there.

But there is sex discrimination here, and then the question is in that interaction was this permitted or not? And what -- not only was it permitted, but was it tailored in a way that is permissible within the confines of benefit assignments

articulated by the ACA and the constitutional claim.

And here we can posit a number of ways in which the deeming of experimental all gender-affirming medical treatment is not reasonable. It's not rational. It's not, let alone, an exceedingly persuasive justification that is being furthered substantially by the regulation because it actually paints with such a broad brush. It runs counter to the very guidance, binding guidance, from the Fifth Circuit in *Rush v. Parham* about how do they find something to be experimental.

And it also, as noted in the expert -- our expert declarations, ignores the reality that this is care that's being provided by Florida Medicaid, undisputedly has been provided before, has been provided in this -- has a history that goes -- and I can point to paragraph 22 of Dr. Antommaria's declaration in docket No. 11-5 noting that gender-affirming care has a long history. The provision of hormone therapy goes as far back as 90 years, and gender-affirming surgery goes as far back as 70 years.

I will also note that *Rush v. Parham*, the facts of that case all predate even the first iteration of the WPATH standards of care, clinical guidelines that are widely accepted by the medical community that were first published in 1979.

And I would add that, as noted with the colloquy with defendant's designated expert, most medical organizations support a provision of this care. And, in fact, if one were to

look at the defendant Agency for Health Care Administration's GAPMS memo, Your Honor, one can see that a plurality -- sorry; having a problem with that word -- of state Medicaid programs explicitly cover this care, and 80 percent of them either explicitly cover it or treat it on a case-by-case basis.

The reality is that this rule as it stands here today stands in stark contrast to not only the medical establishment but how care is provided in the United States and the world. No country has banned or prohibited this care.

THE COURT: Let's move on to the -- a different part of this, and that's these individual plaintiffs.

You would agree, would you not, that sometimes this care gets botched -- not for these plaintiffs, but sometimes this care gets botched?

MR. GONZALEZ-PAGAN: Your Honor, I would agree with the commonsensical supposition that sometimes medical care, as in all medical care, is not provided up to the clinical guidelines standard of care.

THE COURT: Sometimes the surgeon cuts off the wrong arm. I got it.

They've presented some declarations, and it's not a large number compared to the universe, certainly, of people who have gotten gender-affirming care, but they've presented some. It seems pretty clear that there are some providers who haven't followed the guidelines and have jumped to puberty blockers and

hormone therapy without going through the kinds of careful attention that the guidelines call for.

You would agree with that, wouldn't you?

MR. GONZALEZ-PAGAN: Your Honor, I would agree for the sake of argument. I would not agree with that as a factual basis. I would argue that many of these declarants actually have other reasons for why they stopped identifying as transgender, if they ever did, and why they stopped the care. For example, I will note the testimony earlier today about Ms. Hawes wanting to work on her inner self. And I will note that several other people, like Ms. Chloe Coe noted, for example, that it was her religion that led her to the path that she's on now.

So I will not argue that all of -- that these declarations in toto show that this care has not been provided. I will agree, Your Honor, that there are instances in which it hasn't been provided according to standard of care, as with all medical care in the United States.

THE COURT: It's okay for the state Medicaid folks to evaluate any given request for payment to determine whether the provider deviated from the standard of care?

MR. GONZALEZ-PAGAN: Absolutely, Your Honor.

THE COURT: True?

MR. GONZALEZ-PAGAN: And that is what was the case until this rule. This rule eliminates that.

Whether or not --

THE COURT: Got it. No, I understand.

So here we are in a preliminary injunction hearing. You're asking me to order the State to pay for the care the plaintiffs wish to have; true? That's what you've asked for. You want an injunction that says, Pay for it?

MR. GONZALEZ-PAGAN: What we're saying, Your Honor, is an injunction that says, Do not implement the rule that was rushed through the summer that actually disrupts the care, not only of our plaintiffs but of thousands of transgender Medicaid beneficiaries.

THE COURT: What --

MR. GONZALEZ-PAGAN: They clearly dispute a status quo.

THE COURT: What do you want the injunction to say?

MR. GONZALEZ-PAGAN: That the rule is left without -- cannot be enforced and is left without effect while the case is pending and that the State goes back to its existing policy of evaluating medical necessity on a case-by-case basis.

THE COURT: So what does that do for the plaintiffs?

MR. GONZALEZ-PAGAN: Well, as we know from the history from their care and the fact that Medicaid indisputably has covered their care that in their instances some of them are already preauthorized for that care. And I would point to Mr. Rothstein having a surgery that has been preauthorized by

the agency that's scheduled for December but now will not be covered.

THE COURT: But you're not asking for an injunction that says, Provide the care to these plaintiffs?

MR. GONZALEZ-PAGAN: I would ask for an injunction that is a prohibitory injunction that stops the enforcement of the rule and, therefore, permits a case-by-case analysis of medical necessity claims as they come in, as has always been the case in the Agency for Health Care Administration.

Your Honor, what happened in those instances is that plans which AHCA contracts with would apply their own medical criteria, which support and allow this care.

THE COURT: What makes you think that if I enter an injunction that says, You can't enforce this rule, then the responsible state authority won't say to one of these plaintiffs, Your care is not medically necessary, and we're not going to provide it?

MR. GONZALEZ-PAGAN: Your Honor, what I would argue is that the injunctions say that the State cannot implement or enforce this rule and it reverts back to its existing practice prior to August 21, 2022.

And in those circumstances, if, and only if, the plan with which they contract, which apply the medical necessity criteria, were to determine that it wasn't medically necessary, there will be an appeal internally within the Medicaid system

over that.

THE COURT: All right. We've run you out of time. I'll let you keep the rest for your rebuttal, and I'll hear from the other side.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

MR. JAZIL: Thank you, Your Honor. May it please the Court.

I'd like to start with the *Rush* case, Your Honor. I note that the Court said: *We hold that a State may adopt a definition of medical necessity that places reasonable limits on a physician's discretion,* so that was the holding in the case.

As the Court is discussing the holding and what needs to be done on remand, the district court on remand needed to determine whether its determination -- whether the State's determination that transsexual surgery is experimental is reasonable as one of the questions that the district court had to ask and --

THE COURT: So that question's for me?

MR. JAZIL: Yeah.

THE COURT: Whether today or at the final trial, my mandate under *Rush versus Parham* is to decide whether the State's rule refusing to pay for these treatments is reasonable.

MR. JAZIL: Your Honor, there is additional gloss in the case. The Eleventh Circuit goes on -- pardon me. The former Fifth Circuit goes on to say that: *To show such*

reasons -- this is discussing what the plaintiff needs to do on remand -- *we think Rush was required to present convincing evidence that no other form of treatment would improve her condition.*

And, Your Honor, my point is this: That was on --

THE COURT: Fair enough. That's what makes it necessary.

MR. JAZIL: -- Section B.

And, Your Honor, my further point is this: *Rush* doesn't exist in isolation. *Rush* should be read together with *Dobbs*, and *Dobbs* talked about how where you have classifications based on medical treatment or medical conditions, rational basis applies. In *Dobbs* there was a section -- the bulk of the case deals with the substantive due process issues, but the Supreme Court did address what it called another home for the argument that there is a constitutional right, and it was equal protection, and then they went with the rational basis.

THE COURT: Look, everybody likes dealing with the big, sexy issues, *Dobbs* and equal protection. I'm right, aren't I, that this case just turns on the Medicaid statute? If it's experimental, then you win, and if it's not experimental, you lose under the Medicaid statute and we never get to the constitutional issue.

MR. JAZIL: You are correct about that. The doctrine of constitutional avoidance would dictate the result there.

THE COURT: I do want to ask about -- while I'm thinking about it -- and we're probably jumping ahead here --

MR. JAZIL: Yes, Your Honor.

THE COURT: -- but partly they say, Strike down the whole rule, and part of what you said is, Oh, you can only give relief to these four plaintiffs because there's no class. So here's my question:

I get a lot of these cases -- or a good number of these cases. You're in a number of them.

MR. JAZIL: Yes, Your Honor.

THE COURT: So when I get a case like this challenging State action, and the plaintiffs move to certify a class, what the State says, I think, every time is, Don't certify a class. We're going to abide by whatever rule you make for these plaintiffs. There's no reason to certify a class. And then when they file an individual action, the State comes in and says, No, there's no class action.

So, look, you can't have it both ways. I guess you can say that was then and this is now, but it's the position you took, for example, in prior cases. I can cite them for you. Which is it?

MR. JAZIL: Fair enough, Your Honor. And the position we've taken here is that a universal injunction would be inappropriate to provide the relief to the four named plaintiffs And, Your Honor, there's a recent Eleventh Circuit case. It's

called *Georgia versus President of the U.S.*, 46 F.4th 1283, where the Court talks about nationwide injunctions, and it talks about --

THE COURT: I got it and read it the day it came out, but -- but my question is which is it? Because if you're -- if you're telling me the State of Florida's position henceforth is just an injunction for the individual plaintiffs, we're never again going to say in response to the motion to certify a class that you don't need to certify a class because we're going to follow what you said -- if that's what you're telling me, fine; you get to change your position, but you don't get to change it every time depending on what position the plaintiffs take.

MR. JAZIL: Fair enough, Your Honor. And I can't standing here take a categorical position for the State in all future cases. I don't have the authority to do that, Your Honor. I apologize, but --

THE COURT: I get it. That's fair enough. They probably -- probably not be pleased if you came back and told them, By the way, I made a promise for the next case.

MR. JAZIL: Yes, Your Honor.

THE COURT: I just finished one, and I think I've got another one pending where the same issue comes up, and I got the State on both sides.

MR. JAZIL: Fair enough, Your Honor. But at its core, the point that Judge Grand, Judge Edmondson and I think

Judge Anderson all agreed on in the *Georgia* case that I referenced was, Hey, at the very least, you have to provide only the relief that would give the plaintiffs what it is they're seeking, because anything beyond that runs into potential Article 3 issues on case in controversy.

THE COURT: I got it, and that's what I've always done, so you can go back and check my decisions.

MR. JAZIL: Yes, Your Honor. So that's -- that's on the universal nationwide injunction side. And my friend also brought up, I guess, a distinction between prohibitory and mandatory injunctions, as I understood it, and I thought them to be seeking both prohibitory and mandatory relief where they're seeking to prohibit the State from implementing its categorical exclusions and mandating that the State approve these treatments, despite the fact that the State has now gone through the GAPMS process which lays out what state policy is on, you know, whether or not these treatments ought to be approved.

Whether that state policy is applied categorically or on an individual-by-individual basis, GAPMS itself would still be there. It would still be a guiding principle to these determinations, Your Honor. So I think what they're asking for is both prohibitory and mandatory, so I just wanted to at least get my understanding of the relief before the Court.

Your Honor, I'd also like to focus on the broader question of irreparable harm. It's their burden to establish

irreparable harm. It's their burden to establish irreparable harm for the four individual plaintiffs. We've got declarations from the four individual plaintiffs, but we don't have any of the treating physicians for any of the four individual plaintiffs providing any opinions to this Court.

We have Dr. Laidlaw who is an endocrinologist who prescribes hormones and puberty blockers.

THE COURT: And has an opinion about sex reassignment surgery. What is his expertise to talk about these surgeries?

MR. JAZIL: Your Honor, he's someone who's tracking the literature. He is advising people who go into his clinic. And I take Your Honor's point that if it's something that he's not experienced with as a clinician, you're going to give it little weight.

THE COURT: And he's a doctor who says a person with gender dysphoria should not be treated in a way affirmative of the person's perceived gender by any medical professional. So a psychiatrist, psychologist, therapist should never say to a natal male, for example, that it's okay to live as a female.

Now, how far off the standard, the general view in the medical profession, is that?

MR. JAZIL: Your Honor, two points on that: One, his answer there was a little confusing. He -- and Your Honor asked a follow-up question to him. When he initially gave an answer, he said, I could think of possibly some instances where it would

be appropriate, and when there was a follow-up question, he said no.

So, Your Honor, I note that the testimony wasn't the clearest. Further, I note, Your Honor, that in our rule we are not excluding all gender-affirming care. We have a long list.

THE COURT: I got it. But the best doctor you could find to call into court -- and, look, I asked him the question because I thought that would be his answer based on his declaration and his testimony.

Here's the guy who couldn't use the pronoun that somebody preferred, who couldn't refer to somebody by their preferred gender. I mean, I respect his -- he's a well-trained endocrinologist, but here's a person that's that far off from the accepted view, even by the State, even the State. Like you just said, even your rule does not suggest that it would be improper for a mental health professional to work with somebody in an affirmative way.

So, I mean, you do scratch your head when that's the best you can do.

MR. JAZIL: And, Your Honor, his testimony related to -- the use and effects of certain of these hormones is crucial to why he was up there. In addition, Your Honor, I would note that Attachment E to the GAPMS report has another expert report from Quentin Van Meter who is a pediatric endocrinologist who is on the clinical faculty of both Morehouse

and Emory University, and his perspective is also there for the Court. So this is not the only endocrinologist whose perspective we're providing, and we do also have Dr. Cantor. We have Dr. Nagia, who's a psychiatrist, and others, so he is not the only one.

THE COURT: I read every one of them.

I do want to ask you some questions about the process that you went through.

MR. JAZIL: Yes, Your Honor.

THE COURT: First, the background question about the State-administered process, been a long time since I've been involved in a rule challenge in state court, so I really don't know the procedure, and I haven't gone back and looked it up.

In the federal system, if an agency adopts a rule, but the procedure is fatally flawed, then the Court vacates the rule and remands it to the agency, and the agency then goes forward and tries to fix the problem.

That -- is that how it works in the state court?

MR. JAZIL: From the perspective of the challenger it's even better. As soon as a challenge is filed to the rule, the rule does not go into effect.

THE COURT: And when -- and I take it it gets a DOAH officer initially?

MR. JAZIL: Yes, Your Honor.

THE COURT: A DOAH administrative law judge.

And so then does the judge evaluate the process or just the substance? So if the procedure is just biased, if it's clear when you look at it that there was a preordained result and not an honest effort to go through the process, does the judge then invalidate the rule or can the judge say, Well, you know, it's a bad process, but the rule is okay, substantively, and uphold the rule, or do you vacate the rule?

MR. JAZIL: Your Honor, the DOAH judge does get to take a look at the process, and I believe the DOAH judge gets to undo the entire rule if the process is flawed.

THE COURT: So tell me, how do you support a process that goes out and finds five experts -- I think it's five. Clearly, the minority view could be right. I mean, I get it. And they are certainly entitled to express their views, and the agency is certainly entitled to take it into account. But they go out and get five people who are decidedly out of the mainstream, nobody in the mainstream. They have a hearing and they line up all the lay speakers who are opposed, one after the next. So somebody has organized this. And that's how they do it.

And when anybody speaks with some expertise on the other side of the issue, they've got somebody there at the hearing to rebut it instantly. So if you speak on the preordained side, you get to just speak, but if you speak against the preordained view -- or the allegedly preordained

view, you've got somebody right there harking back at you immediately.

How does that work?

MR. JAZIL: So, Your Honor, two points there.

One, not everyone who was instrumental to the GAPMS report is someone who is active in this field. I note that Dr. Rumina Brignardello-Peterson is not someone who has taken a side on either end of this debate.

Second, Your Honor, the hearing was public. Whoever came, came. There was a panel of experts there to respond to issues as they came up, but written testimony was also considered, and it was provided. So you have the -- I'll call it the Yale letter by lawyers and physicians was submitted as well. For example, the various medical associations provided their written comments through that process as well.

THE COURT: But I'm right that the State recruited five?

MR. JAZIL: Yes, Your Honor, the State recruited five.

THE COURT: All -- all well out of the mainstream, all on the same side of the issue?

MR. JAZIL: Your Honor, I'd say four on the same side of the issue. I disagree with the notion that they are out of the mainstream. If we are defining the mainstream as the American medical groups, that's one thing, but we do cite in our paper the Europeans who have gone the other way.

THE COURT: And I have to say, you cite it, and the report cites it. Every one of those allows this treatment, every one of them. So you keep saying these are people on the other side, but they are on the plaintiffs' side in terms of the final result if every one of those countries will pay for this medical care if it's appropriate in the individual circumstance on a case-by-case basis. That's right, isn't it?

MR. JAZIL: Well, I believe, Your Honor, there's a tilt towards exceptional circumstances in some of those countries.

THE COURT: It's gotten harder, and they've slowed it down, and you heard my comments earlier. It seems pretty clear to me from reading some of your declarations that there are people that are not doing this very well. There are professionals that are not doing this very well. So I get it.

But every one of those states will pay for this in an appropriate circumstance; isn't that right?

MR. JAZIL: In an exceptional circumstance, Your Honor.

THE COURT: But in the GAPMS report, it makes it sound -- and in your briefs it makes it sound like these states have decided not -- these countries have decided not to pay for it. That's just not so.

MR. JAZIL: And, Your Honor, the Florida APA also has out clauses that's for exceptional circumstances. This is not

something where we're suspending the general law in the state. 120.542 is the APA provision that deals with variances and waivers from generally applicable rules, for example.

THE COURT: Well, can one of these plaintiffs -- for example, we've got a 28-year-old plaintiff -- I may mess up the details off the top of my head. I think we have got a 28-year-old plaintiff who was approved for surgery by the State, had it scheduled -- has it scheduled, I think, and -- so is that an exceptional circumstance? You already approved it. Can that 28-year-old get the surgery?

MR. JAZIL: Your Honor, if that 28-year-old -- so, for example, under 120.542, if that 28-year-old shows that there is -- I believe the standard is undue hardship and the purposes of the rules will be furthered through this variance and waiver process, they can submit that. There's a time clock under the 120.542 process by which the agency has to act or else the variance is granted as a matter of course.

It's possible that that person could qualify. That person would need to submit the requisite paperwork that -- for example, there would have to be something from their treating physician, which isn't present here. If that something from the treating physician says, I've looked at this person. I believe that this is the only way to go about doing this, that could be something that's attached to that variance and waiver as a consideration that could get this person the treatment they

think they need based on a case-by-case basis.

But that doesn't foreclose the State from having a categorical rule that's generally applicable that says, We believe that in most instances the puberty blockers, the cross-sex hormones, and the surgeries are inappropriate. I think the two can coexist, which is what I think the European experience has taught us.

THE COURT: So what you're telling me is the plaintiffs misunderstand it, and frankly, when I walked into the room, I misunderstood it? This is not a flat ban? There is a route by which they can get their care permitted and paid for?

MR. JAZIL: Yes, Your Honor. As with all rules --

THE COURT: One of their lawyers is going to be in touch with you before you walk out of this room today to try to get you to help facilitate that process, I'm confident.

MR. JAZIL: And, Your Honor, I make that point --

THE COURT: And that may be. If there can be an exceptional circumstance, you've got a 28-year-old who had already been approved and has it scheduled, scheduled it after the State approved it. So they may want to talk to you about that, and you know --

MR. JAZIL: Fair enough, Your Honor.

THE COURT: That's not my bailiwick, but I heard what you said.

MR. JAZIL: And the issue before this Court is -- you

know, the crux of the issue for irreparable harm before this Court is will these four plaintiffs suffer irreparable harm, and the question is what evidence does the Court have to provide this unusual and drastic remedy. The evidence before the Court specific to these four plaintiffs showing that they have suffered irreparable harm is just their declarations. It's not the declarations of their treating physicians. It's not the declarations -- it's not the live testimony from these folks talking about why it is they need it and why it is --

THE COURT: Yeah. In fairness, I'm going to treat their declarations the same as the live testimony.

MR. JAZIL: Fair enough, your Honor.

THE COURT: That's the procedure we all agreed to.

MR. JAZIL: So the Ninth Circuit case *Doe*, which affirmed the district court's denial of irreparable harm, disagreed with the district court on all the legal issues but at its core agreed with the district court that, Look, if you're going to try to show irreparable harm for the folks that are seeking this extraordinary remedy, you need to have someone that's treating them in front of you. Otherwise, you don't carry that burden. So I just underscore on that point, Your Honor, irreparable harm.

And, Your Honor, I know we've talked about the European experience. We've talked about Florida's experts. There is also a comment in our papers from the acting director

of the NIH when he was recently testifying in front of the Senate. He did not say that this is -- he was talking about puberty blockers and cross-sex hormones, not the surgeries. He did not say these things are the medical go-to's in the area. He said that the NIH has only funded observational studies, and the long-term effects of puberty blockers on gender transition are unclear. So, Your Honor, I highlight that just to round out the discussion of experts.

Your Honor, I would also note the Swedish study that went 30 years, looked at 324 folks, and came to the conclusion that if the idea is to prevent suicides and to prevent early deaths in these folks, that simply doesn't happen.

THE COURT: Let me ask about that. And I've read every declaration in the case and the report and the comments. I've been through all that. If the -- I don't think the studies themselves are in the record and -- because I don't think I would have missed them if they had been, but I can tell you I have not read the studies.

And, for whatever reason, we've got people on both sides who have an agenda, and they spin it their way, and I don't think I've had any doctor that gives a really good impartial analysis of the studies. But I haven't read the studies, so I'm not sure of that.

But here's what I -- here is the question that jumped off the page to me that I don't know that anybody has asked. So

that study, I think, is the one that said you look down the road, and the suicides are higher among the people that got this treatment than in the control group. And I take it the control group is the population. And so these are people who often had other mental health diagnoses but certainly encountered gender dysphoria and probably the reaction that -- sometimes the bigotry, the discrimination that that leads to. So I would not be surprised if the suicide rate among those people was higher, even if the treatment was enormously successful.

And, look, if -- if a doctor replaces a heart valve and then you look ten years later how are those people doing and you compare it to the general population, I can tell you more of them are going to have died from heart problems because they had a bad heart valve and they had the surgery.

So that's my question. Is the -- are you just comparing people to the general population? If so, that doesn't tell me much. Or is the control group something else?

MR. JAZIL: Your Honor, I believe the control group was the general population and -- fair point, Your Honor.

THE COURT: I don't know -- if the life expectancy is a little lower, I don't know how that plugged in. That's a little different than the mental health issue.

But, you know, the -- here's my take on it -- and I'll get you to tell me whether this is right or wrong. My take on it is, no, there are not great studies. It's an enormously

difficult thing to study. There are certainly no randomized clinical trials. That's just makeweight stuff on your side of the case. Of course there are no randomized clinical studies, can't be one. So, yeah, the studies aren't great. It's a hard thing to study. And it's -- with any change in medication or change in circumstances, it takes awhile.

We have no long-term studies of COVID. Nobody has had the disease for more than two or three years. So how are people doing after ten years with COVID? We don't have a study. Of course not.

So my take on it is the studies aren't great. They are what they are. Clinicians' views matter. If you get honest clinicians, they know something.

MR. JAZIL: Fair point, your Honor.

And I think what Your Honor is echoing are some of the comments the federal government made in the HHS 2020 rule where it said the medical community is on either end of the spectrum on this, and we don't have a clear answer about whether or not gender-affirming care is something that we can mandate at this time. That's what the federal government said.

THE COURT: You do know it -- that some people who have gotten gender-affirming care have done well with it and have been happy with it.

You know that, don't you?

MR. JAZIL: Yes, Your Honor.

THE COURT: And so -- I mean, some of your experts seem to say, Well, they say they are happy. Well, if they say they are happy, they are probably happy.

MR. JAZIL: It -- And, Your Honor, again, that goes to the point I made earlier. We're not imposing a categorical bar on gender-affirming care. We've concluded that this is a mental health condition, and for this mental health condition, mental health treatment works. We don't think the puberty blockers, cross-sex hormones or the surgeries do.

And with the medical community being divided, as the HHS pointed out and as Your Honor pointed out, the tie should go to the State. The State gets to chose in that instance, I would submit, which way to pivot and which way to create the categorical rule, which is what we're doing through the exclusion. And that categorical rule is not inconsistent with the European experience, which is now trending towards an exceptional circumstance model. That categorical rule is not inconsistent with the NIH acting director's statements saying that we have no long-term studies on this. We've just started funding observational studies on this.

So even if Florida is the outlier, as they paint us to be, which I think is incorrect, what Your Honor has pointed out is the doctors are on both sides of this issue. And in that instance, Your Honor, I would submit that both under *Dobbs* and *Rush v. Parham*, it's reasonable for the State to pick one of

those two alternates to go with and make policy with. And that is what the State is doing here.

So on the substantial likelihood for success prong, we should prevail and --

THE COURT: Why wouldn't the better rule be what you've essentially described here today, maybe with a little -- a little less insistence, but essentially why shouldn't the rule be for puberty blockers, hormone therapy, or surgery, there has to be good medical care and opinion and comply with the conditions and show a real need and evaluate each case to make sure you don't have cases like the ones that you've got in your declarations? Why wouldn't that -- if there's already an exception built in, why not put it in this rule so these people would know it?

MR. JAZIL: Well -- so Your Honor's suggestion is to build an exception into the rule itself and not rely on the broader APA exception under 125.14?

THE COURT: Well, and more than just the exceptional reasons that -- I don't know if anybody knows what those exceptional reasons are going to be. But if it is true that sometimes puberty blockers can be approved, then why not say that in the rule?

MR. JAZIL: Well, Your Honor, I don't think it needs to be spelled out in the rule. If the rule is a categorical rule and you're justifying that based on this broad study that's

looking to see what the categorical rule should be, then I don't think you need a specific exception in the rule when you have the 120 exception available.

Also, Your Honor, Your Honor said something that, so long as someone is providing the appropriate care consistent with the appropriate standards of care -- in that part, Your Honor, the appropriate standards of care, that's also in flux.

We've been provided and we've talked about, my friends for the plaintiffs, the standards provided by WPATH, for example. WPATH has standards. The Endocrine Society has guidelines. We don't have a set of standards that necessarily apply, the standards of care that necessarily apply in this instance. And there's another agency, the Department of Health, that is in the process of hearing from folks and coming up with appropriate standards of care for gender dysphoria.

So -- pardon me, Your Honor -- on the standards of care side, that is a separate process, and I would just note that for the Court.

THE COURT: All right. I've run you out of time.

What else do you need to tell me?

MR. JAZIL: Well, Your Honor, I would simply ask that the preliminary injunction be denied.

Thank you.

THE COURT: All right. Rebuttal?

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

Just briefly, I would like to start with the reference to the waiver variance regulation, Your Honor. I will note that everybody has been proceeding because it is, but this is a categorical ban on coverage.

THE COURT: Don't -- let me just tell you, you are representing four plaintiffs who have just had the State tell me that there is a possible exception. You really don't want to argue that the State is wrong, do you?

MR. GONZALEZ-PAGAN: Your Honor, I -- I will -- I -- I will confer with my co-counsel that's experienced with state APA claims. And, Your Honor, I just don't think this is an accurate statement by the State, and so it's a representation here by counsel here in court; but if they want to stipulate that they will move case by case for people moving forward, that's different than a statement here in court saying that a categorical ban on coverage has some waiver invariance based on this completely separate rule that, as I understand it, has never been applied in this context when the State deems that it is experimental. Because the waiver of variance has to go -- has to still be consistent with the purpose of the rule.

THE COURT: I hear ya. I just wonder why you wouldn't say --

MR. GONZALEZ-PAGAN: I'm happy to enter into a stipulation --

THE COURT: -- thank you very much. I'm happy to find out there's an exception. Please put it in the ruling so that my later judicial estoppel claim will be squarely established.

MR. GONZALEZ-PAGAN: I'm happy for that to be built into a ruling, Your Honor, and I'm happy for that to be entered as a stipulation. But I think it is farfetched for us to accept that based on counsel's representation today when it has never been argued in any of the papers anywhere at all that this is something that applies and that somehow this is not a ban on coverage.

But I think, you know, if the State wants to proceed that way and lead with that effect, the provision, and actually move on a case-by-case basis via a stipulation, that is a completely different matter, and we're willing to entertain it, Your Honor.

I will also note that Your Honor kept asking and expressing the concern about, well, if the State deemed this to be experimental, would it affect the other claims. And I would posit that there is still a valid equal protection and/or 1557 claims because it depends on how is it applied and also the provenance of the rule.

If the State excludes some experimental services but not others -- and that is part of *Rush v. Parham*, Your Honor, where it noted that if the State provided for the experimental care in some circumstances versus others, they couldn't do a

categorical ban --

THE COURT: Look, I think I understand what you just said, and I think I agree with you. If there were comparable services, comparably experimental -- so here's surgery for transgender individuals and here's surgery for something having nothing to do with gender dysphoria and you can say these are comparable in all relevant respects, they are equally experimental, and the State paid for the one and didn't pay for the other, then you've got a viable equal protection claim.

MR. GONZALEZ-PAGAN: Yes, Your Honor. And I would posit --

THE COURT: Point me to the experimental services not for transgender individuals or not for gender dysphoria that the State pays for.

MR. GONZALEZ-PAGAN: Your Honor, the basis for them deeming this experimental in large part relies on the quality of the evidence, which I will note, Your Honor, that low quality -- the terminology "low quality," as many of our experts have explained, is a term of art within the context of scientific literature.

THE COURT: I got it.

MR. GONZALEZ-PAGAN: But based on the fact that there's no randomized control trials or what they would deem high quality, there's a number of other care that is provided coverage for that doesn't meet that bar. I will note --

THE COURT: Absolutely, absolutely. There are a lot of things that you can't get that high quality evidence for. I get that, but that wasn't my question.

MR. GONZALEZ-PAGAN: Yes. The question was comparable treatments that don't meet that bar that are comparable to the ones here, and I will note, for example --

THE COURT: That are experimental in the same way as this one is.

MR. GONZALEZ-PAGAN: Yes. And the reason they are claimed as experimental is because of the quality of the evidence.

I will note, for example, the use of hormone -- post-menopausal hormone therapy which is -- note the use of surgery for cranial facial injuries. They use statins to treat high cholesterol, gallbladder surgery, and the use of surgery for cleft palates are all examples of similar procedures in many instances, like facial feminization surgery, for example, or the use of hormone therapy that are similar and have similar quality bases of the evidence.

THE COURT: All right.

MR. GONZALEZ-PAGAN: And I will point to --

THE COURT: Here's where you don't persuade me.

First, for statins, I would have guessed that there are randomized trials, but maybe not.

But to say that the analysis of statins to treat high

cholesterol is comparable and so it has to be treated by the State the same as the use of puberty blockers for gender dysphoria, you just don't get off the dime with me. They are markedly different treatments for markedly different conditions with markedly different analyses. And nobody would say, Well, because you do this with statins, you have to do the same thing with puberty blockers. It's just a completely different medical analysis.

MR. GONZALEZ-PAGAN: But under the equal protection principle it is the same, Your Honor. And I would point to several of the cases, including *Brandt* from the Eighth Circuit; including *Fain* from West Virginia, a Medicaid case; *Flack* in Wisconsin; and even *Eknes-Tucker* in Alabama, all of which engage in that analysis, because the reality is that even here the competitor -- you don't have to go even that far, Your Honor. These are services that are provided to achieve the same outcome but to non-transgender people. Hormones are provided in order to achieve an outcome that is consistent with the person's identity.

THE COURT: Look, you're right. Medicaid will pay for statins to treat high cholesterol. Medicaid will not pay for statins to treat gender dysphoria, or lots of other things, because statins don't treat all those other things.

There's nothing wrong with the State saying, I will approve a treatment for this, but not for that.

MR. GONZALEZ-PAGAN: Actually, Your Honor, there is.

And there's a comparability argument to be made there which we did not move on the preliminary injunction under Medicaid. But that same analysis can be portended into the equal protection and sexual orientation and Section 1557 claims.

But I think what state Medicaid here is covering and has been covering requires an individualized medical determination. That has always been the rule under the Medicaid program. And the rule as adopted here prohibits that, short-circuits that, and disrupts that. I would note that at the end of the day --

THE COURT: Are there no other procedures that the State flatly prohibits -- or not prohibits -- refuses to pay for?

MR. GONZALEZ-PAGAN: Your Honor, I could give an example of the case of KG, which had to do with a particular form of therapy for the autism population, and in that case that was found to be both unlawful -- and the State deemed it to be experimental and it was found unlawful, and it was enjoined statewide.

THE COURT: I got it. And, look, I told you if I decide as a matter of fact that the State's characterization of this treatment as experimental is not reasonable, you're going to win the case.

MR. GONZALEZ-PAGAN: Your Honor, I would just like

to --

THE COURT: So the fact that some other judge decided some other treatment was not experimental, that -- you don't need to cite that to me because I'm already on your side on that issue.

MR. GONZALEZ-PAGAN: Understood, Your Honor.

I would just briefly correct the record and note a particular part of the argument here, which has to do with both equal protection and to *Romer* but also the pretextual nature of the rule here.

Your Honor already pointed out what seemed to be not an unbiased assessment by the State as to the quality of the evidence or effectiveness of the treatment in this case, but to have a preordained outcome in mind and seeking only a particular view. That is only but one indicia of what we consider to be pretextual animus here, as that term of art is known within the constitutional context.

I would also note that Dr. Brignardello, who counsel pointed out as an exception that doesn't have a view on this -- that's not true. And we pointed to that in our papers, that as a member of SEGM, a particular organization that opposes this care, she's an active member of that.

I will note -- but I will note here that it's not only --

THE COURT: I think she also limited her analysis to

people under 25, but --

MR. GONZALEZ-PAGAN: Correct, Your Honor.

But I will note that that is only but one indicia. Another indicia here of that is that all of the concerns, if we're to read the GAPMS memo, if we were to read all of their so-called expert reports, Your Honor, all of them keep a focus on, well, the ability to consent and whether this is effective or whether this has been proven effective with regards to minors.

But the rule is not drafted that way. The rule is seeking to prohibit care for all transgender people in the state, because the outcome of having transgender people having their body be aligned with their identity, having that be covered by Medicaid is something that they do not want.

THE COURT: Yeah, they don't prohibit the treatment; they refuse to pay for the treatment.

MR. GONZALEZ-PAGAN: Correct, Your Honor.

But for many of our plaintiffs and most transgender Medicaid beneficiaries, they are one and the same. These are people who don't have the medical -- the financial resources. By definition for them to be on Medicaid, most of them need to be extremely medium/low income. They wouldn't be able to access the care otherwise. It constitutes an absolute bar on access to the care.

Your Honor, for those and other reasons stated --

THE COURT: I did mess up my questions earlier, as I look at my note. I was talking about a 28-year-old person. That person has had top surgery. It's just talking about testosterone.

MR. GONZALEZ-PAGAN: Yes. I think Your Honor was referring to Brit Rothstein, Your Honor, who is 20 years old.

THE COURT: The -- so for the 28-year-old, the -- he needs testosterone at a cost of 60 to $65 a month. That's a lot for a person that doesn't have much money. I'm not sure that's irreparable harm.

MR. GONZALEZ-PAGAN: Well, Your Honor, we've established and cited to a number of cases that the loss of coverage does constitute irreparable harm and --

THE COURT: Well, it certainly can, sure, if you can't pay it.

MR. GONZALEZ-PAGAN: Well -- and I believe Mr. Dekker has testified that he can't. He lives on a monthly income of about $841, Your Honor.

THE COURT: I got it. $60 is hard.

MR. GONZALEZ-PAGAN: It's an incredibly high percentage of that and impossible for him to afford.

The same holds true in regards to the surgery with regards to --

THE COURT: Before you mention other names -- by the way, I don't know how many of these names are public.

MR. GONZALEZ-PAGAN: The names I'm mentioning are public, Your Honor.

THE COURT: All right. Good.

MR. GONZALEZ-PAGAN: And, Your Honor, I can point to K.F., one of the minor plaintiffs. His family lives under the poverty line, and they cannot afford this care. They've testified in their declaration that the cost for the puberty blocker could be between 3,000 to $3,600 every three months. They don't have that kind of money, and it would mean the absolute loss of access to this care.

THE COURT: All right. Anything else?

MR. GONZALEZ-PAGAN: No, Your Honor.

For the reasons already -- well, Your Honor, if I may, one brief moment to confer.

THE COURT: All right.

(Discussion was held.)

MR. GONZALEZ-PAGAN: Again, no, Your Honor. We thank the Court for its time, and we'll rest on our papers and the arguments here today.

THE COURT: All right. Thank you.

Give me just a minute.

(Pause in proceedings.)

THE COURT: Let me tell you what the ruling is going to be and give you a very brief summary. The ruling is not going to reach the fundamental issue in the case. The

fundamental issue that eventually will determine the outcome in the case is whether the State has reasonably determined that the treatments at issue are experimental.

Under Florida Statute, Section 409.905: *The agency shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.*

Under *Rush v. Parham* the question is whether the State has reasonably determined that these services are clinically unproven or experimental. There is evidence on both sides of that question.

I deny the motion for a preliminary injunction for a different reason. The controlling law, as I just summarized it, is statutory. If this treatment is clinically unproven or experimental within the meaning of the statute, or if the State has reasonably determined that, then excluding payment is not unconstitutional unless the State doesn't follow the statute as a custom or practice. There are other instances when the State does pay for clinically unproven or experimental treatments. And if that's the case, then the fact there's a statute that's only applied against these plaintiffs and not against others would give rise to an equal protection claim and a whole new layer of analysis. There's no evidence of that in this record.

Discrimination under the Affordable Care Act is essentially the same. The analysis tracks what I just gave you.

So, basically, this comes down to a Medicaid statute.

The plaintiffs didn't move for a preliminary injunction based on a Medicaid statute under the *Ashwander* principle, the constitutional avoidance principle. I'm not going to reach out to decide the constitutional case in a case that's actually going to be controlled by the statute, and this case is an illustration of why that rule is there. A constitutional ruling probably would apply not just to the payment question but to the question whether a State can prohibit the practice. The State of Florida has not tried to do that. That constitutional question is not presented here, and there's no reason for me to address it.

The other reason for denying a preliminary injunction is that the record does not include medical records for these plaintiffs. Before I entered an injunction that would lead to a requirement or it might lead to a requirement to provide service to these plaintiffs, the record would need to include medical opinions that this treatment is indeed necessary, that these plaintiffs are going to suffer irreparable harm from the denial of care. Perhaps I could make that finding based just on their declarations alone, but my finding is that those declarations are not sufficient to establish irreparable harm for these plaintiffs at this time based on this record.

You've noticed from all of that that I haven't decided, as I said earlier, the critical question in the case. That will await further proceedings. This should not take long.

This is not quite an administrative review, but it's not that far off from it.

Tell me how long do you think -- I probably should have asked before I told you I was going to deny the preliminary injunction because answers change depending on which side thinks they won the preliminary injunction motion.

How long do you think you need to present this case fully? And if the answer is "I don't know," I guess I can just tell you to go talk to each other. But if you can give me a rough ballpark at this point, it will help.

MR. JAZIL: Your Honor, I'm happy to confer with my colleagues for the other side and get back to the Court.

THE COURT: It seems to me that you want to find out about the plaintiffs and their doctors and that's about it; right? I mean, you had all you had when you adopted the rule.

MR. JAZIL: Yes, Your Honor. I suppose -- there's a footnote in *Rush v. Parham* that discusses -- well, in my mind it opens up the possibility of additional evidence to provide to the Court on whether or not this is or isn't experimental, but --

THE COURT: At least tentatively I think that's right. I think the question is for me to decide based on the federal trial whether the State's determination is reasonable or not, and I think *Rush* says that's not an administrative review of what the State knew at the time. It's the question at the --

based on the evidence presented at the trial. So, yes, I think that's right.

MR. JAZIL: That's right.

THE COURT: And that goes back to my questions about the Florida administrative procedure. In a rule challenge in state court, they might be stuck with the record they put together to adopt the rule, but I don't think that's the case here.

MR. GONZALEZ-PAGAN: Your Honor, if I may, I just have a question on the Court's ruling.

Will the Court include in its order for representation as to what counsel has stated here today that there is a waiver procedure?

THE COURT: Yes, I will.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

THE COURT: I hope I express it accurately. I'll try to have it in -- an accurately narrow statement of the availability of an exception.

MR. JAZIL: Thank you, Your Honor.

THE COURT: You gave me a cite, and I didn't --

MR. JAZIL: Yes, Your Honor. It's 120.542.

THE COURT: 120.54(2)?

MR. JAZIL: No, Your Honor. It's, I think, 120.542.

Your Honor, with the Court's indulgence, I have one other issue. The trial date is set for August 7th. I'm in a

trial in the Southern District of Florida that week.

MR. GONZALEZ-PAGAN: Sorry, Your Honor. If we can confer just briefly on the time?

(Pause in proceedings.)

THE COURT: While you were talking, Mr. Jazil said that he wanted to raise a question about the time of the trial. The initial scheduling order apparently set it for August 7th. Let me tell you how that got done, and surely we can change it, and we probably ought to move it earlier.

The way that gets done is when the defense appears in a case, I issue an initial scheduling order. It generally sets the discovery deadline. It sets the deadline for the 26(f) attorney conference. Then it sets a discovery deadline, and it sets a trial. Those are just routinely set for the same distance out, unless there is something very unusual about the case.

So August 7th would have been -- the same time would have been set for trial for any case that got filed, and in this case it probably ought to be sooner than that. I mean, this one is -- it doesn't seem to me that there's much to be -- much to be done.

MR. GONZALEZ-PAGAN: Your Honor, if I may, we are happy to confer with counsel. I think there's a 26(f) conference that's coming up in 12 days, but we are happy to confer much earlier than that to come up with a proposed

schedule. I agree with the Court, I don't believe we need a year to do this, and certainly we are talking between a couple to four months for a schedule.

THE COURT: Yeah, that's on the right track. I mean, the -- unless the defense is looking for more experts or the plaintiff is looking for more experts -- if you've already got them -- I assume the defense is going to want to get the medical records and the information about the plaintiffs, and then -- I don't know if you want to depose each other's experts. You probably do, although you might want to save it for cross, but that's up to you. So you need time to do those things, get the 26(a)(2) reports.

But it's -- this is -- nobody is trying to figure out some complicated factual issue other than the complicated factual issue that's the core of the case and that you've already looked at in detail.

So, yeah, let's just leave it this way. Talk to each other. Twelve days off -- and, again, that would have been the standard time. You're all in the same city today. It might be great to talk to each other right now. The room is available. I don't -- I'm not using this room the rest of the day. You're welcome to it and -- or go to lunch and meet at somebody's office and talk about -- if you can get through those things, good -- and talk about it. I'll be available as soon as you are. Sooner is probably better. It's better for everybody to

get the issue resolved sooner and especially for the four plaintiffs.

And talk about the class question. There's not a class allegation in the complaint. I assume there's no interest -- that you don't plan --

And, Mr. Jazil, I think the answer is that if they try this case and I rule that the rule is invalid, then you can appeal that, but in the meantime, I would probably just comply with it. But talk to your client and decide what you want to do. If you can goad them into a class action, we're just going to have a whole lot more work for the lawyers and the judge and probably not much of a different outcome. So talk about all of those things at your 26(f) meeting.

MR. JAZIL: Sure.

THE COURT: I'll try to get you a written order. I would like to say more than I have and address a couple of these things. It's -- as somebody said, I've got a preliminary injunction docket working at the moment. I've had three or four of these. I've got several other things going, so it's going to be a little hard for me to spend the time I need to sit and write something down, but I may try to get something. Don't hold your breath.

I will at least get you a prompt order that confirms the ruling so that you've got a written order if you wish to appeal, which certainly it's an appealable order. Perhaps the

Supreme Court will tell us otherwise here in the next day or two -- in the next few days. It seems to me this certainly would be an appealable order, and I'll get you a written order so that if you wish to appeal, you can.

What else, if anything, do we need to address today?

Thank you all. We are adjourned.

(Proceedings concluded at 12:57 PM on Wednesday, October 12, 2022.)

* * * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy is noted within the transcript.

/s/ Megan A. Hague 10/12/2022

Megan A. Hague, RPR, FCRR, CSR Date
Official U.S. Court Reporter

I N D E X

E X H I B I T S

PLAINTIFFS' EXHIBITS		OFFERED	RECEIVED
P1	American Academy of Child and Adolescent Psychiatry Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth	26	

Doc. 221

Dekker v Weida: 4:22-cv-325

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
v.	)	Tallahassee, Florida
	)	May 9, 2023
JASON WEIDA, et al.,	)	
	)	9:00 AM
Defendants.	)	Volume I
_____	)	

TRANSCRIPT OF BENCH TRIAL PROCEEDINGS
BEFORE THE HONORABLE ROBERT L. HINKLE
UNITED STATES CHIEF DISTRICT JUDGE
(Pages 1 through 250)

Court Reporter: MEGAN A. HAGUE, RPR, FCRR, CSR
111 North Adams Street
Tallahassee, Florida 32301
megan.a.hague@gmail.com

Proceedings reported by stenotype reporter.
Transcript produced by Computer-Aided Transcription.

APPEARANCES:

For Plaintiffs:

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.com
120 Wall Street
19th Floor
New York, New York 10005

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JENNIFER ALTMAN
Attorney at Law
jennifer.altman@pillsburylaw.com
600 Brickell Avenue
Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall
Suite 1800
Sacramento, California 95814

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorney at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DEBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

APPEARANCES (continued):

For Plaintiffs (continued):

National Health Law Program
By: CATHERINE ANNE MCKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

For Defendants:

Holtzman Vogel Baren, et al.
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street
Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(Call to Order of the Court at 9:00 AM on Tuesday, May 09, 2023.)

THE COURT: Good morning. Please be seated.

Are the plaintiffs ready for trial?

MR. GONZALEZ-PAGAN: Yes, Your Honor.

THE COURT: Defendants ready?

MR. JAZIL: Yes, Your Honor.

THE COURT: Opening statement for the plaintiffs.

MR. GONZALEZ-PAGAN: Good morning, Your Honor. May it please the Court, Omar Gonzalez-Pagan for the plaintiffs.

Today, Your Honor, we start a trial to vindicate the rights of Plaintiffs August Dekker, Bri Rothstein, Susan Doe, and K.F., to be free from discrimination and being able to access necessary, safe, effective, and evidence-based medical care for Medicaid.

Over the next few days we will show that Rule 51G-1.050(7), the challenged exclusion in this case which was adopted by Florida Agency for Health Care Administration, is unlawful because it discriminates based on sex and gender status, in violation of Section 1557 of the Affordable Care Act, the Fourteenth Amendment's Equal Protection Clause, and the EPSDT and comparability provisions of the federal Medicaid Act.

This is case because under *Rush v. Parham*, based on current medical knowledge, the State's determination that

gender-affirming medical care is experimental is not reasonable. In fact, Your Honor, under AHCA's very own regulation to determine whether a treatment is experimental, the only conclusion one can reach is that AHCA's determination was grossly unreasonable.

Rule 51G-1.035(4), presented to the Court right now on the screen, of the Florida Administrative Code sets forth six factors to determine whether a particular medical treatment meets Generally Accepted Professional Medical Standards, also known as GAPMS. And while those factors are not binding on this Court, they emphatically illustrate how gender-affirming medical care is safe, effective, and not experimental. The evidence will show, based on the testimony of experts in the field of transgender health and gender dysphoria and the plaintiffs' own testimony and experiences, that gender-affirming medical care is long-standing evidence-based care.

In setting this road map, I will walk the Court through these factors. The first, the existence of evidence-based clinical practice guidelines, Your Honor, there are primarily two evidence-based clinical practice guidelines for the treatment of gender dysphoria. These are the World Professional Association for Transgender Health Standards of Care, specifically Version 8 published in 2022, and the Endocrine Society's guidelines published in 2017. The State ignores these guidelines.

To be sure, given that they exist and that they are widely accepted, the State could like to undermine the fact that they exist by discrediting the organizations that have published them, but the guidelines, which are consistent with one another, are based on best available evidence, which involves volumes upon volumes of research published over the span of not a few months or years, but, rather, decades. Indeed, the guidelines are endorsed and supported by every mainstream medical organization in the United States.

This factor weighs heavily in favor of the care at issue and shows that it falls squarely within Generally Accepted Medical Professional Standards.

The second factor, we look at whether there are published reports and articles contained in operative medical and scientific literature related to the health service at issue. Plaintiffs will show that there is an abundance of peer-reviewed scientific literature supporting the safety and efficacy of gender-affirming medical care which the rule seeks to ban. The literature, much of which will be summarized with testimony of plaintiffs' experts, dates back decades.

Here the State ignores the whole body of the literature and misses the forest for the trees. The State says that because some studies have limitations, as is the case in all of science, the evidence is insufficient. But in looking at this factor, as plaintiffs' experts will testify, one looks at

the entire body of literature, not one particular study in isolation.

The State will argue that the evidence is of low quality and, therefore, insufficient. This is not so. Plaintiffs' expert will testify that the evidence at play is of the same kind and quality that supports countless medical interventions and that AHCA is creating an unprecedented, unequal, and, indeed, impossible standard for evaluating the evidence. This makes sense because defendants are not concerned with the evidence, but, rather, their goal of not covering this safe and effective care.

And because there is no peer-reviewed scientific literature supporting defendants' position, the testimony will show that defendants rely on unpublished reports and not peer-reviewed opinion pieces, which are not what the regulations -- their own regulations call for. The entire body of literature, taken as a whole, as published in peer-reviewed medical and scientific journals, provides strong evidence in support of puberty-delaying medications, hormone therapy, and surgery as treatment of gender dysphoria.

This factor also weighs heavily in plaintiffs' favor and the finding that gender-affirming medical care is not experimental.

The third factor, Your Honor, is the effectiveness of the health service in improving the individual's prognosis or

health outcomes. As noted, the evidence will show that there is an overwhelming universe of medical literature showing that this care is effective to treat gender dysphoria. Not only that, but the testimony from plaintiffs' experts, who together have decades of experience treating and studying gender dysphoria, will show that the scientific and medical literature supporting the efficacy of gender-affirming medical care accords with nearly a century of clinical experience.

The evidence will show that those diagnosed with gender dysphoria may experience high levels of anxiety, depression, and even self-harm and suicidality if their gender dysphoria is left untreated, and that the State's alternative to treat gender dysphoria with psychotherapy alone -- we've met some people who would argue it's akin to conversion therapy -- has no basis in peer-reviewed literature or clinical experience.

Quite fortunately, Your Honor, plaintiffs and their families will attest to the effectiveness of gender-affirming medical care that they have received and which Florida Medicaid previously covered. This care made the lives of Plaintiffs August Dekker, Brit Rothstein, Susan Doe, and K.F. better. It allows them to be themselves, and it helped secure and helped reduce the stress in society and emotional pain that they experience as a result of their gender dysphoria. And Jade Ladue, and Jane Doe will testify about how this care helped their adolescent children finally find comfort in their own

skin.

In sum, Your Honor, this care is not just effective in mitigating the effects of gender dysphoria. It can save lives. This factor goes to the plaintiffs.

Factors 4 and 5, Your Honor, are ordained to utilization trends and coverage policies by other credible insurance payer sources. These factors are so interrelated that we treat them together for purposes of this presentation.

As Your Honor knows, AHCA's fourth factor, utilization trends, is simply an analysis of whether health insurance entities, whether public or private, cover the service that is being analyzed. This is indisputably the case, and plaintiffs' expert Kellan Baker will testify as to that as well. What's more, Dr. Baker will discuss coverage trends across the United States.

The evidence will show that AHCA abandons its own standards by refusing to review private insurance coverage policies which cover this care as medically necessary. That -- AHCA's suggestion that Medicare does not cover this treatment is patently false. Yes, Medicare declined to issue a national coverage determination mandating the coverage of gender-affirming surgery for the Medicare population automatically, but it did so after removing an exclusion for this care when it determined that it was not experimental and after it said the coverage for this care needs to be determined

on an individual basis based on the medical needs of a particular patient.

As for Medicaid, over 45 states and territories of the 56 states and territories in the United States cover this care. By contrast, only a small minority exclude some of it, and we think of that small minority even fewer do it completely, as Florida now seeks to do.

It is clear that these factors also weigh in favor of the plaintiffs and the finding that gender-affirming medical care is not experimental.

The sixth and final factor, Your Honor, is the recommendations or assessments by clinical or technical experts on the subject or field at issue. The last part of this factor on the subject or the field of course implies that the experts being consulted would have actual clinical or technical experience in the health service being analyzed.

Here the State did not do that. Instead, it engaged in what would charitably be called a sham process where it paid quite generously a handful of select vocal opponents of gender-affirming care to serve as consultants. In fact, AHCA had never even hired consultants for a GAPMS process before. To use those consultants to participate in this process, as AHCA former employee and plaintiff witness Jeffrey English will testify and has put it in the past, was a conclusion in search of an argument.

None, absolutely none of AHCA's consultants that worked on creating the GAPMS report had any experience diagnosing, treating, or studying gender dysphoria or its treatment. AHCA employed them specifically because they oppose this care. But of the eight consultants that AHCA hired during the GAPMS report process, only two will be testifying as experts today in this trial, and of those, neither of them -- Dr. Van Meter and Dr. Lappert -- have any experience in treating or studying gender dysphoria, and both of them have previously been disqualified as experts by courts on this issue.

By contrast, the clinicians and technical experts who could provide actual insight into this care, who have experience in treating this condition, as the Court will find, are people like plaintiffs' experts. You'll learn from each of plaintiffs' expert witnesses that they are recognized as leaders in the field of gender-affirming care, that they are experienced. They are published on the topic and have been peer reviewed on the topic. They are qualified to testify as to the efficacy of this care.

This factor heavily supports plaintiffs and demonstrates that AHCA's determination was unreasonable.

On a final note, the process employed by AHCA is an important factor in itself in making a determination of whether their conclusion was reasonable. Here the process that surrounded AHCA's review of the GAPMS factors, as well as the

process used to adopt the final rule itself, were perversions of a standard process, and they support the finding that it wasn't reasonable. AHCA did not legitimately review the evidence as set forth under their own regulations, and there are several other ways in which the process deviated from standard operating procedure.

First, AHCA had never used the GAPMS process before to terminate coverage for a service it previously covered. It just never had. In fact, you'll hear from Mr. English that if a service was already covered by AHCA, then the standard procedure was to not undertake a GAPMS process. AHCA employee Devona Pickle even pointed out to Mr. English via email that eliminating coverage is not something considered under Rule 51G-1.035.

Second, the GAPMS request did not come through traditional channels that typically trigger a GAPMS evaluation. In fact, Jeff English, who was the GAPMS guy at the time, the agency employee who was responsible for every single GAPMS report at the pertinent time at issue, was pulled and excluded from the task of evaluating gender-affirming medical care under the process undertaken by this agency. As the evidence will show, AHCA excluded him because if he followed the evidence as he normally did, he would not reach the conclusion they wanted.

And, third, while it was typical for most GAPMS processes to take months, if not years, and for them to be

evaluated at different stages, here the report was articulated within a matter of weeks, and it was approved within a matter of a day, and just 24 hours later the rule was proposed.

Then there was the rule hearing itself where AHCA paid consultants to respond to comments, where it met beforehand to sketch out a plan for those responses and appearance, and the consultants only responded to those who opposed the rule, not any comment to those who supported it.

And AHCA received thousands of written comments submitted after the hearing but before the close of the rule record that were substantial and included lengthy responses from the Endocrine Society, the American Academy of Pediatrics, and teams of legal and medical experts from various academic institutions, as well as people who stood to be affected by this rule.

Notwithstanding the amount of public comment and particularly opposition to the rule, the agency, a mere three weeks after the close of the comment period, finalized the rule banning coverage of care in identical form to the rule that was proposed in June.

In sum, Your Honor, the totality of the evidence plaintiffs will proffer will show that AHCA's conclusion was not one reached within reason, but, instead, was motivated by discriminatory animus.

Plaintiffs are grateful to have their day in court and

to present this evidence. We are looking forward to vindicate plaintiffs' rights and the rights of other transgender Medicaid beneficiaries throughout Florida whose health, well-being, and very lives are at stake. They deserve and are entitled to the same dignity, respect, and governmental recognition as any other person in Florida.

We thank the Court in advance for its expenditure of its time and its resources in hearing this case.

Thank you, Your Honor.

THE COURT: For the defense?

MR. JAZIL: Thank you, Your Honor. Mohammad Jazil on behalf of the defendants, together with Gary Perko and Michael Beato.

Your Honor, over the next few week this Court will hear from lots of experts: Experts in psychiatry, experts in endocrinology, surgeons, neuroscientists. The State will put on some of these experts. My friends for the plaintiffs will put on some of the other experts.

The State's experts include Dr. Steven Levine, who helped write WPATH's Standards of Care Version 5. The State's expert will include Dr. Sophie Scott, a neuroscientist from the United Kingdom, who has no dog in this fight -- she is not part of either entrenched camp of experts -- talking about the effects of puberty blockers on the brain.

The testimony both from us and from them will focus on

the use, efficacy, safety, and general appropriateness of certain treatments -- puberty blockers, cross-sex hormones, and surgeries -- to treat one mental disorder, gender dysphoria.

The Court will also hear from Matt Brackett, a career civil servant. Mr. Brackett was the one tasked with reviewing the evidence and writing the GAPMS report as an initial matter. The State's experts and Mr. Brackett will tell the Court that the treatments at issue here are experimental. Mr. Brackett's reasons are laid out in his GAPMS report. It's a report that he wrote. It was a report that, together with its attachments, was subject to public comment and public review as part of a rulemaking process. The rule never got challenged.

Under *Rush,* Your Honor, as you know, this Court's task is to assess whether or not the State's conclusion was reasonable based on the current medical opinion. Under *Dobbs,* this Court's task is to assess whether the State's decision was rational and under the weight of the authority -- *Rush, Dobbs*, and *Adams v. School Board* -- the task calls for deference to the State's choices on this issue concerning the regulation of certain medical procedures.

As a further point, Your Honor, I note that -- and to ensure that I preserve this for appeal, I note that the State's position is that 42 U.S.C. 1983 does not serve as a vehicle for challenges under the Medicaid Act. Section 1983 allows for vindication of federally protected rights guaranteed by the

requirements of federal law. Medicaid, the federal at law issue, and the DPSDT and comparability requirements create no federally enforceable rights.

Regardless, Your Honor, the evidence will show that the State is in the right here; its decision was constitutional; its decision complied with the relevant statutes.

Thank you, Your Honor.

THE COURT: All right. For the plaintiff, please call your first witness.

MR. GONZALEZ-PAGAN: Your Honor, if may, Omar Gonzalez-Pagan. We were hoping to -- and I've consulted with my friend -- to admit the joint stipulated exhibits into evidence at the start of trial, if the Court is amenable.

THE COURT: Yes.

This is all the joint exhibits?

MR. GONZALEZ-PAGAN: All the joint stipulated exhibits, and there was a notice filed last night with the Court setting forth which ones those were.

THE COURT: Yeah, the notice last night is ECF 214.

MR. GONZALEZ-PAGAN: It's Docket No. 219, Your Honor.

THE COURT: 219.

214 is the one I'm looking at, but that dealt with the witnesses.

MR. GONZALEZ-PAGAN: We are happy to revisit that at a later time, Your Honor.

THE COURT: No, I've got it right here. The exhibits identified in ECF 219 are admitted into evidence.

(All exhibits listed in ECF No, 219 are admitted.)

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

THE COURT: Most of the witnesses are experts, and I would allow them to be in the room even with the rule invoked.

Does either side wish to have the rule invoked? I'm not entirely sure there are any lay witnesses other than parties. But if there are, does either side wish to have them excluded?

MR. JAZIL: No, Your Honor, not for the defense.

MR. GONZALEZ-PAGAN: Not from the plaintiffs, Your Honor.

THE COURT: All right.

MS. DeBRIERE: Your Honor, plaintiffs call Dr. Dan Karasic as their first witness.

(Dr. Karasic entered the courtroom.)

THE COURTROOM DEPUTY: Please be seated.

DR. DAN HALABAN KARASIC, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name for the record and spell your last name for the record.

THE WITNESS: Sure, Dan Halaban Karasic, K-a-r-a-s-i-c.

DIRECT EXAMINATION

BY MS. DeBRIERE:

Q. Dr. Karasic, what is your profession?

A. I'm a psychiatrist.

Q. How long have you been a psychiatrist?

A. I have been a psychiatrist for 32 years, 36 years including psychiatric residence.

Q. Have you specialized in the treatment of any particular conditions or populations?

A. Yes, I've specialized in the treatment of transgender and gender-diverse people, as well as people with HIV.

Q. What current positions do you hold, Dr. Karasic?

A. I am professor emeritus of psychiatry at the University of California at San Francisco.

Q. Okay. Over your years at UCFS --

A. Yes.

Q. -- what have your duties been?

A. Over the years at UCFS, I've provided health care and created programs and done research and taught on the care of both people with HIV and transgender and gender-diverse people.

Q. Specifically with regard to transgender people, in what settings have you provided clinical care to patients?

A. I was the psychiatrist for the Dimensions Clinic for transgender youth, as well as the Transgender Life Care Program at Castro-Mission health care center, and that was from 2023

until 2020.

I was also the cofounder of -- and coleader of the gender team at the UCFS Alliance Health Project from 2012 to 2020.

Q. Can you describe --

A. Also, just to add, throughout the 30 years, I saw -- would see transgender people in my faculty practice.

Q. Thank you.

Can you describe your experience a little bit at the Dimensions Clinic?

A. Sure.

So the Dimensions Clinic provides care for transgender youth from ages 12 to 25; one of the first places in the U.S. to do so. And there was also the Transgender Life Care Program which was primarily a clinic for people who had kind of aged out of that 12-to-25-year range. And so I saw patients and also supervised therapists there.

Q. And what years did you see patients at Dimensions?

A. From 2003 to 2020.

Q. Can you describe your experience a little bit at the Transgender Life Center as well?

A. Transgender Life Care Program was in the same clinic, but it was providing care for people after they had -- were no longer a part of the Dimensions program because they were 26, 27; they had aged out of it.

And, yeah, so I guess answering that part.

Q. Yeah. How many patients have you treated over the years?
A. So -- well, I would also say, in terms of places I saw people, the transgender team at the UCFS Alliance Health Project, that was a team that we started when San Francisco started covering gender-affirming care for people first with Healthy San Francisco in 2012, and people with Medicaid starting in 2013.

And so we provided the mental health assessments for surgery for the Medicaid patients who were getting surgery through the -- through San Francisco's Managed Medi-Cal.
Q. Thank you. Thank you.

So in all of those clinical settings, can you give an approximation of how many patients you've seen over the course of your practice?
A. Certainly thousands.
Q. Thousands.

Aside from gender dysphoria, what other types of conditions do you treat?
A. So as a psychiatrist, I take care of a lot of patients who are depressed, anxious, have bipolar disorder, people with panic disorder, OCD; the whole range of psychiatric conditions that people have.
Q. Do you also do research?
A. And so -- so yes. Well, I retired from UCFS in 2020. But, yes, I did research as part of my work at UCFS from 1991 to

2020.
Q. 1991 to 2020?
Have you published any scholarly articles?
A. Yes.
Q. Have those been in peer-reviewed journals?
A. Yes.
Q. Approximately how many peer-reviewed articles have you published?
A. Twenty-three.
Q. And what topics did those articles cover?
A. They covered the care of transgender people, as well as care of people with HIV.
Q. In addition to those articles, are there any other professional published works you have authored that relate to transgender health issues?
A. Yes. I was the -- an author of the WPATH Standards of Care 7, and I was the mental health chapter lead of WPATH Standards of Care Version 8. And I also worked on the primary care protocols for transgender care for UCFS, both versions.
Q. Have you served as a peer reviewer for any of the scholarly journals?
A. Yes.
Q. Are there particular areas you are asked to review when you are doing the peer review?
A. Transgender health.

Q. Dr. Karasic, are you being compensated for your time here today?
A. Yes.
Q. Does your compensation in any way depend on the outcome of this litigation?
A. No.
Q. Or your testimony?
A. No.
Q. Dr. Karasic, when you provided a copy of your expert report for this case, did you include a copy of your CV?
A. Yes.
Q. And does that CV present an accurate summary of your qualifications and professional activities?
A. Yes.

MS. DeBRIERE: Your Honor, Dr. Karasic's CV is among the stipulated exhibits provided to the Court listed as Plaintiffs' Exhibit 359.

THE COURT: That's admitted.

(PLAINTIFFS EXHIBIT 369: Received in evidence.)

MS. DeBRIERE: At this time I'd move to have Dr. Karasic qualified as an expert in psychiatry; more specifically, the assessment, study and treatment of gender dysphoria in both adolescents and adults.

THE COURT: Mr. Jazil, any questions at this time?

MR. JAZIL: No, Your Honor.

THE COURT: You may proceed.

MS. DeBRIERE: Thank you, Your Honor.

BY MS. DeBRIERE:

Q. Dr. Karasic, you mentioned that you've treated both adolescents and adults with gender dysphoria, so let's just go over some basic terms.

What is gender dysphoria?

A. So gender dysphoria is the distress about the difference between one's identified gender and one's sex assigned at birth.

Q. What does the term "gender identity" mean?

A. Gender identity is a deeply felt, long-standing sense of being male, female, or another gender.

Q. I think you just mentioned sex assigned at birth?

A. Yes.

Q. What does that mean?

A. So when a doctor delivers a baby, the -- usually based on the appearance of external genitalia, a sex of male or female is assigned.

Q. How is sex at birth determined?

A. Usually by appearance of external genitalia.

Q. What does the term "transgender" mean?

A. So transgender is -- a transgender person is someone whose gender identity is different from their sex assigned at birth.

Q. What about the term "nonbinary?" What does that mean?

A. Nonbinary is someone whose gender identity is other, male

or female.

Q. Is there any diagnosis associated with gender dysphoria that is used in the U.S.?

A. I'm sorry. What was the question?

Q. Yeah. Is there any diagnosis associated with gender dysphoria that is used in the United States?

A. Oh, yes.

So there are two diagnoses that are in the *DSM-5*, and then the ICD-10-CM refers to those diagnoses. There's gender dysphoria of children and gender dysphoria of adults and -- of adolescents and adults.

Q. What is the DSM?

A. Oh, the Diagnostic and Statistical Manual of the American Psychiatric Association.

Q. You also mentioned ICD-10. What is that?

A. So that's the International Classification of Diseases. It's the World Health Organization's list of disorders. And in the United States we use ICD-10-CM as kind of the billing manual, diagnoses for billing.

Q. So turning back to the DSM, how is that used by mental health professionals in caring for patients?

A. So the DSM provides classification with a list of symptoms that define the different disorders. And that's used so that everyone has a common understanding of what a particular disorder is and also for billing purposes.

Q. When you say "everyone," what group of people is that?
A. So clinicians, and also for researchers, that if people are researching a particular disorder, it's -- they are talking about the same thing, the same list of symptoms.
Q. Dr. Karasic, have you ever diagnosed patients with gender dysphoria?
A. Yes.
Q. Can you summarize the diagnostic criteria located in the DSM for gender dysphoria?
A. Sure. So it's having for six months or longer -- so at least six months -- distress about the difference between one's gender identity or experienced gender and one's gender assigned at birth. And it -- and then there are some -- like, six criteria of which you have to have two of those six symptoms. And then you have to have clinically significant distress or social or occupational impairment.
Q. So what does that mean, "clinically significant distress"?
A. So that's distress that is strong enough that you would go to the doctor for it.
Q. And same question for impairment of functions?
A. For social and occupational impairment.
So social impairment is that the symptoms are strong enough that they are getting in the way of your relationship with other people, with your, kind of, interface with the world. And occupational impairment is that the symptoms are getting in the

way of school or job performance.
Q. Does the fact that someone is gender nonconforming mean that they are to be diagnosed with gender dysphoria?
A. No.
Q. Is being transgender a mental disorder per se?
A. No.
So being transgender is just part of human diversity. There are people who are transgender who meet criteria for gender dysphoria. But being transgender per se is an identity that a person might have.
Q. Has the diagnosis of gender dysphoria changed at all over time in the DSM?
A. The diagnosis of gender dysphoria, both diagnosis of children and adults, came into the DSM with *DSM-5* in 2013. Prior to that, there were diagnoses of gender identity disorder of adolescents and adults and gender identity disorder of children.
Q. So what were the differences, I guess, between those two diagnoses?
A. So one big difference was with gender identity disorder of childhood, which did not have an absolute requirement of transgender identity, it could be implied through strong cross-sex behavior. And there was a recognition that -- that that included a lot of people who were not transgender adults. And so in -- for *DSM-5*, they made the A1 criteria of a

transgender identity required for gender dysphoria of childhood.

There is also changing the name from gender identity disorder to gender dysphoria, an emphasis that it was the distress about the difference that was the disorder as opposed to being transgender.

Q. You just mentioned that A1 criteria?

A. Yes.

Q. What -- just tell us what that A1 criteria is. I believe you just --

A. So the A1 criteria in gender dysphoria of childhood is our -- symptoms that speak to having a transgender identity, having an identity of being a gender other than the one assigned -- sex assigned at birth. So it was in the list of symptoms before, but it wasn't a required symptom until *DSM-5*.

Q. Is gender identity something someone can change voluntarily to be congruent with their sex assigned at birth?

A. No.

Q. Have there been efforts through the field of psychiatry or psychology to try to change a transperson's gender identity through therapy?

A. Yes, generally labeled conversion therapy.

Q. How did those efforts impact patients?

A. So major medical and mental health organizations have come out with policy statements against conversion therapy, because there just hasn't been any data that it helps. And we have some

data and certainly a lot of clinical experience of people who were harmed from conversion therapy.

Q. You mentioned major medical associations. Can you name a couple of those?

A. Sure.

The American Psychological Association, American Psychiatrist Association, American Medical Association; the American Psychological Association not that long ago came out with a long document in opposition to what they labeled as gender identity change efforts, which is conversion therapy specifically for transgender people.

Q. So, Dr. Karasic, you said people can't voluntarily change their gender identity, but can someone's understanding of their gender identity change over time?

A. Yes.

So people can have these deep-seated feelings and they can have different conceptualizations or names that they give for those. And certainly I have patients who might identify as nonbinary at one point and as binary/transgender at another point, or vice -- or switching, vice versa.

And so, you know, people can label their gender identity in different ways over time as their understanding of their self evolves.

Q. Can you describe the process that's used to diagnosis gender dysphoria?

A. Yes.

So specifically for -- not gender dysphoria, the symptom of gender dysphoria, the diagnosis in the *DSM-5* has a set of symptoms. The person has a -- the patient has a clinical interview from a clinician, and that includes a clinical history and a clinic exam, and the clinician making the determination if that fits with the gender dysphoria diagnosis. It's really the same process for making any DSM diagnosis.

Q. Are there any differences between diagnosing a child versus an adult?

A. Yes.

Well, for prepubertal children, there is a different set of criteria, first of all. And, secondly, the parents are involved in the clinical interview and typically the exam as well when working with the child.

Q. Are there any recommendations as to who should make the assessments or diagnosis of gender dysphoria when it comes to patients?

A. Yes.

WPATH Standards of Care 8 makes recommendations for adolescents. There's a recommendation of it being a mental health professional with substantial knowledge and experience in the field.

For adults, it's a health professional, but also a knowledgeable health professional.

Q. Is there an understanding of what causes someone to have a particular gender identity or for experiencing gender incongruence?
A. So, we know that there are biological bases for gender identity, but we also know it's more complicated than that. And we don't know specifically why a given individual might have a transgender identity.
Q. Are there any studies exploring these bases?
A. Yeah. So there's a whole literature of biological differences, from increased concordance in identical twins, to brain structure, to hormonal differences in utero.

And so there are -- there is substantial data that -- it doesn't account for all of someone's gender identity, but these are contributory factors.
Q. And some of the State's experts take issue with the legitimacy of the diagnosis of gender dysphoria, asserting that it's a self-diagnosis because it's based on what the patient reports instead of a biological or laboratory test.

Could you tell us your response to that?
A. Sure.

Well, you know, having -- before even being a psychiatrist, having been a medical student and then doing a, you know, general internship, the history you take from a patient and your observation of the patient are among the most valuable things in making a diagnosis. It's not just, you do a lab test and make a

diagnosis.

And then specifically for psychiatry, we make all of our diagnoses by talking with patients and by observing them.

Q. Dr. Karasic, the State and some of its experts have also suggested that gender dysphoria might be caused by something called endocrine disrupting chemicals.

Are you familiar with that term?

A. So I think that's referring to environmental chemicals and the question of can they affect gender identity, and there really isn't, you know, evidence to support that.

Q. Okay. So, I guess, the next set of questions.

Are there any best practice guidelines recognized within medical/mental health fields to treat patients with gender dysphoria?

A. Yes. Those include the WPATH Standards of Care Version 8, the Endocrine Society guidelines from 2017, and then there are recommendations that various professional societies have made.

Q. So let's -- can you talk a little bit about what WPATH is?

A. Sure. The World Professional Association for Transgender Health is an organization of, I believe, approximately 3,000 health professionals, almost all of whom are clinicians, who are working in transgender health, but also including health academics and a few health legal experts.

Q. And what is WPATH Standards of Care 8? Can you describe that a bit?

A. Sure. WPATH has put out periodically standards of care, which are practice guidelines, since -- 1979 was Standards of Care Version 1. Standards of Care 7 was released in 2011, published in 2012, and then Standards of Care 8 came out just in September of 2022.

Q. And are you at all familiar with the process used to develop the Standards of Care, including Standards of Care 8?

A. Yes, I was one of the authors of Standards of Care 7 and one of the authors of Standards of Care 8, including being chapter lead for the mental health chapter of Standards of Care 8.

Q. How many chapters are in the Standards of Care 8?

A. I believe it's 18.

Q. Who is involved in developing the recommendations to include in the Standards of Care?

A. So the -- for Standards of Care 8, the WPATH board of directors appointed an editor and two coeditors, and they were two American clinicians and academicians and one from the United Kingdom.

And those three editors then selected from applications chapter leads, and then the editors and the chapter leads worked together from applications to go through CVs and pick a team for each chapter, and those were people who had considerable expertise in transgender health.

Q. So to follow up on that, in writing the chapters of

Standards of Care for 8, what did the -- these individual who were selected to write the standards, what did they base their recommendations on?

A. So -- so speaking for the mental health chapter -- I was chapter lead -- we had leaders of the transgender health programs of Sweden, Belgium, Turkey, and several people from the United States, and they -- and recommendations were based on our review of the literature, as well as our experience in those programs. There was also -- WPATH commissioned from John Hopkins University systematic reviews of the evidence to provide a basis for the recommendations that were made.

Q. How long did this whole process take?

A. About five years.

Q. Okay. You also mentioned the Endocrine Society guidelines?

A. Yes.

Q. Are you familiar with those guidelines?

A. Yes.

Q. Why, because you're not an endocrinologist?

A. Yes. So there were -- so there was over a decade in between Standards of Care 7 and Standards of Care 8, and the Endocrine Society guidelines were kind of right in the middle timewise. So they were a useful guide in that process of time. I'm sure endocrinologists, for example, you know, might still preferentially look at that. For us certainly in mental health, we would probably look more to Standards of Care 8 that includes

an endocrine section but, you know, is the most current.
Q. In the Endocrine Society guidelines, does it cover all age ranges?
A. Yes.
Q. How are the WPATH Standards of Care and the Endocrine Society guidelines viewed within the medical and mental health communities?
A. They are quite universally accepted or commonly accepted by -- as practice guidelines for clinicians, you know, throughout the United States.
Q. And so what -- when we're referencing these major medical and mental health professional groups, what are some of those groups? Could you name them for us?
A. Sure. American Medical Association, American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, National Association of Social Workers, and many more.
Q. Do you follow the WPATH Standards of Care in your psychiatry practice when seeing patients?
A. Yes.
Q. In your experience, are the WPATH Standards of Care and Endocrine Society guidelines recommended practices that are followed by clinicians?
A. Yes.
Q. And how do you know that?

A. So I've been involved not only practicing transgender health, but teaching transgender health since the 1990s, and so I speak at a lot of conferences. I've trained thousands of people.

Just last week I was doing a training in San Francisco that was put on by UCSF for clinicians. There was this one person I met from Florida there. I've -- I did a train -- a large training in South Florida several years ago.

And so I've also probably presented on transgender health at the American Psychiatric Association probably more than any other one individual since the 1990s.

So I meet a lot of people, and I discuss their practice and WPATH Standards of Care, and some of the principles of gender-affirming care are, you know, utilized in cross-disciplines throughout the United States and internationally.

Q. In practice guidelines like WPATH and the Endocrine Society guidelines, similar guidelines, is it ever appropriate for clinicians to deviate from those guidelines?

A. So they're practice guidelines, and so a clinician still uses their individual judgment, and that takes into account practice guidelines. But they're not laws. They are guidelines for practice.

Q. So just turning to some specifics about WPATH Standards of Care 8, are the recommendations for the treatment of gender

dysphoria the same across age ranges?
A. So -- I'm sorry. Were you talking about --
Q. So in the W -- turning specifically to WPATH 8 --
A. Yes.
Q. -- some specifics there, are the treatment recommendations for gender dysphoria the same across age ranges?
A. No.
Q. So can you describe that a little bit for us?
A. Sure. So there's no medical treatment that is recommended for people before puberty.

And then starting at Tanner Stage 2, the start of puberty, there is the possibility of a medical intervention of puberty blockers.

And at -- later in adolescence cross-sex hormones could be used, and also later in adolescence transmasculine youth can get chest surgery. Other surgeries in adolescences are very uncommon.

And then adults get -- you know, could get -- in addition to hormones can get chest surgery, genitalia surgery, facial feminization surgery.

Q. Dr. Karasic, are you familiar with the Rule 59G-1.050, subpart (7), of the Florida Administrative Code?
A. Yes.
Q. What's your understanding of that rule?
A. So that -- that rule does not allow provision of or payment

reimbursement for gender-affirming care, including hormones -- or puberty blockers, hormones, and surgery.

Q. So let's just discuss a little bit the medical interventions this rule covers, starting with pubertal suppression.

How does pubertal suppression address a young person's gender dysphoria?

A. So pubertal suppression stops the progression of puberty where it is. So if -- a young person could present at these -- a very early stage of puberty. For someone assigned female at birth, you could have -- start breast bud development, and puberty blockers would halt pubertal development where it was when the person started the medication.

Q. Does that have any impact on the individual's mental health condition?

A. Yes, particularly if the person is experiencing distress either at the physical changes that already happened or the anticipation of the progression of those changes, there can be great relief from, you know, knowing that those have been frozen in place.

Q. How about hormone therapy? How does that relate to addressing the diagnosis of gender dysphoria?

A. So hormone therapy helps masculinize or feminize the body to be more congruent with the person's gender identity, and, again, that can certainly provide mental health benefits with a

lessening of the gender dysphoria -- the distress of gender dysphoria and sometimes other co-occurring mental health symptoms.

Q. It would be the same question for surgery, Dr. Karasic.

A. Uh-huh. So surgery also alters the body to be more congruent with the person's gender identity and also can both provide relief from gender dysphoria and also sometimes other mental health symptoms surrounding the distress of gender dysphoria.

Q. In your experience, what are the effects of untreated gender dysphoria?

A. So I've taken care of patients for a long time and through many different kind of eras and have had also had patients who for various family or social or occupational or medical reasons have not been able to take hormones for extended periods of time, and for some people that can cause great distress.

And, by definition, a diagnosis of gender dysphoria has more than six months of clinically significant distress or social and occupational impairment. So that can impair people's performance in school, work, relationships.

Q. Can you give some -- can you describe a little bit more for us how that distress manifests in an individual, what some of the behavior looks like?

A. So that could be depression, anxiety, suicidal ideation, self-harm, withdrawing from loved ones, or from -- or not

performing well in school or work might be some examples.
Q. Are there any minimum age requirements for the treatments we just discussed?
A. Yeah. So as I said, you wouldn't give a puberty blocker until they start puberty. That's not a set age. The -- the adolescent chapter in Standards of Care 8 sets an 18 for phalloplasty. For other interventions it says that they should be age appropriate, and the -- the young person should have the cognitive development to assent to the interventions that parents consent to.
Q. I think you said this a little bit before, but does that mean minors would always receive surgeries to treat their gender dysphoria?
A. I'm sorry. What's the question?
Q. Yeah. Does that mean minors would receive surgeries to treat their gender dysphoria?
A. So minors can receive surgery to treat gender dysphoria. The overwhelming number of those surgeries, in my experience, are transmasculine youth who later in adolescence get chest surgery because of strong persistent dysphoria about their chest. Other surgeries can be done but are quite uncommon.
Q. All right. So we've been talking about the WPATH Standards of Care 8.
Did the Endocrine Society guidelines also make recommendations regarding the use of puberty blockers and

hormone therapy?
A. Yes, the Endocrine Society also says that puberty blockers shouldn't be used until the start of puberty, so no medical intervention until the start of puberty. They refer to the Dutch research in saying 16 for hormones, but also say they could be given at 13 or 14. This was an area of kind of increasing knowledge at that time in 2017 when the guidelines came out.
Q. I see. Do the Endocrine Society guidelines make any recommendations about surgery or surgical treatment?
A. Yes.
Q. And what is that recommendation?
A. They recommend -- they say chest surgery, particularly for transmasculine, youth can be done in adolescents, and genital surgery should be done at age 18 or later.
Q. So these guidelines, the Endocrine Society guidelines and WPATH, are they fairly consistent with one another?
A. Overall they're quite consistent. Again, there's -- they came out at different points in time, and so there are, you know, differences between Standards of Care 7, Endocrine Society guidelines, and Standards of Care 8.
Q. So under the WPATH Standards of Care and these guidelines, how can mental health professionals help patients who come to them because they have distress about their gender?
A. So -- actually, could you repeat the question?

Q. Yeah. So under the guidelines --
A. Uh-huh.
Q. -- we've been discussing, WPATH and Endocrine Society, how can mental health professionals help patients who come to them, you know, expressing distress about their gender identity?
A. Sure. So before puberty it's -- there's only psychotherapy, family support. There's no medications until then. Starting with the start of puberty, there could be an assessment for puberty blockers and later an assessment for hormones.
Q. Dr. Karasic, are you familiar with the term "gender-affirming therapy"?
A. Yes.
Q. What does that mean in your field?
A. So the gender-affirming label has now been put on both gender-affirming medical care and gender-affirming therapy. And so gender-affirming medical care basically refers to the provision of puberty blockers, hormones, surgery.

Gender-affirming therapy refers to a therapy that provides space for the patient to explore and understand their gender without any preconceptions of the therapist being placed in terms of where that should go.

Q. Is it the role of mental health professionals to actively encourage patients to pursue a transgender identity?
A. No.

Q. Would that active encouragement be something that's consistent with WPATH or the Endocrine Society guidelines?
A. No. As a matter of fact, WPATH's Standards of Care specifically says that the therapist should not impose their idea of where the patient should go in terms of their expression of their gender identity, that they should provide a supportive environment for the patient to kind of find their path.
Q. Under the WPATH Standards of Care and Endocrine Society guidelines, are medical interventions that -- gender-affirming care, is that appropriate for all patients who have gender dysphoria?
A. No.
Q. Do the WPATH Standards of Care have any recommendations regarding assessments of patients before the provision of gender-affirming medical interventions?
A. Yes. So there are a separate set of recommendations for adolescents and a set of recommendations for adults.
And so do you want me to --
Q. That would be great. Thank you.
A. -- elaborate?
So for adolescents, there's a recommendation of a comprehensive biopsychosocial evaluation, preferably by a mental health professional. And they lay out some components of that evaluation that include gender identity development, social development, an evaluation for the presence of co-occurring

conditions, and the cognitive ability to assent to care with the parents' consent.

Q. Can you talk about those components a little bit more, starting with gender identity development?

A. Yes.

So -- so, again, these are adolescents, and they may have strong feelings or behavior related to their transgender identity. But there's a process of -- that could be putting words to it, that gaining an understanding as a child develops cognitively, and so kind of understanding that development to the point where they present to the clinician.

Q. And I think another component you mentioned was the social development?

A. Right. And so people's relationship and expression of their gender identity to family, peers, school, et cetera.

Q. And the assessment of possible co-occurring conditions, why do you do that? Why is that a component?

A. So there can be co-occurring conditions that can affect the assessment. For example, if someone has Autism Spectrum Disorder, they might have communication difficulties, and so one might need to do extra work on communication. One also might assess for depression, anxiety, suicidality that might be addressed either beforehand or concurrently with gender-affirming medical care. And that decision needs to be made by the clinician. So it's important to understand

co-occurring conditions and how they might affect the process of transition.

Q. And then I think the last component you mentioned related to cognitive functioning for the ability to assent or consent to care. Why is that important?

A. Well, even the parents' consent for care, but we'd certainly want to have assessment of the child's understanding of the risks and benefits as well and have that be a component along with -- for them to be able to assent along with the parents' consent.

Q. Are these same factors taken into consideration in the assessment of adults?

A. For the assessment of adults there is a separate set of criteria that includes the capacity to consent, that co-occurring mental health conditions that could affect the care have been assessed and the risks and benefits of providing treatment versus waiting to provide treatment are weighed in that assessment before treatment.

Q. So does Standards of Care 8 -- does it recognize that any common -- or does it cover, I should say, any common psychiatrist comorbidities in gender dysphoric patients?

A. I'm sorry?

Q. Yeah. No. Does the -- do the Standards of Care 8 recognize whether some psychiatric comorbidities are common in gender dysphoric patients?

A. Oh, yes.
Q. And what are those common comorbidities?
A. So there is, as I mentioned, Autism Spectrum Disorder before. And there is a bigger overlap than one would expect just from the general population of people who have Autism Spectrum Disorder and gender dysphoria. It's not known why that is. And, in addition, there are many people with gender dysphoria who have anxiety, depression, suicidality, self-harm.

And so those are important things to ask and take into consideration if they are present.

Q. So I heard you mention Autism Spectrum Disorder. Set that aside for just a second.

Just talking about the other common comorbidities, is there any understanding of why these co-occurring mental health issues are common among patients with gender dysphoria?
A. Yes. I think you can put things in two categories.

One is minority stress, the difficulty of living in society or even with family where a person might be subject to discrimination or even just kind of the negative descriptions that are associated with being transgender that are so deeply engrained in society.

And then there's also the distress of gender dysphoria itself. And so people -- that distress can be very strong, and people can have depression, anxiety, self-harm, suicidality related to that distress of having gender dysphoria.

Q. So turning back to Autism Spectrum Disorder, does the WPATH Standards of Care -- do they say anything about that specifically, the co-occurring disorder?

A. Yes. They say that clinicians, and particularly in the adolescent chapter, should be familiar with Autism Spectrum Disorder and working with young people who have Autism Spectrum Disorder and to take that into account in their evaluation.

A big part of the symptomology of Autism Spectrum Disorder is problems with communication or social communication, and so that's something that has to be taken into account in terms of doing the evaluation and ongoing work with the patient.

Q. Is it possible for an individual to be both transgender and neurodiverse?

A. Yes.

Q. Does autism spectrum disorder affect an individual's ability to understand their gender identity?

A. No.

Q. Does it impact an individual's -- an individual diagnosed with autism, does it impact their ability to assent to care?

A. No. I mean, it impacts it in a sense in that -- well, it's called Autism Spectrum Disorder because there is this extremely wide range of symptoms. And there is kind of a small number of people who are really so kind of profoundly impaired maybe in terms of communication that it might affect the process in terms of, you know, understanding what they want, and communicating is

a benefit, et cetera. And so there may be extra kind of work involved in terms of figuring all those things out in people who are more impaired.

There are also a large number of very highly functioning people with Autism Spectrum Disorder where there really isn't an impairment in terms of being able to transition.

Q. Does anxiety affect an individual's understanding of their gender identity?

A. No.

Q. How about depression?

A. No.

Q. Difficult circumstances in their home life?

A. No.

Q. Self-harm?

A. No.

Q. How do you respond to the assertion that gender dysphoria is a type of body dysmorphic disorder and, thus, should be treated with psychotherapy?

A. So body dysmorphic disorder is a separate DSM diagnosis, something more akin to OCD, where somebody has obsessive thoughts about their appearance in particular. And it's really an entirely different thing than gender dysphoria.

Q. The treatment of the other conditions that we've been discussing, would that resolve a person's gender dysphoria?

A. No.

Q. How does a medical -- how does medical treatment, gender-affirming medical interventions for a person's gender dysphoria, impact a person's co-occurring mental health disorder?

A. So doing anything, including making change, can be very difficult if you're depressed or anxious. And, in addition, there are many transgender people with suicidal ideation or suicide risk or who do self-harm. And so whether you're cisgender or transgender, whatever your gender identity is, it's important to address those things. When somebody maybe has some additional stressors of being transgender or of transition, it might be particularly important to have them be feeling as good as they can be while they go through that process.

Q. And that impact of the medical treatment on a person with gender dysphoria, do you have any examples from the patients that you've treated about how that's assisted with their mental health condition?

A. You said the impact of treatment of gender dysphoria on their mental health?

Q. The impact of any of the gender-affirming medical interventions.

A. Yes.

So I've been doing this work for a long time, and that included when at UCFS Alliance Health Project, where I've been for a long time, where our patients with Medicaid were finally,

you know, able to get their surgeries paid for, many other circumstances where people haven't been able to get care and then were able to get care, and as well as just kind of along the way of patients who at some point get gender-affirming care, and it's always remarkable to me the profound impact it makes on so many patients in terms of their mental health.

Q. So that's your clinical experience?

A. Yes.

Q. Does that accord with the scientific literature?

A. Yes. There are -- have been many papers over the decades showing benefit from gender-affirming medical care. Some of them are listed in the Cornell, what we know document that -- that I listed in my declaration from the early 1990s to 2017 when that came out.

But there are also many published peer-reviewed systematic reviews and reports and clinical series and surveys that people take that support the benefit that people have gotten from gender-affirming medical care.

Q. And just to touch on terminology very briefly, what is a systematic review generally?

A. A systematic review is when one looks at the result of multiple studies in a systematic way to try to answer a question using not just one study, but a larger body of literature.

Q. Thank you.

THE COURT: Before we move on, let me just try to

clear up one thing in the record.

You said two or three questions ago that when somebody hadn't gotten care and then did, it was remarkable to you what a profound impact it had on their mental health.

THE WITNESS: Yes.

THE COURT: I don't think you said whether it was favorable or unfavorable.

THE WITNESS: Oh, favorable, yeah.

Yes. Thank you.

I have patients who had tremendous improvement. And, you know, I mention that when in 2013, in San Francisco when people were finally able, sometimes who had waited -- people with Medicaid who had waited for years, decades, and were finally able to have the surgery paid for that they needed and just watching the positive impact that that made in people's lives, as well as, you know, other -- in other ways, but that was one place where it was particularly notable to me.

BY MS. DeBRIERE:

Q. What should be done in the event a patient has other mental health conditions?

A. So if someone has other mental health conditions, we should try to treat them as standards of care. Standards of Care 8 for adolescents says they should be addressed. For adults it says they should be assessed with risks and benefits weighed.

And so -- and I was -- in the mental health chapter that I

was chapter lead of, we say that it is important to evaluate these co-occurring conditions, but that doesn't necessarily mean a halt to providing care. It just gives us information that we need as clinicians to know best how to help people. And often that could be treating the co-occurring condition and providing gender-affirming care together. And it's a matter of kind of weighing the risks and benefits of one versus another.

Q. AHCA and its consultants have suggested that psychotherapy alone is sufficient to address gender dysphoria.

What's your response to that?

A. So in those patients who need gender-affirming medical and surgical care, people who have a lot of distress about their body that isn't going away, psychotherapy doesn't help that.

Q. What does help that?

A. Gender-affirming medical and surgical care.

Q. Do clinicians provide care at the demand of patients or their families?

A. I'm sorry, what?

Q. Do clinicians typically provide care at the demand of their patients or families of the patients?

A. So for any kind of care a clinician makes an evaluation based on their clinical judgment; they make a diagnosis; they come up with a treatment plan based on risks and benefits and make a recommendation to patients. But you can't cut the clinician out of that. They're really, you know, central to,

you know, diagnosing and making the decision to provide care.
Q. What does the term "informed consent" mean?
A. So informed consent is an agreement that a patient makes or a patient's parents and the patient might make with a provider, weighing the risks, benefits and alternatives of a procedure.
Q. Is there anything in the WPATH Standards of Care that address informed consent prior to initiating the medical interventions for gender dysphoria?
A. Yes. People have to have capacity for informed consent and should be advised of the risk/benefits alternatives to treatment.
Q. Is that true for adults and minors?
A. Yes.
Q. What's the process for minors?
A. So for -- for informed consent for minors, it's a process that very closely involves the parents or guardian, because they're the ones who are actually providing the informed consent. The patient also is assenting, and so they're, of course, involved, and they are central to -- you know, to what care is provided. And then in the adolescent chapter, there is an assessment by the clinician that the person -- the young person has the cognitive maturity for that procedure, and it's appropriate for them.
Q. What do the guidelines say about informing patients and their families about possible risks to fertility related to the

medical interventions?
A. So both in the Standards of Care, Version 8, adolescent chapter and adult chapter, one of the requirements is that there be discussion of fertility and fertility preservation.
Q. And are there any recommendations about informing patients and/or their families about what to do if those patients may come to feel over time that care is not a good fit for them?
A. Sure. So with the exception of the histrelin implant that can -- you know, that would have to be removed, that people can -- would have them in for months, each of these treatments requires either daily pills or injections that are over relatively short periods of time.

And, you know, anytime if a patient or, in the -- in the case of adolescents, the parents decide not to -- you know, to continue with treatment, then it -- you know, treatment can be terminated.

So it's a dynamic process, and there is mention in Standards of Care, the adolescent chapter, about the clinician remaining involved not just at the start of treatment, but throughout the process until -- in the case of adolescents, until they reach 18.
Q. And I know you just mentioned an implant, too. Is that something that could be removed?
A. Yes, and it can be removed.
Q. What's your reaction to the assertion that doctors who

provide gender-affirming medical care have an informed consent process that's perfunctory?

A. It's not true. I don't think there is anywhere in medicine that -- where more attention is paid to the assessment and providing -- making sure that people have adequate information and that lay out a process in that -- in that same way where you're having, you know, someone do the assessment, you know, typically aside from the surgeon that's doing their own, you know, provision of informed consent. I think it's a more stringent process than, really, elsewhere in medicine and surgery.

Q. In your practice as a psychiatrist, other than treating individuals with gender dysphoria, are there other areas where you require informed consent for treatment?

A. Yes, for -- every treatment requires informed consent.

Q. Okay. I'm going to show you tables contained in WPATH Standards of Care 8.

MS. DeBRIERE: Which, Your Honor, is marked as Defendants' Exhibit 16, which is on the stipulated exhibits list.

BY MS. DeBRIERE:

Q. And I'm just going to ask you to read these provisions, Doctor, starting with the chapter on adolescents.

What chapter is that?

A. VI.

THE COURT: Dr. Karasic, if you're going to read these, one of the things I try to tell people when you start reading, read it slower than you can read it, because we all need to understand it, and the court reporter needs to take it down.

THE WITNESS: Okay. I will. Thank you.

BY MS. DeBRIERE:

Q. Dr. Karasic, I can zoom in on that if needed.

A. I think I'm okay.

Q. Okay.

A. So these are the Statement of Recommendations as part of Chapter VI of the adolescent chapter of Standards of Care, Version 8. It kind of summarizes the recommendations that are made.

Do you want me to read all of it?

Q. Yes, please. And just before you start, I do want to note it's on page S48 and it's in Bates stamp Dekker FL_ WPATH_34.

THE COURT: You really want him to read this whole single page?

MS. DeBRIERE: Your Honor, my understanding is that if he reads it into the record, then it can be used, not just -- it can be used as evidence.

THE COURT: It can be used as evidence already. It's already been admitted into the record by situation at the beginning, so it's part of the record.

MS. DeBRIERE: So, Your Honor, my cocounsel is advising me that part of that stipulation included an objection to this particular exhibit.

THE COURT: What's the objection?

MS. DeBRIERE: Objection preservation.

MR. JAZIL: Your Honor, we had the motion in limine that we filed and the Court denied related to the reliance on WPATH and Endocrine Society, but this is our exhibit. We said --

THE COURT: The objection is -- even though they've got a witness who says this is a standard followed by practitioners all over the country, you don't think it's true, so you object to it?

MR. JAZIL: No, Your Honor. What I'm saying is we objected. We lost the motion, so this is in evidence --

THE COURT: Right.

MR. JAZIL: -- by stipulation of the parties.

THE COURT: And just so I'll understand the objection -- and, frankly, I can't fathom what the objection would be. So explain to me how it is that when we have a well-qualified expert who says this is the standard followed by practitioners around the country -- what is objectionable about that? The basis of the objection is? Explain it to me.

MR. JAZIL: Your Honor, we don't have an objection to the use of this document.

THE COURT: Well, when I ask the substantive basis of an objection and you can't even answer the question, it tells me -- I mean, I wonder why the objection was made. But I don't know if we'll make much progress with that, but just for future reference, when you make an objection and you can't even explain it, maybe you shouldn't have made the objection.

I understand you disagree with these standards, and I don't fault you that position at all. That's part of the case. But the assertion that they can't even be admitted into evidence strikes me as just a nonstarter. We don't need to go any further with that.

This is in evidence. I've overruled any objection, whatever the basis of it is, and so there is no need to read it into the record. The document is there.

MS. DeBRIERE: Thank you, Your Honor. I'll continue with questioning.

BY MS. DeBRIERE:

Q. Dr. Karasic, I'd like to turn to your clinical experience a bit. You've spoken about a patient you treated who received gender-affirming medical interventions that have been banned by the defendants' rule.

Does that treatment -- I know you mentioned surgeries. Does it also include puberty-delaying medications?

A. Yes.

Q. Does it include hormone therapy?

A. Yes.
Q. Is that for adolescents and adults?
A. Yes.
Q. Okay. Could you just talk a little bit more about, for those patient who have received this gender-affirming medical care, how it's impacted them?
A. Sure. Do you want me to give specific examples?
Q. Whatever you want to talk about.
A. Okay. So more generally, I see an impact that -- in those people who need -- who have persistent and marked gender dysphoria, to use the wording in Standards of Care 8, who have a *DSM-5* gender dysphoria diagnosis more than six months' duration, social and occupational impairment, clinically significant distress, who have marked distress about their bodies in particular, that gender-affirming care that helps make their body more congruent or, in the case of puberty blockers, at least kind of freezes the process, it's tremendously beneficial to my patients. And often that kind of order of benefit is much greater than, let's say, the antidepressant that I'm giving for someone who has major depressive disorder or panic disorder as well as gender dysphoria.
Q. Why is it as a psychiatrist most of your patients have co-occurring mental health conditions?
A. Because that's what we do as psychiatrists. If someone is transgender and they don't have a co-occurring mental health

condition, they're less likely to see me and would be more likely to see a mental health professional who isn't able to prescribe, for example. So I tend to see people -- my practice tends to be people who have gender dysphoria and also have major depressive disorder, or panic disorder, or other psychiatric illness.

Q. How do you know the benefits experienced by your patients is not just the result of your therapy, prescribed medications that you're providing, instead of the gender-affirming medical interventions?

A. So I've been doing this work for a really long time, and I have patients who do get psychotherapy and gender-affirming medical care simultaneously and get better. And one could argue, Why are they better?

But I also have many patients who have not been able to access care and have had a lot of mental health -- who needed the care who have had a lot of mental health interventions, medications, psychotherapy without improving, and then did improve if they were able to access gender-affirming care.

So there's often a temporal difference between when people might be treated or start treatment for the co-occurring condition and when they get gender-affirming medical or surgical care.

So to give you an example, I just the -- the last couple weeks ago I had a patient who was diagnosed in adolescence with

bipolar disorder and eventually was put on an effective drug for bipolar disorder. I saw this patient several years -- several years after that. They had been actually on that medication for a decade. And they said that that medicine really stabilized their mood, but it wasn't until a year and a half ago when he started on testosterone that his suicidal ideation finally went away.

Q. Have you been able to see the impact of gender-affirming medical interventions in patients over a course of time?

A. Yes. So I've had dozens of patients that I've seen for ten years or longer. I was at UCFS for 30 years. I still see patients in -- after I -- I semiretired from UCFS in 2020 and have been doing private practice with a chunk of my time since then. So, anyway, I've been around doing this work for a long time, and so I -- you know, that includes seeing some patients over many years and seeing continuing benefits of -- you know, of treatment.

Q. And when you say "treatment," what are you referencing?

A. Oh, of gender-affirming medical or surgical care.

Q. If a patient continues to experience a co-occurring mental health condition, does that mean gender-affirming care was not effective at treating their -- and I should say gender-affirming medical care was not effective at treating their gender dysphoria?

A. No, people can get relief from gender dysphoria but still

have the co-occurring conditions. People who are not transgender have chronic depression and anxiety, and people -- some transgender people have, for example, PTSD that they experience as a result of trauma related to being transgender, but even when they have the bodily changes that reduce gender dysphoria, they still have that experience that has, you know, caused the PTSD symptoms. So it's not unusual for other symptoms to persist.

Q. And you testified a bit earlier about speaking with clinicians around the country.

So are you familiar with the clinical experience of others in the field?

A. Yes. So, you know, I'm teaching and training a large number, in the thousands -- at least a couple thousand folks with the WPATH training initiative for -- for clinicians working with trans people, teaching at UCFS, giving visiting lectures.

So I interface with a lot of other providers at the APA, and I am struck by, you know, the community of healthcare providers taking care of transgender people's, you know, firm belief that gender-affirming medical care helps their patients, often tremendously.

Q. Do you have experience reviewing treatment recommended -- excuse me. Let me start again.

Do you have experience reviewing treatment recommendations for individuals that are not your patients to determine whether

those treatment recommendations are medically necessary?
A. Yes. So I'm a consultant for Maximus, and Maximus in a number of states and for the federal government makes determinations of medical necessity. So when, particularly, if, in the state of California, there's a question of medical necessity and it's appealed to the State Department of Managed Health Care or the State Department of Insurance, they contact Maximus. And specifically for transgender people, I'll often be the person doing the independent medical review of whether the care was medically necessary or not.
Q. What kind of care are you reviewing?
A. So these are medical -- well, typically surgical procedures. Occasionally they've been for puberty blockers, for example, but the great majority of them are transgender people who are requesting surgery from their insurance and then receiving a denial.
Q. And you mentioned the process in California, how it gets to Maximus, but are your cases limited to only cases in California -- people in California?
A. So predominantly I see California cases. Sometimes Maximus has asked me to consult with them in making determinations in other states.
Q. And how many cases have you reviewed?
A. When -- the old system that Maximus used to have had, like, a running count number, and so as of a couple of years ago, I

had seen 110, and then there are those that I've seen in the last couple of years.

Q. Can you estimate for us what that number might be?

A. The number has -- it's certainly over 110. It's more of a trickle now, because in the early days, there were just a lot of insurance policies that weren't as refined, I guess. In the earlier days -- I'm talking about since California in 2013 started requiring insurance to pay for gender-affirming care. So it's been a process, and now I see fewer of them, but they are more difficult cases.

Q. Okay. Okay.

A. But it's certainly -- I don't know if that means there's now 150. I don't know. It's well over the -- it was 110 two years ago. I don't have a count anymore, but I still do them. You know, I still get the cases. I've had a few in recent weeks.

Q. Does Maximus provide you with any instructions in terms of reviewing the cases for medical necessity?

A. Yes. So they give us a State definition of medical necessity, and they say that our answers have to -- that we have to provide literature citations in our justification for our decision. And one of those literature citations has to be WPATH Standards of Care.

And I know one time I put in these really good articles because it was kind of a specific issue, and I didn't list a

Standards of Care citation, and I was contacted by Maximus saying, you know, you have to -- that they look -- their kind of overruling kind of source of what's medically necessary in transgender care is Standards of Care. And I had to include a Standards of Care citation among the others.

Q. So given your decades of experience treating people with gender dysphoria, in your expert opinion, how will AHCA's elimination of Medicaid coverage for gender-affirming care impact the beneficiaries being denied access to that care?

A. I think it's going to do tremendous harm to a lot of people.

Q. What about patients who haven't yet started care but for whom it's been recommended? Do you have any concerns about them?

A. Yes. I'm concerned that they are going to suffer needlessly.

Q. Can you talk about experience with patients who were forced to detransition and other situations you mentioned, like, for example, unsupportive families?

A. Yes. So I have -- I had a patient recently who started on puberty blockers at age 11 and then later was started on gender-affirming hormones. This was someone assigned male at birth, also had Autism Spectrum Disorder. The parents had read some of the things that are out there about concern for people with autism, and that transgender identity could just desist,

and they stopped treatment. They told the therapist that they are going to cross their fingers that their child will just be gay.

And I started -- and this patient from that time on was on psychiatric medications, not provided by me, from another psychiatrist. I wasn't involved in the care at that time when she stopped. And was on antidepressants, which didn't work very well, and really struggled.

And I started seeing the patient at age 18. They were still having tremendous struggles with depression and anxiety. At age 18 they started gender-affirming care. Not that long after, they socially transitioned. They had just started off in university, and they are doing tremendously well in school. She's doing tremendously well in school. She's not depressed anymore. I am available to see her if she needs to be seen, but I've stopped seeing her because her depression has resolved and she doesn't feel a need to see me anymore because she's feeling so well.

Q. Okay. Let's touch base quickly --

A. I would just say that she still has regret and anger even, and she loves her parents, but that they made this decision to stop her care. Because she is now -- her parents are paying for facial feminization surgery. But she's having to go through a lot in terms of really wanting to not always be identified as trans, basically, post-transition. And those are things, had

the family stayed the course, she wouldn't have had to go through. And so she -- she still has a lot of anger at what happened, but she is happy that now she's able to -- you know, to live her life as, you know -- as, you know, she desires.

Q. I'm going to switch gears about research, which is something that you've both done --

THE COURT: Why -- before we switch the gears --

MS. DeBRIERE: Yes.

THE COURT: -- let's take a morning break. Let's take 15 minutes. Let's start back at five after 11:00 by that clock.

(Recess taken at 10:51 AM.)

(Resumed at 11:05 AM.)

THE COURT: Dr. Karasic, you are still under oath.

Ms. DeBriere, you may proceed.

MS. DeBRIERE: Thank you, Your Honor.

BY MS. DeBRIERE:

Q. Dr. Karasic, just before the break, we were going to talk -- I was going to touch a bit on research in your experience reviewing the scientific literature related to gender-affirming medical care.

In assessing that literature, how does it compare to your clinical experience?

A. Sure.

So there are many publications over the years, publications over even the last 60 years that have shown benefits from

gender-affirming care. And that is -- you know, goes along with my clinical experience that people have benefited.

Q. Are there limitations in that research that you've just described?

A. Yes.

So it really isn't possible or ethical to do a randomized control trial of whether or not to give a child a puberty blocker who is having gender dysphoria, or start giving someone hormones or not giving hormones, or randomizing one person to vaginoplasty and another person to a sham surgery. None of those things are things that, you know, are ever going to be done.

Already by the time it was established that puberty blockers and hormones were beneficial to transgender people, it was known that puberty blockers stopped puberty and that feminizing and masculinizing hormones have those physical effects on whoever they're given to.

Q. I think you inferred it, but tell me why it's not ethical to do a randomized controlled trial regarding these particular medical interventions.

A. So there is both ethical and practical reasons, but when we know that -- we already know that if someone is at the start of puberty and you give a puberty blocker, that it will stop their puberty. It was established with precocious puberty. The -- you know, it's very clear from the Dutch data, which is the

early data on puberty blockers for gender dysphoria and onward, that puberty blockers do stop puberty; that if you are assigned male at birth and you take estrogen, that you'll feminize; if you are assigned female at birth and you take testosterone, then you will masculinize. There is no scientific question there.

The question is really, you know, that continues to be explored is what are the benefits outside of that to people's quality of life for mental health?

But you couldn't even practically do a study if somebody -- let's say somebody is assigned female at birth; they were -- they had gender dysphoria; they were seeking testosterone to masculinize. You couldn't even do anything in a blinded way because very shortly the person getting -- a person would know whether they got testosterone or didn't; but also that if they're somebody already seeking masculinization, we know that that will be provided.

The kind of controversy in the literature has been -- or not among the providers of gender-affirming care and not among the major medical or mental health organizations, but kind of the challenge has been when -- when opponents of gender-affirming care point out, rightly, that there are no randomized controlled trials, that when you do a systematic review according to the grade criteria that's used to score systematic reviews, that the gender-affirming -- so that grade criteria ranks the strength of the certainty of the

recommendation for that intervention, and there's not going to be a high certainty in the systematic review when you don't have -- when you don't have randomized controlled trials.

But also -- so the grade criteria have been -- are being used in kind of a peculiar way when they're being used to stop the provision of gender-affirming care. If you look at the broader literature -- for example, there was a review of all systematic reviews published in 2016 by Fleming in the *Journal of Clinical Epidemiology*, where, if you look -- they took from Cochrane Database, which is a collective database of all of the systematic reviews, and they did it for a year and a half period. So they looked at systematic reviews from medical interventions from all sorts.

And they found that there was a high degree of certainty to support the provision of care only 13 and a half percent of the time. And if you looked at the provision of care where you -- if you looked at when there was a high certainty, if there was a high certainty and a significant outcome, and there were a favorable response as kind of assessed by a panel, that only 4 percent of all of the systematic reviews showed a high certainty of making that -- making a recommendation for that outcome.

Q. This is all medical intervention, it's not just --

A. This was all -- every published systematic review in an 18-month period.

And so only 4 percent really met that highest standard. And -- but in this case, you know, in terms -- people are using that grade criteria and systematic reviews to try to stop care.

The same year there was a publication in the same journal, *Journal at Clinical Epidemiology*, by Movsisyan, et al. -- it was a team at Oxford University in England -- where they divided the reviews into a simple intervention versus a complex intervention

And so to give you an example in gender-affirming care, a simple intervention would be if you took someone assigned female at birth right at the start of puberty, and you gave that person a puberty blocker, and you measured breast bud development to see whether that would -- whether the breasts were continuing to increase or not. That would be simple: You'd give a drug; there is something you can measure, you know, is it growing or not.

But these -- these systematic reviews and with the research, we are not arguing about that. Everyone knows and, you know, it was being put forward precocious puberty research with Dutch data, et cetera, in that case that puberty blockers stop puberty. But what we are looking at is that puberty is stopped and that -- and perhaps then people get gender-affirming hormones and progress in terms of their transition.

But then you have an outcome where people have -- are basically happier, that they're -- the quality of life improves, their mental health improves. And that is from -- this

Movsisyan is really a complex intervention because of the complex result.

There's also a complex intervention in terms of that there are multiple factors of social transition and puberty blockers and hormones. But what you have very clearly is what they would define and they kind of charted out as a complex intervention.

So when you look at all of the systematic reviews of any medical intervention in the time span that they looked in the Cochrane Database, there were no interventions that had a high certainty of recommendation. And the most common systematic review result for a complex intervention was a very low certainty.

And they suggest that the grade criteria might -- kind of might not be the best way of measuring, since all of these complex interventions don't meet a high standard.

So grade -- I mean, WPATH Standards of Care 8, we use -- you know, we did a systematic review with John Hopkins. They used grade; it's not an objection to grade, it's just understanding that there are limitations to grade. And when you have the kind of interventions that we do, grade wasn't meant to deny people care, it was meant as a tool to try to kind of understand the result from the systematic review.

And so -- but when it's used that way, when it's said that the systematic reviews are not showing a high certainty of result, while that's the case for every complex intervention and

there's -- no matter how much research ever gets done, there is never going to be a high -- even if -- probably if someday somebody did, you know, a randomized controlled trial, which really can't happen. But there is never going to be a high certainty from a systematic review.

And so, you know, grade should be used for what, you know, it's used for, but it's not a reason to say, you know, that a particular kind of care shouldn't be supported. Otherwise, we in health care should stop doing complex interventions for any health care issue and only do interventions that have a simple intervention and a simple measured response.

Q. And do those Standards of Care 8 -- do they discuss any of the limitations in research?

A. Yes.

And so, as I said, Standards of Care 8 did commission systematic reviews of the literature. While there is another place where they talk about limitations in the literature that in giving informed consent to the parents of young people, you know, expressing that there are limitations to the research -- you know, because there are limitations to the research, and I think it's -- you know, it's important to give people, you know, kind of a best sense of what that is.

But there's also a ton of research, and it's been going on for decades and decades and decades. And people in all kinds of political climates and social climates have been providing this

care.

So I trained at UCLA in psychiatry, and my first mentor in transgender care was Bob Stoller who coined the term "gender identity" and started in, like, 1963 the gender identity research clinic at UCLA. And he had a patient come to him in 1958, and even though he's a psychoanalyst, he came to the conclusion that for people who needed gender-affirming medical care, psychoanalysis was not going to cut it, that they needed medical and surgical interventions.

And they at UCLA did their first vaginoplasty on a woman in 1959. And then through the 1960s and '70s, you had gender clinics all around the U.S. You had a backlash towards providing gender-affirming medical and surgical care, and those programs shut down. And in 1981, the federal government stopped funding care under Medicare.

And there was a long quiescent period, essentially, where the academic centers for gender care shut down in the U.S. You couldn't get funding for research.

I tried -- in my -- I was in, you know, kind of that age period where I did research having to do with treating depression and HIV. But, you know, I met with people in the San Francisco Department of Public Health and tried to do research on the mental health effects of gender-affirming medical care, and, you know, was basically told, It's impossible. The federal government is not funding this.

And, you know, we finally had, you know, a sea change in the 2010s in terms of funding. But, you know, we've kind of -- anyway, we've been through all this before. But even then you have a study I cited from University of Virginia in my declaration where they tried to find the people at University of Virginia's gender program from the 1970s. And they found -- I don't know. It was -- maybe it was 15 of them 40 years later and found that they had continued to benefit from gender-affirming medical care over those four decades that there was no one to follow up with them because the program had been shut down.

So, you know, we know that these people are getting better, and there's a lot of evidence for that in the literature.

There are weaknesses to that literature as well. You know, it's certainly something that we acknowledge and take into account. But, you know, that's all known by the various committees at the American Medical Association, the American Psychiatric Association. I was on the Work Group on Gender Dysphoria, you know, some experts from the American Psychiatric Association discussing the research and weighing things, et cetera. And, you know -- but when you put all the pieces together, it's -- it's very clear that gender-affirming medical care is an effective powerful intervention. And that's why all these professional organizations that -- you know, mainstream organizations that reflect the kind of bulk of American medical

and health providers support that care.
Q. When you were testifying, Dr. Karasic, you did mention something about limitations in informed consent. I think there's a discussion of limitations in the research during the informed consent process --
A. Yes.
Q. -- is that correct?
A. Yes.
Q. Okay. Okay.
A. It's important when you give informed consent that you lay everything out there for people. People should, you know, go into getting care with eyes open.
Q. And you also just mentioned the major medical and mental health professional organizations that we've been discussing, the AMA, the APA, the APAA, AAP, et cetera. Some of the State's experts have asserted that those organizations have taken a position on gender-affirming medical care based on ideology rather than science. What's your response to that?
A. So each of those organizations, they are membership organizations with thousands -- tens of thousands of members. Those members elect representatives that discuss issues and come up with position papers. I can say specifically the process within the American Psychiatric Association.
So we have -- we elect members of the APA Assembly, as well as the APA -- American Psychiatric Association Board of

Trustees. The Assembly represents each, kind of, small body of psychiatric societies around the country, and they meet, and they come up with position papers and debate them. And if they're approved, then they go to the Board of Trustees, and the Board of Trustees approves them. Each -- all -- you know, at each level those are elected by the membership in annual elections.

And there's even a provision within the APA where if people don't like a decision that's made by the leadership that they can petition for a vote. I'm aware of that only happening once at the APA, which was in 1973, the APA removed homosexuality from the DSM, and there were opponents of that who petitioned for a vote, and then the whole membership voted, and they supported the Board of Trustees' decision to take homosexuality out of the *DSM.*

So these organizations are large membership organizations that are representing their constituency. If the constituencies don't agree, they do have the opportunity to -- you know, to change those positions.

Q. Is advocacy a normal part of those organizations? Is that a part of what they do in those organizations?

A. So each organization has as part of its mission to create policy or position papers that are based on its clinical knowledge. So there are kind of papers that compile clinical knowledge of treating a certain condition or -- and sometimes

there is an aspect of -- of having an opinion on something that is an issue in society, but it always goes back to the clinical expertise.

What that organization brings is they have, you know, clinical expertise in psychiatry, or pediatrics, or whatever they bring to that opinion, and each of those organizations does -- even though, you know, they are this -- a membership of professional organizations, they do make policy statements that, you know, are broadcast to the society at large.

Q. Is that abnormal?

A. No. It's what every organization does.

Q. If I can talk just briefly about WPATH.

Does WPATH's -- you know, membership of these medical and mental health organizations, talking about WPATH's membership, does that include any nonprofessional members of your community?

A. So WPATH has two categories of members. It has full members and associate members. Only the full members are voting members, and to be a voting member, you have to be a health professional, a health academic, or they've also accepted some legal experts in transgender health as part of those professionals that are allowed to be full members.

Other people could join as an associate member, but that's really just providing financial support for the organization and getting information from the organization, but you can't vote, you know, for the Board or -- you know, for example.

Q. So in your testimony, you've talked about the agreement among medical and mental health professional groups in the U.S. About the use of gender-affirming medical care to treat gender dysphoria.

As you're probably aware, Dr. Karasic, the State's experts assert that the U.S. is an outlier and points to reports from other countries and say -- and those reports say they're halting care for minor children at least.

What's your response to that?

A. So there are a handful of countries in Europe where government bodies have changed statements to exert more caution in the care of transgender youth, and -- and -- a few things.

One is that care is still provided, puberty blockers and hormones, to some youth in each of those countries even if the criteria is more restrictive than before. There's no -- there's certainly no ban or categorical withdrawal of funding for care in any of those countries. The -- those statements have been put out by government bodies, not unlike Florida's government bodies have put out statements, that aren't always reflective of the health professionals in that country, from my experience.

I was keynote speaker at -- there's kind of a Pan-Scandinavian transgender health conference and -- you know, so I've met many healthcare providers in -- from all of the Scandinavian countries who go to that conference.

And I've worked with Cecilia Dhejne, who the -- some of the

opponents of transgender care often refer to, like Dr. Levine. Expert statements always refer to her study where there was elevated suicidality in transgender adults who had received care through their program.

And Cecilia Dhejne described to me what happened in Sweden at -- with the government committee for youth, that the process had been hijacked or -- was her word, by opponents of gender-affirming care for youth that had connections to people in the United States and the United Kingdom and was opposed by many providers in Sweden.

And so what happens is, you know, something like that happens, and then, you know, with -- often with involvement with some of the same folks who are involved here, and they bring back, you know, a changed policy statement from the federal -- in the federal committee from Sweden as evidence that there's a sea change.

But, in fact, just a couple of weeks ago there was a European Professional Association for Transgender Health conference was held in Ireland, and the keynote speaker was the European coeditor of Standards of Care 8. Overwhelmingly, if you look at the schedule, it's presentations about gender-affirming care from teams from Spain, France, Italy --

MR. JAZIL: Objection, Your Honor. Hearsay, outside the scope of his expert reports as well.

THE COURT: Overruled. I'll follow up in a minute.

THE WITNESS: Okay. So, you know, Croatia, Turkey, Syria, a whole session from a Polish multidisciplinary team.

So you know, there may be differences of opinions from federal committees in Europe, but the overwhelming majority of those providing transgender health, as represented, you know, in this conference, are not going along with -- are not necessarily in line with what these statements from a handful of countries have made.

And so it's just important -- it's interesting, but it's important to take with a grain of salt that -- when there are these statements saying Europe has changed course, that that just isn't true.

THE COURT: Before we move on, Dr. Karasic, here's my question about the description you just gave me of the conference and your discussions with professionals over there.

Is that the kind of thing that experts in this field reasonably take account of in doing your own assessments and forming your own opinions?

THE WITNESS: Yes, yes. So we're -- there's an active community of people and -- you know, in Europe and the United States, and we're always, you know, in touch with each other and discussing developments. And so it's -- you know, there is an international body. It's not just those of us in the United States that are in that kind of communication.

MS. DeBRIERE: Thank you, Your Honor.

THE COURT: You may continue.

BY MS. DeBRIERE:

Q. For the record, Dr. Karasic, could you spell Cecilia Dhejne's name for us?

A. Sure. D-h-e-j-n-e.

Q. Thank you.

A. You'll see it in, you know, Dr. Levine's report and other reports.

Q. And the reporting that's coming out of this handful of countries, does it in any way pertain to gender-affirming medical care for adults?

A. No. In all those countries that are -- where there have been references to changes in policies, those countries have national health systems that fully pay for gender-affirming care for adults and have not changed -- and those minors who are accepted, and have not -- you know, there's been no change in terms of any restrictions for adults.

Q. Any of the reporting coming out of these countries on which defendants are relying, are they peer reviewed?

A. Not that the government -- the government statements are just government statements.

Q. Okay. Thank you.

Dr. Karasic, are you familiar with the term "detransition"?

A. Yes.

Q. Does it have a particular meaning in your field?

A. It sometimes has some different meanings depending on who is using it and the context. Sometimes it refers to someone who starts hormones and then stops it without necessarily regret or just as part of their journey to -- you know, how they want their body to be.

And then it also refers to people who stop gender-affirming medical care because of a -- well, people -- there's people who stop because of external circumstances, which in my experience is the great majority of people: People who stop gender-affirming medical care because they are incarcerated, because their spouse threatens to leave them, because their parents will kick them out of the house, or, you know, other kinds of -- similar kind of external reasons for stopping care, or they stop care because of a change in gender identity.

Q. How common is it for someone to stop care because of the change in gender identity?

A. That seems very uncommon.

Q. Are you familiar with the term "retransition"?

A. Yes.

Q. What does that mean?

A. So you see that, for example, in the Kristina Olson group's work on prepubertal children who have changed pronouns and socially transitioned and elsewhere. And it speaks to that not everyone is transitioning and then reverting back to the sex assigned at birth, but that people are making -- kind of moving

to different places gender-wise, that many people who -- of the relatively small number of people who change.

What's maybe more common is people changing to binary gender identity from -- I mean, to a nonbinary gender identity from a binary one. So someone assigned female at birth, for example, identifying as male and then later realizing there is a better fit being nonbinary and giving themselves that identity would be -- it's an example of retransitioning.

Q. In your clinical experience with more than a thousand patients that you've treated for gender dysphoria, have any of your patients who have medically transitioned then detransitioned in the sense of coming to identify as the sex they were assigned at birth?

A. So I've had in my practice people who detransition for external circumstances, but I've never had someone come to me and say that they have detransitioned because they no longer identify as trans and they're no longer having gender dysphoria, and, therefore, they're, you know, not getting treated anymore. That's never -- that hasn't happened. No patient of mine has said that to me.

Q. Out of all of those patients, how many patients have regretted their decision to transition?

A. Very few. And when -- it's very rare, and it -- when -- if I'm trying to think of an example, I can think of someone who -- this was years ago -- someone who had moved to San Francisco

from the South after transitioning -- had essentially transitioned and lost it all, job and family and really kind of rejected by community, and came out to San Francisco and was living in a homeless shelter. And in one of the Department of Public Health-run clinics that I was working in, this person was saying, you know, they didn't regret transitioning because they identified as female, but they -- the cost was greater than they thought it would be. So they had regret because they were in such a desperate circumstance that they hadn't anticipated.

Q. How do you react to the assertion that individuals with gender dysphoria should not be provided medical interventions because they will outgrow it?

A. That doesn't make sense to me.

So the -- some of the opponents of gender-affirming care put out these very high detransition numbers. And many of the people in those studies that were recruited, even before there was -- even before gender identity disorder of childhood came into the DSM in 1980, often they include the Feminine Voice Study at UCLA. And I knew Richard Green who did that study when I was at UCLA. And when he wrote -- published his book on that study, he called it the Sissy Boy Syndrome and something about the development of homosexuality, not the development of being transgender.

So they -- his original goal was to follow the -- to see whether feminine boys became transwomen. And very few of them

did. But as it turns out, it was because basically from a time when even homosexuality was in the DSM, parents were bringing in feminine boys because they just weren't accepted in their schools, you know, or bullied by peers. And I even spoke to some of the people who had been in that study who identify as gay men, and they never had transidentity.

There was another study that -- kind of a group of publications from Toronto that, again, they started recruiting people in 1975, before there was a GID childhood diagnosis. And they are mostly feminine boys; they're mostly pre-gay men.

The one modern study -- the one modern American study is Kristina Olson's group where they've published on over 300 pre-pubertal youth who had changed the pronouns that they used, and that was their marker for socially transitioning. And they followed them over -- I think it was a mean of four years. They followed them over a few years. And only 2 and a half percent of those who had changed their pronouns in a binary way had changed them back to their sex assigned at birth. So within that population, detransition is very rare.

It's clear that there are kind of different populations of folks, and different studies have kind of found different groups of youth. But I think we are moving in the direction of more specificity. I talked about in, you know, the *DSM* of gender dysphoria -- *DMS-5* gender dysphoria at childhood, adding this identity A1 requirement. And so -- and then, also, I think over

the years parents are less likely to bring a feminine boy in to the doctor.

And so, anyway, I don't think that old data with the super high desistance numbers is really reflective of, you know, what happens.

Q. Those older studies, what types of clinics -- what types of clinics did those studies?

A. So UCLA was a psychiatric clinic. It was before puberty blockers were administered. That was in the 1960s and '70s. It was published in 1987. It's when they had to follow up with people to adulthood.

Then the other two clinics, before Kristina Olson's work were the gender clinics for children and adolescents in Toronto -- University of Toronto, Clark Institute, CAMH, are kind of the various names of that clinic -- and then in Amsterdam, the Dutch group in Amsterdam.

And what's notable in each of those clinics is that if gender dysphoria persisted into puberty that they treated those kids with puberty blockers and then with hormones.

And so even as they were reporting on desistance, they were noting it as a prepubertal phenomenon and that if it did persist, if it did give them what was a GID of adolescents in adulthood and later gender dysphoria of adolescents in adulthood, that those people with that diagnosis were -- their gender dysphoria was likely to persist, and they offered them

medical treatment.

Q. How many individuals or professionals in the field of providing gender-affirming medical care address the concept of detransitioning? Is there attention given to it?

A. I'm sorry. What was the question?

Q. Yeah. Is there attention in the professional field of those providing gender-affirming medical care to the concept of detransitioning?

A. Yes.

So I was the chair of the first US --

(Reporter requested clarification.)

A. USPATH, United States Professional Association for Transgender Health, conference in Los Angeles in 2017. And I helped organize a panel of therapists and therapist trainees who were detransitioners themselves.

And we were contacted by some detransitioners wanting their perspective to be addressed. And we had a very lively discussion with attendees at the conference.

Later, WPATH put on a training that was devoted to helping -- help practitioners work with detransitioners. And then Standards of Care 8 talks about detransitioners and the importance of involving folks with health providers of multiple disciplines to -- you know, to help them get the care they need.

BY MS. DeBRIERE:

Q. You've been discussing that the detransition is rare, so

why would professionals pay attention to this in developing the standard of care and otherwise practicing their forms of medicine?

A. Sure.

Well, I think detransition, especially because of a change in gender identity, and also this other sense of people stopping and starting hormones, is maybe a little bit more common than rare, you know, not quite -- still uncommon, but maybe not rare.

But, you know, we -- it's one of the things that we, both as health professionals and it's something that's in the WPATH Standards of Care, that we're not invested in what any one gender identity for a patient. We are trying to help people find the best place for themselves and, you know, the -- helping them get the care that they need to, you know, be the healthiest, most comfortable person, and, you know, recognizing that for some people that -- you know, the initial transition might, you know, not provide that.

So we want to, you know, help them no matter what their, you know, identity is.

Q. The fact that detransition exists, why do you continue to recommend gender-affirming medical care as part of your practice?

A. Because the vast majority of people benefit from care. And even, in my experience, the people who have, you know, detransitioned because of external circumstances still might

need gender-affirming care in the future. And so even for some of the detransitioners, the availability of gender-affirming care is important.

Q. Is the possibility of regret -- this concept of regret, is that unique to gender-affirming medical care?

A. No. As a matter of fact, when you talk with surgeons, it's -- who are working in gender-affirming care, it's one reason that they often prefer working with their transpatients to some of their other patients, because regret is so low with transpatients. So if you look at -- there's a meta-analysis of posts by Bustos of almost 8,000 patients in various studies where they reported regret, and regret was less than 1 percent in transgender patients who had had surgery.

And then you compare that, I put in any declaration to Sheehan in 2008, where people -- women who had breast cancer, had mastectomies because of breast cancer, who were then offered or given -- had gone ahead with breast reconstruction -- so it's medically necessary breast reconstruction -- and about 40 percent of those women had some degree -- 40 percent of those woman had some degree of regret related to breast reconstruction.

So regret is there for every -- if you look at any surgery where they have reported regret, regret is present. And it's typically much higher than the regret rates for gender-affirming surgery.

Q. Dr. Karasic, are you familiar with the concept of social contagion?
A. Yes.
Q. Can you describe it for me, please?
A. So social contagion is the theory that if someone is exposed to someone who is trans, or social media or other media accounts of being transgender, that that could make that person trans.
Q. Has there been a rise in numbers of referrals to gender clinics in recent years?
A. Yes.
Q. Is that due to social contagion?
A. No.
Q. What's it due to?
A. First of all, you have in the United States, whenever you see these numbers of number of insurance claims or number of gender dysphoria diagnoses that were made, that's comparing from the early 2010s to now, and you see these numbers go up dramatically, you have to remember that transgender care had been shut down in the U.S. by the prior backlash. And because of that, there was no funding for those people to get care. There were no -- there were very few gender clinics. If you are a provider -- like even working in a gender clinic, and even though we were funded by San Francisco Department of Public Health so that it wouldn't really threaten our care, the

providers in Dimension's clinic and Transgender Life Care Program would never use the GID diagnosis, because we knew in other settings, as well as there, that it would lead to insurance rejection of care, even if, you know, we were also treating depression or, you know, other things.

And so people weren't using the diagnosis until -- 2013, the gender dysphoria diagnosis started, and it was also around when reimbursement became, you know, very common for the gender dysphoria diagnosis.

So, of course, people are using that diagnosis much more when they are getting reimbursed for it and -- as opposed to it being a specific reason for reimbursement denial.

Second of all, you can't refer people to clinics that don't exist. And they had been shut down, you know, decades earlier. And starting in the early 2020s, they grew in number. And so the numbers are going to increase greatly, the number of referrals, when you have a place to refer that person to.

When -- because I've been in this field for a long time, I think I made reference in my declaration about being contacted around the year 2000 by a parent from Florida who had resources and wanted to fly his transchild anywhere in the world that would -- could provide some care for them. And I had a colleague at Emory, and it would be a short flight, and -- that I referred him to. But he could not find any care in Florida.

And then -- also, then thinking of the very first trial and

adolescent gender clinic full meeting in San Francisco at UCFS in 2012, and the family was a family that had left Florida because their child could not get care and could not get accommodated in school. And so they moved to San Francisco and, you know, were there for that first session.

Q. What is your reaction to the assertion that if kids have lots of trans peers or consume a lot of social media regarding transpeople that this can cause gender dysphoria?

A. So my transpatients seek out other transpeople. They are looking for support. And so if you're just externally looking at a phenomenon of -- let's say, even, you're a parent and your trans kid has just come out as trans to you and you, you know, remember that six months ago they brought another kid home who was trans, that's not that that kid six months ago being trans infected the child, you know, to make them trans; it's that children are trying to understand -- adolescents, they are trying to understand themselves, and they are finding peers who are similar to themselves.

Q. Similarly, what's your reaction to the assertion that a patient is identifying -- has a transidentity because their parents or people in trusted positions want them to?

A. So are you asking that young people transition because their parents want them to?

Q. What's your reaction?

A. That's not been the experience of the young people that I

work with. You know, it's very much the young people coming to their parents in distress, or, for some, you know, from their earliest days, having very strong cross-sex, you know, cross-gender, you know, behavior and the parents, you know, recognizing that.

Q. And just touching very briefly, again, on the concept of detransition, in speaking of detransitioners, you used the phrase "change in gender identity."

By that you mean someone who stopped identifying as transgender?

A. Yeah. That some -- there are some professed detransitioners -- they are not patients of mine, per se, but, you know, I go to the conference and I see some of them in the media who say that they were -- you know, that they identified as transgender, and now they no longer do. And so people can come to some evolution of an understanding of themselves, presumably.

Q. Okay. Dr. Karasic, as this last part I just want to turn very briefly to the plaintiffs in this case.

As part of your work in this case, did you review any of the plaintiffs' medical records?

A. Yes.

Q. Specifically, did you review any records related to adult plaintiff August Dekker?

A. Yes.

Q. What did the records reveal with regards to Mr. Dekker?
A. Mr. Dekker was assessed for gender dysphoria and received testosterone and masculinizing chest surgery.
Q. Did you review any records related -- when you reviewed the records of Mr. Dekker, did the medical care he was receiving -- did it, based on your understanding, reflect the standard of care that we've been discussing?
A. Yes.
Q. Okay. Did you review any records related to adult plaintiff Brit Rothstein?
A. Yes.
Q. What were your findings?
A. Very similar to August Dekker, that they had received gender-affirming medical and surgical care, also in accordance with -- with the standard of care.
Q. How about minor plaintiff Susan Doe?
A. Yes.
Q. Can you discuss your findings about that?
A. That that plaintiff had received puberty blockers for gender dysphoria in accordance with WPATH Standards of Care.
Q. Was she diagnosed with gender dysphoria?
A. And diagnosed with gender dysphoria, yes.
Q. And then, finally, just minor plaintiff K.F.?
A. Yes.
And so minor plaintiff K.F. was diagnosed with gender

dysphoria and also received puberty blockers.
Q. Was that care in line with the standards of care?
A. Yes.
MS. DeBRIERE: All right. Thank you so much, Dr. Karasic.
Your Honor, those are all my questions.
THE COURT: All right. Cross-examine.
MS. DeBRIERE: Your Honor, I'm so sorry. May I ask one more question?
THE COURT: Surely.
MS. DeBRIERE: I'm so sorry.
BY MS. DeBRIERE:
Q. Final question, Dr. Karasic. My apologies.
In your opinion, are any of the gender-affirming care medical services listed at 59G-1.050 experimental?
A. No.
MS. DeBRIERE: Thank you.
THE COURT: All right. Cross-examine.

CROSS-EXAMINATION

BY MR. JAZIL:
Q. Good afternoon, Dr. Karasic.
A. Hi.
Q. Karasic. I apologize.
Dr. Karasic, based on your testimony, it's my understanding that your practice is devoted to helping transgender

individuals.

Did I understand that right?

A. Yes.

Q. And you're also a member of WPATH, as you testified?

A. Yes.

Q. And you'd agree with me that WPATH advocates for the rights of transgender individuals, right; that's its purpose?

A. No, it's -- I mean, like any -- as I think I've talked about, any membership organization does, you know, provide position statements and advocacy of sorts, but the primary purpose of WPATH is to provide educational trainings for its members, so continuing education trainings for its members and for others who want to increase their knowledge in transgender health, and also in formulating the standards of care. So really the organization is focused around those two things. They also do advocacy or, you know, position statements on issues that are related to transgender health.

Q. I got it.

And so the organization itself is not made up exclusively of medical professionals, though; right?

A. So the organization -- almost all the full members of the organization are health professionals. There are some health academics, legal academics who are full members. There are some associate members who are not health professionals.

Q. Okay. When you say "health professionals," you're

including folks other than MDs; right?
A. Sure, yes, psychologists, psychotherapists.
Q. Psychotherapists?
A. Yes.
Q. Anyone who self-identifies as a health professional can join as a full member?
A. You have to fill out an application, and you have to, you know, list your qualifications as a health professional, and so I suppose somebody could lie about that, but yeah.
Q. Okay. So you said the full members include lawyers; right?
A. There are a few legal advocates within the full membership of WPATH.
Q. When you say "legal advocates," you mean advocates for transgender rights who are members -- full members?
A. No, I meant -- like, I only can think of a couple of people that -- one of them is not a practicing lawyer but got a doctorate in law in the UK, and -- so there are some people who are really kind of within the kind of broader realm of health academics, I guess one would say, but the vast majority of the members are practicing clinicians.
Q. Sociologists are included, too, in the full membership group?
A. No. I mean, there -- they could be as a health academic, but when I'm talking about non-MDs, I'm talking about licensed clinical social workers, psychologists, marriage and family

counselors. And so, you know, there are a number of non-MDs who are. The vast majority of the members are people who are taking care of patients, but there are some health academics who are members as well.

Q. And the membership includes folks who provide alternative health care? I'm thinking folks who might practice Eastern medicine, for example.

A. You know, I wouldn't be surprised if -- there are maybe 3,000 members, you know, but we -- you know -- and there are some members in Asia, and, you know, their practice might reflect that. There are also psychotherapists who use mindfulness and meditation as part of their practice. So, you know, there are a range of health professionals that are in the organization.

Q. And you serve on the Board of Directors for WPATH; right?

A. Yes.

Q. Were you on the board when WPATH issued its Standards of Care, Version 7?

A. I was not on the board. I was involved as a committee member for Standards of Care 7, but that came out in 2011, and I had not -- was not yet on the board when that came out.

Q. Were you on the Board of Directors when WPATH decided to pursue Version 8 of its Standards of Care?

A. Yes.

Q. Were you on the board when the Version 8 standards came

out?
A. No.
Q. When you were on the board that decided to pursue the Version 8 Standards of Care, how many members of the board were there?
A. How many members of it -- were on the board? There would have been 7 general members and 4 Executive Committee, I believe, so 11.
Q. And this 11-member board included the UK-based lawyer, person with a Ph.D. in law --
A. Yes.
Q. -- is that right?
And all of them cared about furthering transgender health; right? That was a common denominator among the board members?
A. Yes.
Q. Now, Doctor, I'd like to walk you through the Standards of Care.
MR. JAZIL: Can we pull up DX-16, please?
Your Honor, can I approach the witness with a copy?
THE COURT: You may.
BY MR. JAZIL:
Q. Now, Doctor, your name is on the cover of this document; right?
A. Yes.
Q. Third row down?

A. Yes.
Q. What I'd like to do is start at the back of this document. If you go to what's Bates labeled page 249, so the bottom right. If you'd look at page 249.
A. Yes.
Q. And, Doctor, I'd like to direct your attention to subheading 3, which is on the right side of the document.
A. Yes.
Q. This lays out the process that WPATH took in coming up with Standards of Care, Version 8; right?
A. Yes.
Q. And if we look at step 17, it says that the document had to be approved by the WPATH Board of Directors before its publication and dissemination?
A. Yes.
Q. That's the 11-member board?
A. Yes.
Q. Let's move on to page 250. So if you can just flip over to the next page, Doctor.
I'd like to direct your attention to 3.3, "Selection of chapter members."
A. Yes.
Q. Now, this says that a call for applications was sent to the WPATH membership?
A. Yes.

Q. And it says that the chapter leads and members were required to be WPATH full members?
A. Yes.
Q. Now, were you a full member when the call went out?
A. Yes.
Q. Now, if we go down to the third paragraph, it says: *Each chapter also included stakeholders as members who bring perspectives of transgender health advocacy or work in the community, or as members of a family that included a transgender child, sibling, partner, parent, etc.*
A. Yes.
Q. Did your -- Doctor, you wrote a chapter for --
A. Yeah.
Q. -- the Standards of Care 8?
A. I was a chapter lead, yes.
Q. And it was a chapter on mental health; right?
A. Yes.
Q. And did your chapter include the stakeholders that included the folks listed in 3.3, transgender children, et cetera?
A. Yeah. So the stakeholder on our chapter who we -- there was an appointment in our chapter, and there was a stakeholder who was a licensed psychotherapist who is transgender herself.
Q. So your stakeholder group included a licensed psychotherapist who is transgender herself; it included you as a lead; it included other mental health professionals?

A. Yeah. So it included leaders of the gender programs of Sweden, Belgium, and Turkey, and then included a psychiatrist who -- it was a mental health chapter, so it was very psychiatrist heavy -- a psychiatrist who's vice chair of psychiatry at Northwestern University. It included a psychologist at the Whitman-Walker clinic in Washington, D.C. -- I think that's where he practiced at the time -- a psychiatrist at Columbia University, and myself. And I'm trying to think if I'm missing anyone there. I think that kind of makes up the chapter.

Q. I understand.

And your committee talked to people about the issues involved and sought their perspectives; right?

A. So our -- the charge of our committee was to review relevant research. We came up with potential statements that were reflections of -- not only reflections of research, but recommendations that could be made, and that was in consultation with the editors.

Each of us, though, came with the background, of course, of having, you know, much discussion about providing mental health care for transgender people. You know, there was the lead psychiatrist for the gender programs in Sweden, Belgium, and Turkey, and, of course, they, you know, talked with patients and professional colleagues like I would do in the United States.

Q. And so, Doctor, you said folks talk to professional

colleagues.

Did you reach out to Dr. Stephen Levine to get his perspective on the chapter on mental health?

A. No.

Q. But he was the author of the Standards of Care, Version 5 -- right? -- the mental health chapter?

A. Right. So what had happened -- my understanding of what happened with Dr. Levine was that after Standards of Care 5 came out, that he attended a conference, and there were people who objected to Standards of Care 5. There were some transgender people there who objected to Standards of Care 5, and he ended up cutting off ties with the organization.

So I became involved with WPATH not until 2001, and it was right around the time that Dr. Levine was cutting off ties with WPATH. So I never saw Dr. Levine at -- you know, at any WPATH conferences. Dr. Levine did present at a couple of APA conferences over the years, but I was always somewhere else -- presenting somewhere else.

Q. So you didn't talk to him, but did you seek him out just to get his perspective on it as a former author of the chapter that you worked on?

A. No.

Q. Okay. Do you know who Dr. Hilary Cass is from the United Kingdom?

A. Yes.

Q. You know that she takes a more cautious approach to providing gender-affirming medical care than you would like; right?

A. So I -- I have read the Cass report. It was a little confusing to me because there was part of the report where they talked about expanding access to care, and then the report became -- what came out of that became more conservative. And I read the Robers (phonetic) reporting that the report had changed at the Prime Minister's office or Ministry of Health after the last two Prime Ministers had announced support for restricting gender-affirming care.

So I certainly have read the report and, you know, what was put out. I don't know the whole process and what was behind it, you know, going -- you know, what was going on in the United Kingdom.

Q. Understood.

And you testified earlier that your chapter included folks from Sweden; right? It included folks from Turkey; right?

A. Yeah.

Q. But did you think about picking up the phone and calling Dr. Cass to get her perspective on the issues?

A. So the supervisor, the person who is the leader of our chapter, was John Arcelus, one of the coeditors of WPATH Standards of Care, who is one of the leading academics in the United Kingdom in transgender health.

When we were starting the process, I'd never heard of Hilary Cass. I did not hear -- I did not know who she was. She was somewhere kind of coming through the National Health Service of Britain. She was not somebody in -- you know, that I was aware of in transgender health at the start of the process. I only became aware of her when she -- you know, when the Cass report came out.

Q. So that's a no, is the answer to my question?

A. Yeah. You asked when we were doing this.

Q. Did you pick up the phone and call her and get her perspective?

A. I don't have her phone number.

Q. Okay. Fair enough.

Now, you testified earlier about some of the European countries that are taking a more cautious approach. That was, I believe, the word you used.

Do you recall that testimony on gender-affirming care?

A. So there are -- as I said, there are a handful of countries that are -- that kind of urge caution in the sense that became more restrictive of care for transgender youth.

Q. And did you contact any of the advocates for this more cautious approach in these countries as you were working on the mental health chapter for the WPATH report?

A. One of the members of our mental health chapter was the founder of the Swedish gender clinics, Cecilia Dhejne, who

Stephen Levine and others are always making reference to with the high sucidality numbers in one of her papers, and so I have spoken with Cecilia Dhejne through the process since we were working on the mental health chapter together. And since that chapter was done, we -- you know, I've known her for many, many years. And I've also spoken with others in Scandinavia, you know, over time. I went to -- you know, was a speaker at a Pan-Scandinavian Transgender Health conference several years ago.

Q. And is she one of the advocates for taking a more cautious approach now?

A. No. She's the founder -- she's kind of the most prominent person in transgender health in Sweden, and she is a supporter of WPATH Standards of Care 8.

Q. So, Doctor, in the mental health chapter in WPATH Standards of Care, Version 8, I count ten statements from your chapter that were put out there.

A. Yes.

Q. Does that sound right?

A. Yes.

Q. And were all of those statements approved by the committee that was working to put the chapter together?

A. Yes, the ten statements.

Q. Any statements that were rejected as the committee was working to put its chapter together?

A. Yeah. So we -- we initially had 20 statements provisionally, and the editors had said that we needed to -- that many of them were kind of good practice statements, and we needed to focus really -- for the sake of Standards of Care not being *War and Peace,* we needed to focus on statements that were recommendations that could improve care.

And so, you know, there was this back and forth. It was our committee coming up with statements and literature related to those statements and reasons for maybe doing those statements, and then also the editors saying, Well, you can incorporate some of that into your explanatory text and not everything has to be a statement.

And so they -- their mission was not an ideological way to change things one way or the other, but they were using, you know, their, kind of, knowledge base of putting out a document like this to -- you know, to guide us, and that dwindled things down to ten statements.

Q. Doctor, of the folks who were working on the mental health chapter for WPATH Standards of Care 8, did all of them share the perspective that the availability of medical gender-affirming care is a good idea?

A. Yes, they were all -- you know, you look at that -- our representative from Turkey was the president of the Turkey psychiatric association. These were not marginal, you know, people. They were representing the mainstream of health in

their various countries.

Q. Now, Doctor, I'd like to walk through the chapter on mental health, Chapter 18.

A. Sure.

Q. If you can go to page 173 of the document, the second full paragraph on the left column: *Some studios have shown...*

A. I'm sorry. You said 170?

Q. 173, Doctor. I apologize.

A. 173, yes.

Q. And it should also be on your screen if you need it.

It says here that: *Some studies have shown a higher prevalence of depression and suicidality among TGD people than in the general population.*

A. Yeah.

Q. Now, Doctor, first, what does TGD stand for?

A. Transgender and gender diverse. That was the editor's initials for -- for transgender and gender-diverse people.

Q. And then if we go to the next page, Doctor, statement 18.1, where it says --

A. Yes.

Q. -- *Psychiatric illness and substance...*

It's halfway down.

A. I'm sorry. 18.1?

Q. Yes, Doctor. If you go three-fourths of the way down, it says: *Psychiatric illness and substance use disorders, in*

particular cognitive impairment and psychosis, may impair an individual's ability to understand the risks and benefits of the treatment.

A. Yes.

Q. *Conversely, a patient may also have significant mental illness, yet still be able to understand the risks and benefits of the treatment.*

Now, Doctor, putting the statement we just saw from page 173 together with the statement here, when you're working with patients who present for gender dysphoria, are you trying, as part of your practice, to disentangle the other psychiatric illnesses and substance use disorders they may present with as well?

A. So for these references we're talking about even the general population. These were not specifically just with transgender people. This -- these couple of sentences refer generally in psychiatry that cognitive impairment and psychosis can impair the individual's ability to give informed consent, but other people can have significant mental illness and still be able to give informed consent.

That's a separate thing if you are saying disentangling it. I'm not sure when you say "disentangling," disentangling from what?

Q. Suppose a patient comes to you and they present with depression.

A. Yes.
Q. They present with anxiety, and they also have gender dysphoria.
A. Yes.
Q. As part of your discussions with those patients, you're trying to figure out the root cause of their mental anguish; right?
A. Yes, sir.
Q. And that root cause could be just depression; right?
A. Yes.
Q. It could be just the anxiety; right?
A. Well, not if they have all three. But, yes, it -- there could well -- it could well -- I mean, theoretically it's possible that they could have depression, anxiety, gender dysphoria. And there are certain kinds of anguish that one could assign to each of those. I'm not sure if that's what you mean.
Q. So all three of those things are mental disorders; right?
A. Yes.
Q. In the *DSM-5*?
A. *DSM*, yes.
Q. And you could help the patient and make sure that they have a fulfilling life if you treat just the depression in a particular patient; right? It's possible that if you treat just depression, they will feel better; they might not need

treatments for the other two issues?
A. It hasn't been my experience that if people need treatment for gender dysphoria -- you know, I had people who have already transitioned, for example, or are in a stable place with their gender dysphoria, but are depressed and -- you know, so you take into account that the person is transgender, but, you know, the focus is really the depression. But if this is somebody who is coming in with active distress related to their gender dysphoria, one needs to look at both and, you know, certainly, as in the Standards of Care 8, one might need to treat both simultaneously, both the gender dysphoria and the depression.
Q. Okay. And the preexisting psychiatric illnesses could impair a particular patient's ability to give informed consent; right?
A. Yes.
Q. That's what this statement is getting at?
A. Yes.
So this, as it says --
Q. Was it a yes, Doctor?
A. This says "Cognitive impairment and psychosis," -- "in particular cognitive impairment and psychosis." And so generally it's cognitive impairment and psychosis that impair informed consent. And even some people can have cognitive impairment and psychosis and still be able to give informed consent.

So I haven't -- I can't recall a patient where depression or anxiety has prevented them from capacity for informed consent.

I used to do consultation liaison psychiatry early in my career, and we would get called to somebody out of capacity to consent, let's say if they decided to leave the hospital or accept or reject care, and, you know, it's either that they were cognitively impaired, delirium or dementia, or that they had a severe psychosis, not just -- being depressed would not be a reason that somebody couldn't consent for their health care.

Q. I understand.

So let's break this down. If I have a psychiatric illness, and I come to you for gender dysphoria treatment, does my preexisting psychiatric illness make it more difficult for you to get my informed consent for a treatment? Yes or no.

A. Well, it depends, right.

So if somebody is really psychotic, then of course it would. But if somebody has a preexisting psychiatric history, but they, you know, are not in acute psychosis, then they can still give informed consent.

Q. Okay. So let me ask you another question.

I come to you with a substance use disorder.

A. Yes.

Q. And does that make it more difficult for you to get my informed consent for medical care? Yes or no.

A. So it can, you know. That's why -- okay. Yes or no is kind of incomplete.

People can be substance abuse users and be able to give informed consent. It's possible for someone with substance abuse to impair their capacity for informed consent.

That certainly is possible.

MR. JAZIL: Okay. Can we go to page 78 -- 178?

BY MR. JAZIL:

Q. Let's look at the part that says: *Experience suggests many transgender and nonbinary individuals decide to undergo gender-affirming medical care with little or no use of psychotherapy*.

A. Yes.

Q. Now, you agree with that statement; right?

A. Yes.

Q. And you've said that you've studied Florida's rule concerning gender-affirming care that you are testifying here about; right?

A. Yeah, I've read it. Yes.

Q. And that rule doesn't prohibit the reimbursement of any psychotherapy treatments for anyone diagnosed with gender dysphoria, does it?

A. No, it doesn't ban coverage for psychotherapy.

Q. Okay. And, Doctor, I'd like to move on to another topic.

You testified earlier that you diagnosed gender dysphoria

using the *DSM-5*; right?
A. Yes.
Q. Remind us again what the *DSM-5* is.
A. The *DSM-5* is the *Diagnostic and Statistical Manual for Mental Disorders* put out by the American Psychiatric Association and updated periodically.
Q. And we agree that gender dysphoria is a mental disorder under the *DSM-5*; right?
A. Yes.
Q. But we also agree that transgender is not a mental disorder under the *DSM-5*?
A. So transgender people can have gender dysphoria, but being transgender, as *DSM* states, in and of itself is not a mental disorder.
Q. You'd agree with me, Doctor, that there's no blood test that we can use to diagnosis someone with gender dysphoria; right?
A. Right.
Q. And there is no X-ray we can use?
A. Right.
Q. No MRI?
A. Right.
Q. No CT scan?
A. Right.
Q. No imaging of any kind?

A. Right.
Q. And there's been no gene that's been identified linking that gene to the existence of gender dysphoria, is there?
A. Correct.
Q. And, Doctor, just so the record is clear, not all transgender individuals suffer from gender dysphoria; right?
A. Yes.
Q. I'm a little confused by that answer. I apologize. I should have asked a better question.
THE COURT: I got it. You said that twice.
THE WITNESS: I can say, you know, we know that there's, you know, at least a half a percent of people in large population surveys who identify as transgender, that that number is substantially larger than the number of people who are going to clinicians and getting a diagnosis of gender dysphoria.
So that does speak that there are some people out there who are transgender, they have not received the diagnosis of gender dysphoria. We might not know whether they have gender dysphoria or not. But there is a discrepancy in terms of the numbers who identify and the numbers seeking treatment.
THE COURT: Well, Mr. Jazil, I tried to stop you because I thought I had the answer, and now I'm not sure I do.
THE WITNESS: Okay.
THE COURT: The last thing you told me is the percentage of the population compared to the number that have

sought treatment or been diagnosed.

THE WITNESS: Yes.

THE COURT: That really wasn't the question.

THE WITNESS: Okay.

THE COURT: So you're the clinician.

THE WITNESS: Yes.

THE COURT: You've worked in this field.

THE WITNESS: Yes.

THE COURT: Are there people who are transgender who do not have gender dysphoria?

THE WITNESS: And so I would say --

THE COURT: That really is a yes-or-no question.

THE WITNESS: I would say yes. To have gender dysphoria, it's not just that you have the distress, that the distress has to be significant enough that it's causing social or occupational impairment or clinically significant distress. So not -- some of those other transgender people may well have a symptom of gender dysphoria. They may have distress about some aspects of their body being different than their gender identity, but they don't meet criteria for gender dysphoria.

So I assume that those people exist. The people who come to see me are people who are seeking help, and they're transgender people. And at least until they have received, kind of, adequate treatment for their gender dysphoria, they have gender dysphoria like in the *DSM*.

There are some people who have transitioned and are not suffering from clinically significant distress. The *DSM* does have this post-transition modifier that we don't really use very much to try to account for them. And I see 11 which we don't use yet in the United States, just talks about gender incongruence. So the distress part isn't a part of it to kind of account for people maybe needing refills on their hormones but otherwise no longer in distress.

So there are people who are treated, for example, who are not impaired by their gender dysphoria now. And so one might say they don't have the disorder, except maybe this specifier in the *DSM*, so in addition to those people who never come into care.

THE COURT: Are there some transpeople who are just fine with it?

THE WITNESS: So there are some transpeople, mostly nonbinary in my experience, who are not seeking hormones and are not seeking surgery. They may have some level of distress. But especially some nonbinary people don't feel that maybe taking testosterone, for example, that they -- you know, they might see pros and cons to doing it. Some of them have taken it for a little while and stopped, but they don't want full masculinization because they don't identify as men either.

THE COURT: That, again, was a little different than what I was precisely trying to get at.

THE WITNESS: Yeah.

THE COURT: I wasn't asking about people seeking treatment.

THE WITNESS: Okay.

THE COURT: I really am asking about their mental state.

THE WITNESS: Yeah.

THE COURT: Are there people who are trans --

THE WITNESS: Yeah.

THE COURT: -- who are not upset about it, don't have a concern about it, so that they don't have a mental health issue with being trans, whether or not they seek hormones, for example?

I'm not asking whether it's somebody who is happy with their condition and does not seek hormone treatment or happy with their condition and they do seek hormone treatment. Either way, I'm just asking, are there people who are trans that are not upset about it?

THE WITNESS: Oh, yeah, sure. And that's why being trans is not a mental disorder; it's the presence or absence of distress. It's just that gender dysphoria happens within the population of transgender people.

THE COURT: Precisely. To add --

THE WITNESS: You can have a Venn diagram of transgender people, and then within that are the people with

gender dysphoria. That's a diagnosis, at least.

THE COURT: And the point of, I thought, Mr. Jazil's question and certainly mine is when you look at that Venn diagram, the little circle is going to be entirely inside the big circle --

THE WITNESS: Yes.

THE COURT: -- but it's not going to be congruent; it's going to be a smaller circle.

THE WITNESS: It's a smaller circle in terms of people, right, who've -- either aren't seeking treatment or have already had treatment and no longer meet the diagnosis.

THE COURT: Well --

THE WITNESS: Either way.

THE COURT: -- the little circle I'm talking about is the people that are -- concerned may not be the best word. The people who have mental dissatisfaction --

THE WITNESS: Yeah.

THE COURT: -- or a mental issue with their gender identity, that circle is smaller than the number of people who are trans, who identify as a different gender than the sex assigned at birth?

THE WITNESS: Yes.

THE COURT: Mr. Jazil, I interrupted. And I don't know if I made it better or worse, but at least I made it different.

You can proceed.

BY MR. JAZIL:

Q. Doctor, when you are diagnosing someone with gender dysphoria, the first step in that process is to figure out whether or not there is an incongruence between a person's gender identity and their natal sex; right?

A. Well, I don't mean to be difficult, but it depends. I mean, I have people who come to me very -- quite clearly and say, you know, I'm transgender. So I don't know if it's -- but, yes, it does. You know, making a diagnosis of gender dysphoria is kind of a required part of the process.

MR. JAZIL: Can we go to PX45, please, page 834?

Can we blow up the line by Rationale.

BY MR. JAZIL:

Q. Now, this -- now, Doctor, it says that: *Gender identity is defined as a person's deeply felt, inherent sense of being a girl, woman, female, a boy, a man, or male; a blend of male or female; or an alternative gender.*

Do you see that statement?

A. Yes.

Q. Do you agree with that statement?

A. Yes.

Q. And how do you, when presented with a patient who's coming into your practice, disentangle a person's deeply felt, inherent sense of being?

A. I -- I'm doing a clinical interview --

MS. DeBRIERE: Objection, Your Honor. It's my understanding that the exhibit that Mr. Jazil is referencing is not admitted into evidence and, therefore, lacks foundation.

THE COURT: Is there an objection to it?

MS. DeBRIERE: There is, Your Honor. That's my objection.

THE COURT: What --

MR. JAZIL: Your Honor, I just asked if he agreed with the statement that was made.

THE COURT: That's probably okay. But let me catch up.

I was pulling up the exhibit, and I didn't immediately find it. But I will. Give me just a second.

(Pause in proceedings.)

THE COURT: Let me make sure I've got the right document. Is this the Guidelines for Psychological Practice from the American Psychological Association?

MR. JAZIL: Yes, Your Honor.

THE WITNESS: From 2015.

THE COURT: It's the plaintiffs' exhibit and you object to it?

MS. DeBRIERE: Your Honor, we are happy to admit it into evidence. But if Mr. Jazil is going to rely on it, then we wanted to have a discussion of amending it.

MR. JAZIL: Your Honor, I'm not moving it into evidence. I just simply asked him if he agrees with one sentence in the paper, and then I'm asking him a follow-up question.

THE COURT: All right. You don't want it admitted?

MR. JAZIL: No, no, Your Honor.

THE COURT: All right. Now I've at least caught up, and I know what we are talking about.

Go ahead.

I overrule the objection.

But ask the question again so I'll have it.

MR. JAZIL: I'll try, Your Honor.

BY MR. JAZIL:

Q. Doctor, you'd agree with me that it's difficult to -- as part of your diagnosis to disentangle a person's deeply felt, inherent sense of being a girl or a woman or a female for a natal boy; right? That's a difficult task when someone comes to you and you've got to disentangle that?

A. Disentangle it from what?

Q. How do you substantiate someone's deeply felt, inherent sense of being? That's a difficult task that is put on your shoulders when you're the clinician; right?

A. Well, you know, I'm an experienced clinician, and whatever people are presenting with, you know, I am doing my psychiatric evaluation and -- whether that's one thing -- one complaint that

they have or multiple complaints. So I'm not sure what you mean by difficult to -- you know, it's what I do all day.

Q. You -- let me see if I understand this. All day you try to assess people's deeply felt, inherent sense of being?

A. No, all day I work as a psychiatrist with people and try to get a sense of the complaint that they bring into initial treatment and, you know, how best to understand it and how best to address it.

Q. Okay. Doctor, you talked with my friend about the Endocrine Society guidelines. I'd like to ask you a few questions about those.

MR. JAZIL: Your Honor, if I may approach the witness with a copy?

THE COURT: You may.

Give me the exhibit number.

MR. JAZIL: Your Honor, it's Defendants' Exhibit 24.

BY MR. JAZIL:

Q. Now, Doctor, when my friend was asking you questions, you testified that the Endocrine Society's guidelines, together with the WPATH guidelines, are the standards that you adhere to in your practice; right?

A. Well, I have the proviso that the Endocrine guidelines -- each guidelines is a product of its time. The Endocrine guidelines was -- came out in 2017, and so it was useful because Standards of Care 7 came out in 2011, published in 2012. And so

there were times where recommendations were updated relative to Standards of Care 7. Now we have Standards of Care 8 and -- so, you know, it's still important, but personally I'm more referring to Standards of Care 8, but there are still many people who are, you know, still using the endocrine guidelines from 2017.

Q. Do you think the Endocrine guidelines are a useful tool --

A. Yes.

Q. -- when --

A. Yes, yes, they're a useful set of information.

Q. Let's take a look at the cover of the Endocrine Society guidelines, Doctor.

A. Yes.

Q. Where it says "Cosponsoring Associations," it says the World Professional Association for Transgender Health was a cosponsoring organization.

You see that; right?

A. Yes.

Q. Now, looking at the authors, do you recognize any of the authors of this guideline as being WPATH members?

A. Yes.

Q. Which ones?

A. So in terms of people that I recognize as having been involved in WPATH, Peggy Cohen-Kettenis, who is also very involved with the APA revision of the *DSM-5* and World Health

Organization ICD-11. Walter Meyer had been involved -- has been involved in WPATH. Steve Rosenthal has been involved in WPATH. Joshua Safer, Vin Tangpricha, G. T'Sjoen have all been involved in WPATH.

So it's not unusual for the people whose academic focus is any given field to be part of multiple professional efforts, you know, around that, but these certainly overlap with people who are members of WPATH, as well as these other associations.

Q. And these other associations, Doctor, I think you mentioned a few. Could you repeat those? I think you said the --

A. Oh, I was saying this says cosponsoring organizations, and I assume -- I don't -- this is not an endocrinologist. I don't know, you know, where each of these folks are also members, but I assume -- you know, this was Endocrine Society of North America, but I assume that some of these people are also active in the European Society of Endocrinology, in the European Society for Pediatric Endocrinology, and the Pediatric Endocrine Society.

So all I would say is people who are experts in the field are often drawn in or invited into efforts from different organizations when it comes to practice guidelines.

Q. Understood.

You yourself, I think, mentioned that you work with the American Psychiatric Association --

A. Yes.

Q. -- on gender-affirming issues? Did I get that right?
A. Yes.
Q. Now, Doctor, if we turn to page 14 of that document. On the bottom right, that's the number I'm referring to.
Let me know when you are there.
A. So -- okay. 14.
Q. Yes, under "Evidence," the paragraph --
A. Yes.
Q. -- that says: *Individuals with gender identity issues may have psychological or psychiatric problems.* Then it goes on to say: *Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder...or certain forms of eunuchism...*
Do you see that, Doctor?
A. Yes.
Q. So you'd agree with me that someone responsible for diagnosing gender dysphoria needs to be able to separate the diagnosis of gender dysphoria from these other similar disorders with similar features?
A. Well, I would -- I would say I would disagree with the little part of this statement that says they have similar features. Maybe the similarity is that they are -- might be involved with perception of the body. But the part I would agree with is that, yes, a clinician, you know, in making any diagnosis also excludes other possibilities.

Q. And you'd agree with me that that clinician should be experienced; right?
A. Yes.
Q. And that clinician should be careful in making the diagnosis; right?
A. Well, you know, we should certainly be careful in everything we do as clinicians. So, you know, I would agree with that.
Q. Fair enough.
You'd agree with me that someone with only a handful of hours of training should not be responsible for making a diagnosis of gender dysphoria?
A. So licensed clinicians have more than a handful of hours of training. You have to do hundreds -- even if you are a licensed clinical social worker, a licensed marriage and family therapist, you have to do hundreds and hundreds of hours of training in mental health. And so -- I mean, there may be some people who only have a few hours of training going to a conference that focuses on transgender health, but they're trained, you know, in making diagnoses from -- you know, from the other parts of the practice in order to be licensed.
Q. So you have a mental health counselor. That mental health counselor goes to one of the trainings that you've put on in Miami or San Francisco, just the one.
You'd feel comfortable with that person making a diagnosis

of gender dysphoria?
A. So it's a little bit of a complicated question because --
Q. It's a yes-or-no question.
A. No. So, first of all, when we have those conferences, we -- they were part of a certification process, which was attending several conferences, having supervision with a mentor where one could discuss cases, taking an exam. So that certification process is -- is much more extensive than just going to one conference.

In order to make a *DSM* diagnosis by yourself, people have to get licensed, and you get licensed in making, you know, a diagnosis through -- you know, through much experience.

WPATH Standards of Care has another set of recommendations, which are, you know, practice guidelines recommendations, and they recommend that people be -- have knowledge and experience in making the diagnosis.

So certainly we would support people who make the diagnosis having knowledge and experience. So that's just -- maybe I'm just being a picky academic.
Q. Understood.

Doctor, can we go to page 15 of that document that I gave to you, the column on the left under "Evidence"?
A. Yes.
Q. Now, it says here, second sentence in that paragraph: *However, the large majority (about 85%) of prepubertal children*

with a childhood diagnosis did not remain GD/gender incongruent in adolescence.

Do you have any reason to disagree with that for prepubertal children?

A. Yes. So, first of all, this was before the one large American prospective study happened from Kristina Olson and her group.

So the -- the information that backs this up are these three older studies. But even the -- the Dutch study that very often people are relying on, the Steensma 2013 study on factors relating to gender identity, even that study says there's a heterogeneity to the population of gender-nonconforming youth, and they attempted to find factors that could be associated with those people persisting.

So -- anyway, the -- you know, the other thing I would say just about this is this is all about a prepubertal phenomenon and not affecting those who have a gender -- who get a gender dysphoria diagnosis in adolescence and adulthood, which is not given until after the start of puberty.

Q. So you disagree with this statement because the science is evolving on this issue?

A. Yes.

Q. Understood.

If we go to recommendation 1.4, which is just slightly higher on that same page --

A. Yes.
Q. -- it says: *We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence.*
Do you agree with that recommendation?
A. Yes.
Q. So for prepubertal children, we shouldn't be expecting them to get puberty blockers; right?
A. Right. Well, it wouldn't do anything anyway because puberty hasn't started.
Q. Okay.
A. But, yes, we wouldn't give them puberty blockers.
Q. And then you brought up the Olson study.
A. Yes.
MR. JAZIL: Can we go to Plaintiffs' Exhibit 140, please?
THE COURT: Mr. Jazil, when you're changing gears, we need to take a lunch break in here somewhere. Is before the next document as good a point as any? If you're close to finishing, we'll finish.
MR. JAZIL: Your Honor, if I could just have a couple of minutes with this next document, and then we can take a break.
THE COURT: Sure. Sure. Tell me the number again.
MR. JAZIL: Plaintiffs' Exhibit 140, Your Honor.

BY MR. JAZIL:

Q. Now, is this the study you were referencing, Doctor?

A. Yes.

MR. JAZIL: Can we go to Table 3 in this study, which is on page 4.

Can you blow up the first -- can we make the first row a little bigger and the headings.

There you go.

IT STAFF: Any better?

BY MR. JAZIL:

Q. So, Doctor, looking at this table, it looks like the sample size in the study was 317 individuals; right?

A. Yes.

Q. And 92 of those individuals were already on puberty blockers; right?

A. At the end of the study.

Q. And 98 were on cross-sex hormones?

A. Yeah. At the end of the study, yes.

Q. Okay. So here we're talking about a study that looked at kids who weren't necessarily prepubertal, were they?

A. They were prepubertal when they started the study, and it's a longitudinal study. So at the end of the study, some had already gone on puberty blockers, some had already gone on gender-affirming hormones over the several years of the study.

Q. Now, Doctor, when someone begins using puberty blockers,

are they, in your experience, likely to desist?
A. So the people who are -- in my experience, who have been started on puberty blockers by and large have persisted in transgender identity.
Q. What percentage of people who start with puberty blockers go on to take cross-sex hormones?
A. So it kind of depends on the study, but certainly, the great majority of people started on puberty blockers go on to cross-sex hormones.
Q. Is that number greater than 90 percent based on those studies?
A. So, yeah, I -- in -- certainly if you look at the Dutch series and the overwhelming -- the overwhelming majority of people, you know, go on to cross-sex hormones.
Q. So you'd agree with me that desistance rates are low when someone has been on puberty blockers or cross-sex hormones; right?
A. So of the people who start puberty blockers or hormones, remember, are people who then have received a diagnosis of gender dysphoria of adults -- of adolescents and adults are likely to persist, and that these are a different population than people who have received -- especially the GID of childhood diagnosis in the past.
Q. Doctor, when we're looking at a study like this, wouldn't the study be better -- be of a higher quality if we could

control for the ratio of folks who are on puberty blockers and cross-sex hormones and those who aren't?

A. Well, when the people -- everyone who is started in this study was prepubertal when they were started on this study. They are just following people for years, and so people do, you know, eventually hit puberty and go on puberty blockers, and so -- but there was another interesting thing with this -- with Olson's group where they tried to -- they did psychological testing and found that with other children within the study or within -- you know, or in the early period of time within the longitudinal study, and they found that -- that presocial transition -- basically, they could predict the kids more likely to socially transition because they were more likely to have a cross-gender identity even before they socially transitioned. And so they were -- Olson's group was really trying to tease out kind of chicken-and-egg problems.

Q. One last question before lunch.

A. Yes. Okay.

Q. We've talked about prepubertal children.

A. Yes.

Q. For most children, doesn't puberty hit somewhere around the 12-year-old range?

A. For many children, but for some assigned female at birth, it can be early, and it's getting -- it's interesting it's a little earlier in the United States than in Europe and -- yeah,

so it can be earlier, especially for some people assigned female at birth.

MR. JAZIL: Your Honor, we can go to lunch, if that's okay with Your Honor.

THE COURT: Yeah. We'll take the lunch break.

Tell me, how much longer do you think you have with Dr. Karasic?

MR. JAZIL: I'd like to think 30 minutes, Your Honor. I'll try to be short.

THE COURT: Then the rest of the day is a couple more experts; is that the plan?

MR. GONZALEZ-PAGAN: Yes, Your Honor. We have at least one more expert for today, and we have another one on call.

THE COURT: All right. When you made openings, you didn't give me much of what you really expect. You expect experts for the foreseeable future?

MR. GONZALEZ-PAGAN: We do have five more experts, Your Honor, but they will be more targeted. We wanted Dr. Karasic to do more of an introduction to the whole topic.

THE COURT: All right. Let's take -- it's your first day finding your way around town. Let's take an hour and two minutes. Let's start back at 2:10 by that clock.

Dr. Karasic, if you'll be back on the witness stand by 2:10, please.

(Recess taken at 1:07 PM.)

(Resumed at 2:11 PM.)

THE COURT: Please be seated.

Dr. Karasic, you are still under oath.

Mr. Jazil, you may proceed.

MR. JAZIL: Thank you, Your Honor.

BY MR. JAZIL:

Q. Dr. Karasic, can we go back to the Endocrine Society guidelines?

A. Sure.

Q. If we can go back to page 15.

We talked about the statement in here about the large majority of children who remain GD incongruent.

If we go down to that paragraph, the last sentence says: *Social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.*

Do you see that, sir?

A. Yes.

Q. Do you agree with that statement?

A. No. No. First of all, there is more data from Kristina Olson's group that -- one of things they did is psychological testing on children prospectively, and they found that social transition appeared to be more consequence of the prepubescent child's gender identity as opposed to the social transition preceding the expression of their gender identity.

Q. So, Doctor, if someone's peers accept them as a transgender person, that's something that we can categorize as an environmental factor, right, the environment the person is in?
A. Well, if they're a transgender person, being accepted and respected by their peers can be a positive factor for that --
Q. Okay.
A. -- for that person.
Q. So can we also then say that those positive environmental factors can contribute to a person's persistence in continuing to identify as they are?
A. Well, I don't think we know that. I think from the Olson group, when they actually followed people prospectively, that the gender identity preceded the social transition as opposed to vice versa.
Q. Let me ask it another way.
Do environmental factors play a role in persistence or desistance?
A. So the environmental -- can you explain what you mean when you say "environmental factors"?
Q. Well, let me ask you a couple of questions about that.
A. Okay.
Q. We agree that social acceptance is an environmental factor; right?
A. That social acceptance is an environmental factor, yes.
Q. Is social rejection an environmental factor?

A. Yes.
Q. Can we say that social media is an environmental factor as well?
A. Well, yeah. I mean, it can be. Certainly exposure to things on social media, it can be part of one's environment.
Q. Okay. And one's environment can play a role in persistence; right?
A. So I don't -- as I said, I don't think we know that. As I said, the Olson group's research kind of showed that even before social transition and, therefore, before people were -- before a child is even getting people accepting or rejecting their social transition, that they already had the cross-gender identity that -- the identity, you know, different from their sex assigned at birth.
Q. Understood.

Now, Doctor, in your practice do you counsel patients on the use of puberty blockers?
A. So I -- in my practice I'm not seeing prepubertal children. I -- there are sometimes adolescents who get started on puberty blockers as kind of a transition into hormones. But I'm not -- I'm usually -- by the time I see somebody, they are well past Tanner Stage 2, for example.

So there are times when I will, though, advise people who are a little bit past Tanner Stage 2 and their parents about puberty blockers.

Q. Okay. And when you are talking to these folks about puberty blockers, you walk through the side effects of puberty blockers with them as well?

A. Yes.

MR. JAZIL: Okay. Can we go to page 18 on this document, DX24, left column under Side Effects.

THE WITNESS: Is this a different -- which document is this?

BY MR. JAZIL:

Q. It's the Endocrine Society guidelines.

A. Okay. I'm sorry. What page?

Q. Page 18, on the bottom right.

Now, the first sentence: *The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development.*

Do you walk through these side effects with your patients as they are coming to you for counseling on whether or not to be on puberty blockers?

A. So when -- if a patient is going on puberty blockers, we do talk about bone mineralization. I'm not the person prescribing, but we do talk about that. We do talk about fertility.

We -- there's not a lot known one way or the other about

brain development, so that's not usually -- that's not known as a risk; it's more a question.

MR. JAZIL: Okay. Can we go to the next page, 19, top left.

BY MR. JAZIL:

Q. It says: *Limited data are available regarding the effects of GnRH analogs on brain development.*

So you agree that there is limited data on that issue, right, Doctor?

A. Yes.

Q. But it goes on to say that: *...animal data suggest there may be an effect of GnRH analogs on cognitive function.*

Do you broach that issue with your patients as they come to you for puberty blocking counseling?

A. No. You know, I think it's consistent with my counseling generally, which is if something has been shown in animal models, but there's not some evidence in people -- unless I'm counseling pet owners, I suppose. But I'm not -- yeah. I don't -- I can't think of another example where I counsel people because an animal model has, you know, said there is a problem.

But, you know, for any -- I'm not the one prescribing puberty blockers. But for any medicine I am prescribing, I always talk about risks and benefits.

Q. Now, Doctor, you are not a surgeon, either; right?

A. No, I'm not a surgeon, either.

Q. Now you do counsel patients who get gender-affirming surgery; right?
A. Yes. So I do talk about both hormones and surgery with people.
Q. So if we could go to page 29 of this document, Doctor, bottom right.
Heading 5, the second sentence in the first paragraph says: *The type of surgery falls into two main categories; those that directly affect fertility and those that do not.*
Do you agree with that, Doctor?
A. I mean, certainly that's one way to categorize them.
Q. And then it goes on -- the third paragraph down says: *Surgery that affects fertility is irreversible.*
Do you counsel your patients about surgery that affects fertility being irreversible?
A. Yes. In terms of a patient getting, for example, an orchiectomy or -- with a hysterectomy nowadays a lot of people are maintaining an ovary. But certainly with an orchiectomy the people are not going to be able to, you know, maintain fertility.
Q. So if you look at the first sentence of the paragraph that follows: *Gender-affirming genital surgeries that affect fertility include gonadectomy, penectomy, creation of a neovagina* --
A. I'm sorry. Where are you?

Q. It should be highlighted on your screen, sir.
A. Oh, okay.
Q. So which one did you say, Doctor, is something that --
A. Well, it's really what is -- the part that's really affecting the fertility primarily is the gonadectomy or orchiectomy in transwomen.

If the presence or absence of a penis or the creation of a neovagina is not directly what eliminates the chance of fertility, it's that the person doesn't have testes anymore.

Q. And, Doctor, as you are counseling patients on surgeries, do they ask you questions about the long-term quality of life associated with the surgeries?
A. Well -- can you rephrase the question? I'm not quite sure what -- you are saying the patient asks me about their long-term quality of life?
Q. Yeah. Will the surgery improve my long-term quality of life? Will it adversely affect my long-term quality of life? Do you have those conversations with your patients?
A. We have those conversations. The patients usually don't ask me whether, let's say, having vaginoplasty is going to improve their quality of life. They have usually, you know, kind of thought about it one way or the other, you know, even before. But we have a conversation about the risks and benefits of having surgery.
Q. Okay. So if we go to page 31, Doctor, of that document,

the last sentence of the first paragraph: *We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.*

Do you see that statement, Doctor?

A. Yes.

Q. First, let me ask you, do you agree with that statement?

A. Well, I think that more research is always welcome. And certainly even since 2017, people have continued to publish on quality of life psychosocial outcomes of surgery as well as hormones.

Q. Okay. So when you are having conversations with people who are coming to your clinic, do you talk about how, Well, we just don't have that much long-term data on whether or not this is going to improve your life or not?

A. No, because we do have a lot of data that people -- people who need gender-affirming surgery are going to benefit from it, and a lot of experience in that regard.

You know, there are issues that are risks and benefits of surgery. But I am not saying -- you know, this sentence says, we need more studies. The question is we need more studies for what? I don't think that we need more studies in order to be providing the surgery. We've been providing the surgery for almost 100 years. But certainly more research is always welcome.

And so it's certainly, you know, my place to discuss with a patient, you know, the risks and benefits of whatever procedure they are going through. But I'm not saying to them, We need more research on what your long-term quality of life is going to be after surgery.

Q. Understood.

MR. JAZIL: We can take that down.

BY MR. JAZIL:

Q. Doctor, when you were being questioned by my friend, do you recall being asked about the state of the scientific literature on the availability of gender-affirming medical care?

A. Yes.

Q. And do you recall some testimony about how it would be nice to have randomized controlled trials, but we just can't do it?

A. Yes.

Q. So in the abstract, you would agree with me that randomized controlled trials are the gold standard for scientific research; right?

A. Well, it's -- randomized controlled trials give a particular kind of information. But we are providing care all the time without randomized controlled trials. Working with youth, most of the prescriptions I give of psychiatric medicines are medicines that have never been tested on minors and not FDA approved on minors, do not have -- they had a randomized control trial in adults, but sometimes they don't work as well in minors

as adults, even when there is finally a randomized controlled trial.

So we are always prescribing in a world where information is incomplete, and we are trying to use the best information we can.

Q. And did I understand your testimony correctly earlier where you said that randomized controlled trials in this area would just not be ethical?

A. Right. Because at this point we couldn't -- we already know that hormone blockers block puberty. And we already know that masculinizing and feminizing hormones masculinize or feminize the body. There is plenty of data for that.

The question that people are continuing to do studies are about its impact in other ways.

Q. Understood.

Doctor, I'd like to show you an article.

MR. JAZIL: Defendants' Exhibit 28, please, the title page.

THE WITNESS: Yes.

BY MR. JAZIL:

Q. Doctor, are you familiar with this article?

A. I actually have seen this article, just very briefly. It just was released. I think they actually did the systematic review in Sweden some time ago, but just did this publication in English just extremely recently.

Q. Are you familiar with any of the authors listed here?
A. No.
MR. JAZIL: If we could zoom out.
BY MR. JAZIL:
Q. Can you see the institutions that they are associated with, Doctor?
A. Yes.
Q. And are you familiar with these institutions?
A. Yes, particularly -- well, Columbia University, but also Karolinska Institutet.
Q. Are these reputable institutions that study gender dysphoria and gender dysphoria treatments?
A. Yes.
But, I mean, when we talk about Karolinska Institutet, I was just in a conversation with Cecilia Dhejne, who started the gender program there and is still there after all these many years, who I think agrees with some of the criticism that I gave early about the limitations of, you have a systematic review, and say the data is not as high certainty as one would like. But it does also seem like sometimes these articles have been coming out like in Florida as part of an effort to actually shut down gender-affirming care.
Q. So, Doctor, let me ask you about a particular point raised in this article.
MR. JAZIL: If we can look at page 13 of 27, please?

The second paragraph, *Our review highlights*.

BY MR. JAZIL:

Q. Doctor, where it says: *First, randomized controlled trials are lacking in gender dysphoria research*, we can all agree that's true; right?

A. Yes.

Q. The second sentence that follows says: *We call for such studies, which may be the only way to address biases that we have noted in the field.*

Then it goes on to say: *Given the current lack of evidence for hormonal therapy improving gender dysphoria, another ethically feasible option would be to randomize individuals to hormone therapy with all the study participates, independent of intervention status receive psychological and psychosocial support.*

Do you see that, Doctor?

A. Yes.

Q. Do you think that's one way to get to better, more high-quality studies on the efficacy of gender dysphoria treatment?

A. Well, I think that that is -- you know, so the one proposal is providing psychological and psychosocial support to -- so this is saying randomized individuals to hormone -- so hormone therapy to all study participants, independent of intervention status.

So are they saying giving people hormones and not giving people hormones, but giving everyone psychotherapy? I'm not quite sure exactly what they mean in this proposal.

Q. Doctor, I think if you read the next sentence, that may give you more guidance.

However, controlled trials do not necessarily require placebo treatment, but could for example build on the date or time of starting hormonal therapy to generate comparison groups.

A. Right.

Q. Is that one way to build control groups that would give you better high-quality data?

A. Well, you know, I think that's an approach, but I also think, you know, given what I talked about -- you know, this is based on a systematic review that it does -- when we are talking about complexity, you know, you can be talking about efforts to reduce the complexity of the intervention, but I still don't think that you're going to get high certainty on systematic review given the complex intervention.

Q. Fair enough.

Doctor, you testified about the work you do for Maximus?

A. Yes.

Q. Do you recall that testimony?

A. Yes.

Q. And my understanding is that Maximus is subcontracting with the State of California; right?

A. Yes.
Q. And Maximus gives you a set of files for individuals who were denied coverage for gender-affirming care; right?
A. Yes.
Q. And your job is to review those files and decide whether or not to change the initial determination of denial; is that right?
A. Right.
I'm supposed to make a determination of whether there's an -- there's a question as posed about medical necessity, and I'm supposed to answer that request.
Q. Okay. And, again, my understanding of your early testimony is that because of your experience in the field, you get the difficult cases?
A. Yes.
Well, what's happened is in the beginning I got a lot of denials. Years ago I was getting a lot of denials, simply because insurance companies in their bureaucracy had not updated their, you know, systems for approving or denying surgery where people were, you know, clearly -- and under California law they qualified for care, were receiving denials and then they appeal, and it was a very easy thing.
Over the years, there are fewer and fewer of those. And the ones I'm getting are actually more likely to be quite challenging in terms of the medical necessity.

Q. And, Doctor, correct me if I'm wrong, but you recommended that the treatment be made available to the individuals who were initially denied in about 80 percent of the cases?
A. I said in the deposition 70 or 80 percent. But if I would -- I guess you might -- I'm not sure if it's since the deposition, but the ones that I've done in recent times -- I've just done four recent ones, and two were denials -- and two were I said it was medically necessary, and two I said it was not medically necessary, in my most recent ones.
But early on, I would get a whole slew of them where there didn't seem to be any reason for the insurance company to be denying it. And so my percentage of approval started out very high, and it's gradually been going down, because I think the insurance companies are now approving more of the appropriate ones, and the denials tend to be ones that are -- where there is a little more question.
Q. Understood.
I have one last set of questions. And I want to make sure I understood your testimony correctly on this.
You testified earlier that you were on the APA, the American Psychiatric Association, Work Group on gender dysphoria?
A. Yes.
Q. And while you were on that Work Group, the APA endorsed the WPATH Version 8 Standards of Care, if I've got the chronology

right?
A. So I'm not involved in -- our Work Group is not involved in position papers or endorsements of the APA. That's a separate process. Our charge as the Work Group on gender dysphoria was, basically, what's the research. There were two position papers, one before I joined the Work Group and one after -- not position papers. I'm sorry -- research papers that basically discussed, you know, issues and care for psychiatrists, and which, within this kind of big APA, it's just a totally different track than the assembly and work trusties kind of track of approving the statement.

So there were times when I might be in touch with a scientific committee about something, but it was not about the position papers of the APA.

Q. Understand.

But the APA did endorse the WPATH Version 8 Standards of Care?

A. The APA has, in various documents, endorsed the use of WPATH Standards of Care and the provision of gender-affirming care in various statements, and has opposed discrimination against transgender people in the provision of health care.

I don't -- if they've -- I don't think they've specifically endorsed Standards of Care 8. They may have, because I'm not, kind of, involved in that kind of wing of the APA. Standards of Care only came out in September, and the APA usually doesn't

move that fast.
Q. They endorsed the Version 7 Standards of Care?
A. Well, it was in multiple documents, including our research papers and elsewhere, about, you know, referring to WPATH Standards of Care as -- for practice guidelines by the APA.
Q. Okay. And when the APA in various documents says that the Version 7 or Version 8 Standards of Care are to be considered as a clinician, do they send out a membership email blast? Do you know?
A. They usually -- APA doesn't usually send out a membership email blast, so I'm not -- I mean -- yeah, I'm not aware that they -- that they did. I'm just thinking of, you know, things like research papers and things like that that -- if they talk about transgender care, that they -- they refer to the WPATH Standards of Care.
Q. And these resource papers would be on the membership part of the website for the APA?
A. Well, for example, you know, I mean, I'm familiar with a resource paper that I was involved in, and a version of that got published in *Transgender Health*, which was openly available to everyone. There was a version that -- a shortened version that was in *American Journal of Psychiatry*, which is the journal owned by the APA. And then within APA there resides kind of a resource document on considerations in transgender care that also was a result of that document.

And then there was a document a few years earlier, before I was on the committee, that was published as an article and that also I think is a resource document for the APA.

Q. Do you know how many people at the APA are responsible for putting these resource materials up?

A. No.

MR. JAZIL: I have no further questions, Your Honor.

THE COURT: Redirect?

MS. DeBRIERE: Yes, Your Honor, just a few.

REDIRECT EXAMINATION

BY MS. DeBRIERE:

Q. Dr. Karasic, at the beginning of my friend's cross-examination, he was talking about the process for approving the Standards of Care 8.

Was approval by the board the only step taken to develop the Standards of Care 8?

A. I'm sorry. Can you repeat the question?

Q. Was approval by the board the only step taken to develop and adopt the Standards of Care 8?

A. No, there was a hands-off quality between the board and the Standards of Care committee -- the editors and the committee, and the board was involved initially in appointing the -- the editors, and then they were involved at the end in approving the documents.

And there were members of the board who were also members

of various Standards of Care 8 committees, but they weren't operating as board members. They were just experts, you know, in a particular field. But the board did not -- did not -- right, just -- was just -- had that initial appointment of editors and then final approval of the document, and everything that went on with the Standards of Care really were -- the three editors were the bosses.

Q. Were the authors adopters of Standards of Care -- Standards of Care 8, did they consider divergent viewpoints in developing and adopting the Standards of Care?

A. Yes. You know, Dr. Levine and others often will mention Laura Edwards-Leeper, and she was one of the only people -- there may have been one other -- who was on both the adolescent committee and the child committee. So, you know, somebody who the defendants' experts, you know, make reference to was on the Standards of Care adolescent committee, which is the most controversial committee, in a sense, because you did have these laws being passed or these, you know, debates about denying care to adolescents that were already kind of rumbling near the end of the process.

So, yes, there was a -- quite a -- there was an agreement, I think, among people who are on the committee about the utility of gender-affirming care, but there were also, you know, disagreements on all kinds of things.

And the Standards of Care's use of the Delphi process,

where recommendations were put to a vote, and everyone voted and also commented on any potential changes they would make -- if it got 75 percent, the statement, in essence, could stay, and if it got less than 75 percent, then it could be resubmitted, but only in an altered way, to Delphi, taking into account the comments. And so there was a process for resolving those kind of differences.

And then near the end of the process, there were two things. One was the Standards of Care were revealed publicly and actually as just -- you know, being chapter lead on the mental health chapter, some of it I saw for the first time at that time, and it got public comment. And so then public comment was incorporated.

And there was also an effort with the editors to bring together people on the various chapters to -- you know, if an inconsistency was found between something that was said in one chapter and something that was said in another.

Q. My friend also mentioned a Dr. Hilary Cass and whether --

A. Yes.

Q. -- she was involved in any of this process.

To your knowledge, does Dr. Cass provide gender-affirming care?

A. No, not to my knowledge. And I had never heard of her when we were actually doing this process, you know, most of which took place years ago and -- because she wasn't somebody -- I

think she was, you know, just somebody within DNHS and not somebody providing transgender help.

Q. How did you -- as the chapter lead, what was the process for selecting the authors?

A. So we had a whole pile of PDF -- virtual pile of PDFs of people's CVs, very impressive people, and I met with the three editors, and we went through the CVs. And we -- we definitely wanted people who were experts and also people who were leading efforts for gender care, in this case mostly psychiatrists in various systems, and so that's -- you know, we had experts from different places.

Q. How did you obtain those CVs?

A. So there was a -- WPATH had sent out a call for CVs for people who wanted to be involved in the effort.

Q. Did Hilary Cass submit a CV?

A. No.

Q. Did any of the other applicants my friend was discussing during your cross-examination --

A. No, Stephen Levine did not submit an application to be involved in Standards of Care 8.

Q. We discussed a bit about Cecilia Dhejne and your conversations with her and her viewpoint on gender-affirming care.

Did defendants at any time, their experts, rely on Dhejne's research in their own expert reports?

A. So did you say did the defendants rely on Cecilia Dhejne?
Q. Yes.
A. Yes.
Q. Okay. Shifting gears a little bit, what's your response to defendants' assertion that once an adolescent receives puberty-delaying medications that they're put on this conveyer belt of care and then they won't receive hormone therapy and, inevitably, surgery?
A. Yeah. So it's not true. For some reason it always brings into mind the "I Love Lucy" chocolate factory where Lucy and Ethel are stuffing, you know, the conveyer belt. To me, it's not an analogy that's relevant at all.

First of all, if you look at -- that criticism was often done in England where the wait for youth to be seen in the adolescent gender clinic -- that there was a three-year wait for the child in the adolescent gender center. So that doesn't seem to me like a very sufficient conveyer belt.

And then, secondly, once you get care, you have to continue, you know, taking the care. Presumably, the people who continue care are not trapped on a conveyer belt. They are feeling better, and if they are feeling worse, then they, you know, would stop the medication. And I gave the example of participants who had second thoughts and stopped the process for their kid. And you know, parents can do that.

Q. Judge Hinkle asked if there are transgender people who are

perfectly comfortable living as they are.

To get a better understanding of that, what is your view of how a transperson would be impacted if they are not able to live consistently with their gender identity?

A. Right. I guess I was a little confused. Just in the area of, like, living as they are, it could be living as they are when they're already living in a gender other than their sex assigned at birth.

It could be, you know, the people out there that I don't see who have endorsed on a phone survey that they have a transgender identity, and we don't know if they have clinically significant distress because they haven't presented to doctors.

Did I -- am I on the right track? I'm not quite sure.

Q. How would an individual be impacted if they weren't able to live consistently with their gender identity?

A. Right. And so for people who are needing to transition and when a halt is put to that, there can be tremendous distress, and that's something I've witnessed with many of my patients who have had -- one circumstance or another has kept them from social transition, from hormones, from surgery. And I've had patients who have suffered tremendously, patients who made suicide attempts as a result, people who have just had prolonged, you know, misery as a result.

And so I would say that's not something I would -- you know, I don't think that's, like, a reasonable option, to just

deny people from -- you know, from living as they need to live.
Q. Are there transpeople who do not have gender dysphoria because they can live consistently with their gender identity through social transition --
A. Yes.
Q. -- without gender-affirming medical care?
A. Yes. And so -- you know, I was talking about the example I see most often with people who are nonbinary identified, and I see some young people for depression or anxiety who are -- have a nonbinary identity and are not desiring hormones or surgery, at least at this time. You never know in the future.
Q. And others are able to live consistently with their gender identity with the use of medications --
A. Yes.
Q. -- or surgery?
A. Or surgery, yeah.
Q. So what is the predictable effect, then, in your opinion, of a transperson -- transgender person not being able to live consistently with their gender identity?
A. Suffering.
Q. Just a few more question, Dr. Karasic.

Are side effects unique to gender-affirming medical care?
A. No. And, you know, when the bone mineralization thing came up, I think about antidepressants. There are a number of studies that show that people who have been on antidepressants

after the age of 55 have higher rates of hip fractures, and yet not much is really even discussed, I think, with most patients about that fact.

So, you know, there are side effects to every -- or, you know, one that has gotten more attention is -- that what -- and involves my work is young people getting antidepressants, that for people under 24, antidepressants can cause increased suicidal ideation, and we always talk about that with our young people, that -- you know, we're making the judgment with the parents that giving them the antidepressant is going to do more benefit for them than harm, but there's always a chance it could make them suicidal and, you know, that they could end up, you know, needing to be hospitalized as a direct result of my prescription. So it's something we live with -- you know, doctors live with -- with every intervention we do.

Q. Are there any other types of medical care that may impact fertility?

A. Yes.

Q. Does the existence of that mean that the care should not be recommended?

A. No.

Q. And then, finally, my friend read select passages from the Endocrine Society guidelines.

But those guidelines taken as a whole, do they recommend gender-affirming medical care when medically necessary?

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023 /s/ Mohammad O. Jazil

No. 23-12159

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME V OF XIII

Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
(850) 274-1690

Counsel for Defendants-Appellants Florida Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

Ashley Moody
Attorney General of Florida

Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
(850) 414-3300

Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

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Dated: September 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
Phone: (850) 391-0503
Facsimile: (850) 741-1023
mjazil@holtzmanvogel.com
mbeato@holtzmanvogel.com
Counsel for Defendants-Appellants Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

/s/Joseph E. Hart
Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
Phone: (850) 414-3300
henry.whitaker@myfloridalegal.com
joseph.hart@myfloridalegal.com
Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

A. Yes.

MS. DeBRIERE: That's all I have, Your Honor.

THE COURT: Dr. Karasic, I have several questions.

THE WITNESS: Okay.

THE COURT: Mr. Jazil asked you a question about the reference in the Endocrine Society paper --

THE WITNESS: Yeah.

THE COURT: -- what everyone calls that track, that referred to animal studies.

THE WITNESS: Yeah.

THE COURT: And you said something about you're not a veterinarian. If they were bringing you their pets, it would concern you.

I take it whoever did this animal study wasn't trying to determine the effect of these hormones on the animals. They were trying to determine the effect of -- puberty blockers, I guess, not hormones.

THE WITNESS: Yes.

THE COURT: They were trying to determine the effect of puberty blockers on people.

THE WITNESS: Yes. And -- so I apologize for being glib. I actually saw a presentation that could be the one that was referred to. I think it was at the WPATH conference in 2009 in Oslo. And it was -- they had sheep who were going through puberty, and they had puberty blockers, and then they dissected

their brains and were looking at comparisons of people's brains.

The thing is that there are potential side effects of all kinds of drugs in animals where we don't know that that affects people, and we don't warn people about potential animal side effects unless we really have a sense that this is -- that there's substantial evidence that's going to cross over. For --

THE COURT: I get it --

THE WITNESS: Yeah.

THE COURT: -- not everything that affects animals affects people.

THE WITNESS: Right.

THE COURT: Lots of studies are done using animals, and sometimes that carries over; sometimes it doesn't --

THE WITNESS: Yeah.

THE COURT: -- sometimes the dosages are different. I understand you have to be very careful with this.

THE WITNESS: Yeah.

THE COURT: But I have to tell you, as I listened to that exchange --

THE WITNESS: Yeah.

THE COURT: -- I think if I'd been the parent deciding -- helping to decide for my 12-year-old --

THE WITNESS: Yeah.

THE COURT: -- what I was going to do, I wouldn't be very pleased if I found out later that there was an animal study

that at least had this and the doctor didn't even tell me.

THE WITNESS: Yeah.

THE COURT: I think what I would have expected the doctor to say is, We've got this animal study. We don't know how it carries over.

THE WITNESS: Yeah.

THE COURT: It's not something that concerns me, but it's there.

THE WITNESS: Yeah.

THE COURT: But if I understood what you told me, you don't tell people about this at all.

THE WITNESS: Well, first of all, I am not usually the person counseling people for puberty blockers at the start of puberty, which is when this happens. So it's not part of my usual practice. I see post-prepubertal adolescents.

So there can be -- puberty blockers are sometimes used up even through age 17 even alongside -- sometimes they start people on puberty blockers, and then they add in hormones even when people are past Tanner Stage 2.

And that is the kind of more common experience with my patients, because I'm not seeing the prepubescent children that are then being, you know, followed for when they start puberty. So I'm not usually in that situation to give that kind of counseling.

But the -- it is true that there are kind of a legion

of side effects for almost any drug that we give, and what I do prescribe all time and where I'm the -- because I'm the prescriber, I'm the main responsible person for prescribing -- for talking about risks and benefits.

Every psychiatric medicine I prescribe has a list of potential side effects that's so long that it is up to me to try to filter out what's relevant in part of the discussion, and I can tell people that, you know, of course they can read more on it. But, you know, it's like if you watch a commercial for medication, there's this long list. Well, if you say the actual list of things that are possible, it is actually even much longer and so --

THE COURT: I get it.

THE WITNESS: I don't know if -- I just don't know if I would tell -- you know, discuss an animal model unless I felt that that was -- that there was some reason to connect it.

And I think the same -- in the same passage they said, you know, the one -- a study in people did not show a cognitive difference.

THE COURT: Or at least on executive function.

THE WITNESS: On executive function.

THE COURT: I'm not going to get down into the weeds about --

THE WITNESS: Right, right, right.

THE COURT: -- whether that's different than

cognitive.

Let me ask you about something else.

There was some discussion back and forth about what may be described rather imprecisely as detransitions.

THE WITNESS: Yes.

THE COURT: I take it that there are some people, some kids, who start on puberty blockers, and at some point they go back to the gender identity matching their natal sex; true?

THE WITNESS: Probably, yes. There have not -- there are not a lot of them.

THE COURT: Well, I'm not talking about how many. I understand --

THE WITNESS: Okay. Sure. Yes.

I would say -- I would say it's probably true.

THE COURT: There are examples; people have testified to it; right?

THE WITNESS: Right.

No, I think that's true that somebody -- you're saying somebody goes on puberty blockers, and then when they are still in puberty, they decide to stop because -- yeah, I think that's true.

THE COURT: There are some people who -- we'll just pick one gender to start with -- sex assigned at birth is male.

THE WITNESS: Right.

THE COURT: They identify as female.

THE WITNESS: Yes.
THE COURT: They see a doctor; they start gender-affirming care.
THE WITNESS: Yeah.
THE COURT: And at some point the person then identifies again as male.
THE WITNESS: Yes.
THE COURT: That happens?
THE WITNESS: Yeah. Yes.
THE COURT: And the other way around, too?
THE WITNESS: Yes.
THE COURT: Somebody natal sex, female identifies as male.
THE WITNESS: Yes.
THE COURT: Goes back --
Is that always the result of one of the two things I'm going to describe?
The first, I think you referred to change in gender identity?
THE WITNESS: Yeah.
THE COURT: So I take it a person can identify and then change their identification?
THE WITNESS: Yeah.
THE COURT: The second would be malpractice, or close to it; a doctor that fails to ask all the questions and do the

treatment and get it right, so start somebody that shouldn't have been started in the first place.

Is it always one of those two things?

THE WITNESS: Well, no. The example that I gave was one where the adolescent did not change her gender identity, but the parents decided that they didn't want to support it. And that was -- that's the one patient that I've had that has had that experience.

THE COURT: I would not --

THE WITNESS: So there might be a third.

THE COURT: I would not have included that in my description. I get that.

THE WITNESS: Yeah.

THE COURT: But I'm talking about the patient who really identified and got treatment and then so-called detransitions.

THE WITNESS: I would think in terms of the first case that there are some people who might identify in a binary way as trans and then later realize that they may be more comfortable identifying as nonbinary and, thus, don't want to make a binary transition.

That's as opposed to -- although I'm sure there are some -- as opposed to people who, you know, are diagnosed with gender dysphoria, have six months or more of gender dysphoria that's strong enough to be impairing, and then it just vanishes.

In my experience, when I've seen people make changes, it's more just to -- kind of a reconceptualization of how to make sense of the symptoms they have, and that some feel like a binary transition doesn't feel right for them either and chose to be identified as nonbinary.

THE COURT: So you don't think there's going to be somebody that says at, say, 12 years old, born male but identify as female, and then sometime later says, I just got it wrong. I really -- I was born male and now I identify as male? You don't think that happens?

THE WITNESS: So -- and you are saying within -- within adolescents, and then stopping the puberty blocker, or are you saying that they have regret later on?

THE COURT: I'm trying to eliminate all that.

THE WITNESS: Okay.

THE COURT: All that other stuff.

THE WITNESS: Yeah.

THE COURT: And, I mean, I may have it wrong.

THE WITNESS: Yeah.

THE COURT: You're the first witness in the case.

THE WITNESS: Sure.

THE COURT: And apparently there are going to be a lot more.

THE WITNESS: Yeah.

THE COURT: And I say that just to show we can all be

glib every now and then.

THE WITNESS: Yeah.

THE COURT: So I'm not trying to prejudge anything or say I know this.

THE WITNESS: Yeah.

THE COURT: But I think I understand the defense position to be that sometimes people come in for this treatment and get the treatment, and it turns out they shouldn't have gotten it; they were wrong, that they believed --

THE WITNESS: Right.

THE COURT: They may think -- they may assert it's from social media or from peer pressure or whatever.

But I take it that's part of the theory, that sometimes impressionable kids -- and peer pressure is a big thing when you are 12 or 13 -- that sometimes the peer pressure causes somebody to say that they identify as the opposite sex when they really don't, and later they realize that they really didn't. That's the theory.

Apparently there are some people who will testify that, Yes, that's what happened to me.

THE WITNESS: Yeah.

THE COURT: And I sort of had the impression from your testimony when Mr. Jazil was asking questions that you think that just never happens.

THE WITNESS: No, I wouldn't say it never happens.

It's -- in my experience I haven't had -- I've had patients detransition for various reasons, but they've continued to have gender dysphoria and then retransition again with gender dysphoria.

THE COURT: I understand.

THE WITNESS: But I'm not denying --

THE COURT: There is a reason why somebody would stop the treatment or whatever.

THE WITNESS: Sure.

THE COURT: But I'm talking about what -- the real subjective --

THE WITNESS: Yeah.

THE COURT: -- identity the person has.

THE WITNESS: Right.

THE COURT: So I'm saying somebody who says --

THE WITNESS: Right.

THE COURT: -- I identify as female; later comes to say, I was wrong. I really identify as male, my sex assigned at birth, and did all along, I was just incorrect.

THE WITNESS: Right.

THE COURT: And then we can talk about how often it happens and what difference it would make.

But does it happen, or are you telling me it just never happens?

THE WITNESS: I always counsel people that there's a

chance of regret. And that we -- you know, that people don't always -- doctors or patients are not always able to foretell the future, and as part of weighing risks and benefits, and for every drug, for every prescription, for every intervention we make, there's a set of risks and benefits.

For many of those, the risks are actually far more common and far more severe, even than, let's say, going on a puberty blocker and then stopping the puberty blocker where, presumably, one would resume normal puberty, like the patient that I described his parents stopped.

So no intervention is risk free. And, you know, certainly there can be people who wished they had never had gender-affirming care. It's a small minority people, but it doesn't make their experiences any less valid.

But there's also risks and benefits to everything.

THE COURT: Yeah. I really wasn't getting into that.

THE WITNESS: That's what -- I'm just -- what I mean to say is, like, the present -- the fact that there are some people who may be coming later to testify, you know, of course, their stories are important and valid. But it doesn't -- when I'm providing care for people, I'm looking at, you know, risks and benefits, including the risk of regret. But that risk has just been very small in my -- you know, in my practice, in terms of numbers of -- you know, numbers of people.

THE COURT: Well, and that is a little different than

what I was trying to get at. But that's very much what I was going to ask you about next.

You're right, there are bad outcomes in almost any medical treatment. Maybe there are exceptions, but very few. Any kind of medical treatment, there's sometimes bad outcomes. And often the medical provider can put that in some kind of a percentage. So -- and we've all had these experiences. It's kind of a common experience. But I can tell you several that I've known people involved with.

So there's a procedure where you replace a heart valve in elderly people that's too old to crack open the chest and do it the old way, and you can run a heart valve up through the leg and push the old valve out of the way and put in the new one. And there's, of course, the risk of stroke and infection and various things. And they'll tell you before they do that look, here's our experience. We get -- you know, the average in the country of doing these are 6 percent infections, and we've got our rate down to 3 percent.

They can replace your hip, and they'll tell you, Look, the biggest problem you are going to have with this is if you get an infection, it's not good. And we are running about 2 percent.

For all of us that get old enough, at some point if you grew up in Florida, or you wind up with cataracts and they'll tell you, you know, 80 percent of the people come out of

this and do fine, and 20 percent are going to wind up with halos when you are driving down the road.

THE WITNESS: Yeah.

THE COURT: Percentages. Anybody got any percentages for how many folks that go through with puberty blockers lined up with bad outcomes or less than optimal outcomes? Anybody put percentages on any of this?

THE WITNESS: Yes.

So the Dutch have been following -- because they were the first people to really use puberty blockers for children with gender dysphoria, and so they've been following people for years. And they published some data that -- of people started -- who started on puberty blockers in the program who were followed for several years, that 98 percent of them were still on hormones.

And so the Dutch, of course, are very good, careful clinicians. Does that apply in every circumstance? You know -- but I think the percentages are very high of people who -- and particularly when we are talking about -- you know, we were talking about people on puberty blockers and then going to hormones. The percentage of people who stay on hormones is very high in the information that we have.

And the Dutch -- the number that the Dutch have is 98 percent.

There was, I think, a survey -- an American survey of

people who had gone off hormones at any point that was higher, but most of those people were people who went -- who had gone off hormones for other reasons, not because they weren't -- because of a change in gender identity. And that was not done as carefully as the Dutch who were just following their whole population longitudinally.

THE COURT: Questions just to follow up on mine, Ms. DeBriere?

MR. GONZALEZ-PAGAN: No, Your Honor.

THE COURT: Mr. Jazil?

MR. JAZIL: No, Your Honor.

THE COURT: Thank you, Dr. Karasic. You may step down.

THE WITNESS: Okay. Thank you.

(Dr. Karasic exited the courtroom.)

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Yes, Your Honor. Ms. Coursolle will be calling our next witness.

MS. COURSOLLE: Dr. Daniel Shumer, Your Honor.

(Dr. Shumer entered the room.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

Dr. DANIEL SHUMER, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name

for the record.

THE WITNESS: Daniel Evan Shumer, S-h-u-m-e-r.

DIRECT EXAMINATION

BY MS. COURSOLLE:

Q. Thank you, Dr. Shumer.

Can you share your profession with the Court, please?

A. Yes. I'm a pediatric endocrinologist.

Q. Can you please summarize for the Court your education and training?

A. Certainly.

I did my undergraduate and then continued medical school at Northwestern University. Afterwards I was a pediatrics resident at the University of Vermont in Burlington. I stayed for another year as for the chief resident. Afterwards I did a pediatric endocrinology fellowship at Boston Children's Hospital. And concurrent with that I received a master's of public health from the T.H Chan School of Public Health at Harvard University. And that completed my training.

Q. What is your current position?

A. I'm a pediatric endocrinologist at the University of Michigan. I'm the clinical director of the child and adolescent gender clinic at our Mott Children's Hospital at the University of Michigan. I'm also the medical director for something called the Comprehensive Gender Services Program at the University of Michigan, which is how that university provides care to the

transgender population in general, adult and pediatric.
Q. So what is your patient population overall at the University of Michigan?
A. Yes. So as a pediatric endocrinologist I don't only see patients in the Child and Adolescent Gender Clinic, but I do two half days a week, and then another half day a week I see patients in Type 1 diabetes clinic, and then another half day a week I see patients in general pediatric endocrinology clinic.
So I'm seeing patients with a whole cast of pediatric endocrine issues, about half of the time seeing patients with gender-related issues, the other part of the time other endocrine problems that children may have.
Q. What is the age range of the population -- the patient population that you see?
A. In the Child and Adolescent Gender Clinic, we are primarily seeing kids from maybe just before puberty or at the start of puberty on up to 18.
Q. And in your other clinics?
A. So other endocrine problems may occur in infancy or younger childhood. So, you know, kids with Type 1 diabetes is developed at that age. Other endocrine problems have more to do with infancy. So generally birth to 18.
In the -- my role as the medical director for the comprehensive gender services program, I help to coordinate the care for both the pediatric and adult population.

Q. Of your own patients, approximately what percentage comprise adults?
A. So I will oftentimes see patients as new patients that may be 16 or 17, for example, because they can't be seen on the adult -- in the adult clinics. And as they turn 18, I don't automatically just send them over to the adult clinic. I sometimes have a problem hanging onto patients too long because it's hard to say good-bye sometimes. So that 18- to 21-year age group is a time where we will talk about transition to adult care.

So I would say I don't have any patients probably older than about 22 that I personally take care of.
Q. And about what proportion of your patient population -- speaking of the patients to whom you're providing -- or you're seeing in the gender clinic, what proportion are prepuberty?
A. Well, of course, if a child is prepubertal, then they wouldn't require or be eligible for any medical intervention. So it's not very frequent that I'll see a young person, you know, much younger than the expected age that puberty starts.

Sometimes the parents of a young person, you know, maybe 5 or 6 years old, that patient may be referred to the pediatric gender clinic, and, you know, when a patient is referred, whether -- whatever age they are, the very first step is a triage phone call with our social worker.

And at that time the social worker gathers information

about, okay, Why were you referred? What are your goals and expectations for this referral?

The parents of a 5-year-old might say, you know, This is so new to us. We don't know where to turn. We'd like -- you know, we'd like to see you for assessment.

The social worker may then schedule that assessment but explain to the parents, You don't need to see a doctor, that -- you know, one of the nice things about prepubertal kids with differences in gender identity is they can just focus on being a kid and safely explore their gender identity, that seeing a doctor isn't needed. Sometimes those parents do want to see me to sort of learn a little bit more about the state of, you know, health care for their kid down the road, but it's kind of uncommon.

But I always am happy to see those types of families to just provide the reassurance that if their child does have a difference in gender identity, that they have gender dysphoria as puberty is starting, and that we'll be there to help. If they don't have gender identity at that time, then it was nice to meet you.

Q. Over the course of your career, how many people -- to how many people have you provided gender-affirming care?

A. I'd estimate somewhere between 4- and 500.

Q. And I think you said earlier that you do two half days a week in the gender clinic currently and two days in other

endocrine clinics.

Does that mean about half of your concurrent practice is comprised of gender-affirming care?

A. Yes.

Q. Will you summarize your professional affiliations for the Court, please?

A. Yeah. So I'm a member of the Pediatric Endocrine Society, and I'm a member of the Endocrine Society.

Q. Dr. Shumer, are you a member of the World Professional Association for Transgender Health, or WPATH?

A. I'm not.

Q. When you submitted your expert report in this case, did you submit a copy of your CV?

A. I did.

Q. And does that CV accurately summarize your professional activities and qualifications?

A. It does.

MS. COURSOLLE: Your Honor, Dr. Shumer's CV is Plaintiffs' Exhibit 360 in the stipulated exhibits provided to the Court.

THE COURT: That's admitted.

(PLAINTIFFS EXHIBIT 360: Received in evidence.)

MS. COURSOLLE: Great.

At this time we'd move to have Dr. Shumer qualified as an expert in endocrinology and specifically the treatment of

gender dysphoria.

THE COURT: Questions at this time?

MR. JAZIL: No questions, Your Honor.

THE COURT: You may proceed.

MS. COURSOLLE: Thank you, Your Honor.

BY MS. COURSOLLE:

Q. Dr. Shumer, what is puberty?

A. Puberty is a stage of life, basically where a child becomes an adult through a process of physical changes.

Q. And do clinicians think of puberty in any kind of stages?

A. Yeah. Oftentimes it's helpful for a doctor to specifically describe where a person is in puberty. There's, you know, changes in the chest, changes in the genitals, changes in secondary hair, and those can be described in Tanner stages.

Dr. Tanner was someone that came up with this system of describing puberty, I think in the 1930s.

And so, for example, Tanner Stage 1 means that there's no visible signs that puberty has started.

Tanner Stage 2 is the stage where there's the first sign that there's physical changes associated with puberty. So, for example, in someone assigned female at birth, the present of breast buds would be Tanner Stage 2. A small amount of pubic hair and testicular enlargement would be the first signs that someone assigned male at birth is in Tanner Stage 2.

3, 4, and then, subsequently, Tanner Stage 5 is adult

pubertal status.

Q. At what age does someone assigned female at birth typically reach Tanner Stage 2?

A. The average is in the 11 age range, but there's a range where it's considered normal for someone assigned female at birth to reach Tanner Stage 2 anywhere between -- around 8 to 13.

Q. What about for someone assigned male at birth? When does Tanner Stage 2 usually begin?

A. Averaging in the 11 and a half sort of window, but considered normal for someone assigned male at birth to start puberty anywhere in the window from about 9 to 14.

Q. As an endocrinologist, what is endocrine treatment?

A. So endocrinology is -- has to do with hormones. So endocrinology is the science of hormones. An endocrinologist treats hormone problems or hormone differences.

So I think a hormone -- people think they might know what the word means, but it really means any chemical that's made in a -- one part of the body but then circulates throughout the body and does something.

So the place where a hormone is made is called a gland. So, for example, endocrinologists take care of people with diabetes because insulin is a hormone. Insulin is made in the pancreas, which is a gland, and insulin goes throughout the whole body and has an effect on blood sugar.

Thyroid hormone is a hormone made in a gland called the thyroid, and that thyroid hormone goes throughout the body and regulates metabolism.

Testosterone and estrogen are hormones made in testes or ovaries that go throughout the body and have a variety of different effects on the body, including the development of puberty.

Q. What kind of treatments do you provide as an endocrinologist?

A. Most endocrine treatments involve assessing and managing someone that may have a hormone that's underproduced or a hormone that's overproduced, right.

So with diabetes -- Type 1 diabetes, we are treating with insulin because insulin -- that hormone is underproduced in Type 1 diabetes.

Someone with Graves' disease has hyperthyroidism. We are giving medicine to suppress down the thyroid hormone level.

When someone has precocious puberty, puberty that starts too young, we are using medications like GnRH agonists to lower hormone levels. When someone has delayed puberty, we would be using hormones to raise hormone levels, to get that hormone level into the normal range for a person that age.

Q. Are those treatments usually provided in the form of medication?

A. Yes, the majority of endocrine treatments, because we are

raising or lowering hormones to a goal range, involve giving medications to make that happen.

Q. How do endocrinologists determine that a particular medication is effective to treat a particular endocrine condition?

A. So I think there's two things there, right. So using the example of hypothyroidism, if someone has hypothyroidism, they have low thyroid hormone. Then they have symptoms related to hypothyroidism. So they may be tired, have trouble with sleep. They may be gaining weight. And we can measure that their hormone level is lower than normal. So by giving them medication like thyroid hormone, one goal is to bring the thyroid hormone level into the normal range and, second, sort of, I'd say, bigger picture goal is are they feeling better, are those symptoms of hypothyroidism improved with the treatment.

So I think as an endocrinologist seeing that patient in follow-up we're saying, Here's where the labs are showing. We are within the normal range. And how are you feeling? Are you feeling better since we started that treatment? And let's now reevaluate the plan. Is the prescription we prescribed the right dose? Do we need to make an adjustment? Do you still need treatment for hypothyroidism? How do we move forward?

Q. How do endocrinologists determine that a particular medication is safe?

A. I think that the job of physicians is to stay up to date on

available medical literature on a whole host of topics.

Every medication that is available for prescription in the United States has been tested through a process of FDA approval, and that process involves testing the medication on humans to determine safety profile so we understand the range of possible side effects, how frequent those side effects occur.

And so we have that information from a review of the literature and also, you know, review of the approval process for a medication.

Q. When you're looking at a particular medication and looking at the literature and the results of the FDA process you described, do those speak to the safety of the drug with respect to treating a particular condition, or is it looking at the safety of the drug overall?

A. Right. So I think that when the FDA approves a drug, it goes through a process of approval where first it's determined whether the medication is safe, what side effects are found when someone takes this medication and at what rates. And so regardless of what a medication is being used for, we have that information.

I think another part of the approval process for a specific indication is what is the outcome related to that particular indication. So, for example, I think we'll be talking a lot about GnRH agonist today. That -- we know that GnRH agonists, which have been referred to as puberty blockers, are medications

that endocrinologists use all the time for precocious puberty and in treatment of precocious puberty. We know exactly how they work; right? We know that they suppress the signals from the brain that tell the pituitary gland to send messages to the ovaries or testes and -- so subsequently those hormones are suppressed.

And we know from, you know, the process that those medications went through to get approval that they're extremely safe medications to give, that in precocious puberty they're effective at stopping puberty. And they also -- when taken away, puberty picks up where it left off. So we have, you know, decades worth of experience using that particular medicine and have a really clear safety profile of its use even prior to it being used for gender dysphoria.

I think that in -- when used in precocious puberty, the outcome is does it suppress puberty -- right? -- and the answer is, of course, yes, it does. It works very well.

I think when used for gender dysphoria, one question is does it suppress puberty, and, just like in precocious puberty, yes, it certainly does.

I think another question is, is this intervention then helpful for a person's quality of life -- right? -- does it reduce gender dysphoria over time. And so we can talk more about that later.

But the long and short of it is that the literature does

support the effectiveness in both logistically stopping puberty, but also -- probably the more important question, does that help.

Q. As an endocrinologist, do you ever rely on clinical guidelines?

A. I do.

Q. And who publishes those guidelines on which you rely?

A. Well, so I think we've been talking some about the Endocrine Society today. I think that for many endocrine problems that endocrinologists treat, there's a whole host of sources that we rely on for how to chose the treatments, you know, review of the literature. You know, when I'm treating someone with hypothyroidism, I don't have to go back to the literature anymore. I know the standard of care. I know how to adjust thyroid hormone doses.

But I think what the Endocrine Society has done in some of these, you know, maybe more common endocrine conditions have helped endocrinologists by compiling that data, organizing it for us, and then providing these recommendations called Endocrine Society Clinical Practice Guidelines.

Q. You touched on this a little bit already, but maybe you can expand.

When the Endocrine Society is developing those guidelines, do they consider the quality of the evidence when they're compiling the literature on which they -- that go into those

guidelines?
A. They do. You know, I think with all of these Endocrine Society Clinical Practice Guidelines, there is a section at the beginning which kind of goes through how they've assigned grades of quality and abundance of evidence based on their sort of systematic review before writing their recommendations, and then subsequently throughout the document they then are able to explain, you know, this is the -- both the amount and quality of evidence that we use to make this particular recommendation.
Q. We've already talked -- you've been here all day. We've talked a lot about gender dysphoria already.
So maybe just tell me briefly, as an endocrinologist, what is gender dysphoria?
A. I describe gender dysphoria as a difference between someone's sex assigned at birth and their current gender identity which also is causing distress to that person that's affecting them clinically in their life.
Q. And something we talked a little bit about already today. Do all transgender people have the clinical diagnosis of gender dysphoria?
A. No, not -- transgender is sort of an umbrella term to describe someone whose gender identity does not exactly match the sex they were assigned at birth. So you can have -- you can be transgender but not have distress associated with that.
Sometimes I find it helpful to sort of compare to another

medical problem which we may have more familiarity with, which is anxiety, right. So if someone says they're anxious, right, that's not necessarily a clinical diagnosis. But there are recommend -- there are descriptions in the *DSM* to diagnosis someone with clinical anxiety.

So someone could say, I'm an anxious person, but they don't have clinical anxiety. Then someone could have -- meet -- they could meet the criteria for clinical anxiety, and then what do we do about it; right? So there's lots of treatment options for anxiety. Some are nonmedical, and some are medical.

So if an adolescent has anxiety, they're going to meet with their family, with their mental health team, with their doctor, and they are going to say, Okay. We have this anxiety. The goal is to reduce the anxiety.

So we can do nonmedical things like seeing a therapist, or avoid things that make us anxious, or meditating. And we also have medical options like antidepressants, anti -- anxiolytics. So the right combination of nonmedical and medical approaches that young person, their family, and their health team would decide upon together, and enact that plan, and then continuously reevaluate the anxiety: Is it getting better? Maybe we modify this part of the plan and continue that relationship with the goal of continuing to reduce that anxiety.

So someone who identifies as transgender would be someone that says, I'm anxious, but they don't have a clinical diagnosis

of gender dysphoria unless they meet certain criteria. Someone may have gender dysphoria and meet that criteria that the previous witness was describing. And they meet with their parents, their mental health provider, their doctor, and they say, Okay. I think that -- let's try a social transition. And the goal of that would be, Does that reduce my dysphoria?

So someone may, you know, bind their chest, or use a different name or pronouns, or, you know, do any host of things that are nonmedical. And for some people, that might really help, and a lot of them feel more comfortable and confident in the world, and that person wouldn't necessarily need another intervention, wouldn't need to see me, perhaps, wouldn't need a medical intervention.

But for some people, their gender dysphoria is more significant or severe, or those nonmedical interventions have helped but not enough. They're still having a really challenging time, and then that's where discussion of what medical interventions are available, what are those risks and benefits of those interventions, making a decision with that adolescent and family about what to do, and then, just like any other medical decision, coming back together, reevaluating: Is this helpful? Is this working? Should we continue treatment?

THE COURT: Ms. Coursolle, let me interrupt you. We're getting a reflection. That skylight is probably not helping you.

MS. COURSOLLE: Yeah, I would appreciate that. Thank you, Your Honor.

(Pause in proceedings.)

MR. JAZIL: Your Honor, might I indulge the Court for a five-minute break?

THE COURT: Sure. Six minutes. Let's start back at a quarter to 4:00.

(Recess taken at 3:39 PM.)

(Resumed at 3:47 PM.)

THE COURT: Dr. Shumer, you are under oath.

Ms. Coursolle, you may proceed.

MS. COURSOLLE: Thank you, Your Honor.

BY MS. COURSOLLE:

Q. Dr. Shumer, there is no blood test for gender dysphoria, is there?

A. There's not.

Q. You mentioned -- sorry. Let me reformulate that question.

You mentioned earlier the criteria that are used to determine whether someone meets the standard for clinical gender dysphoria diagnosis; is that right?

A. Yes.

Q. So how do doctors determine whether someone meets those criteria?

A. Well, in adolescents, most pediatric gender clinics are what we call a multidisciplinary team. For example, in the

clinic that I work in, we have four medical doctors, a nurse practitioner, two social workers, a psychiatrist, and we work together as a team.

So when a patient is referred, as I said, the social worker does the triage phone call. And then the majority of the time the next step is a biopsychosocial assessment, as I think those words were used by the last witness. What that means is the social worker will meet with the child, meet with the parents, meet with the family all together, to really get a better understanding of the child's experience with gender identity, sort of the history of the evolution of understanding of gender identity as described by the child, what the parents have noticed along the way with respect to gender identity, how that gender identity is perhaps affecting them in their daily life, how it's manifesting in their world, and, of course, getting more information about any other medical or mental health problems that the individual may have, really understanding their social situation, where did they go to school, how is school going, who is in their family, who lives at home. Sort of a really comprehensive view of who this person is who is coming to see us for help.

And at the end of that assessment phase, the social worker is able to, number one, tell the team whether that person does, in fact, meet *DSM* criteria for the diagnosis of gender dysphoria, but then also provide that richness and subcontext

that's helpful for subsequent interactions with the team. For example, if that family is going to meet with me, then I know some of the issues that they've been thinking about, some of the challenges that the child may be facing. And it gives me a good idea of sort of where to pick up that conversation and whether or not the child may benefit from any medical interventions, what sort of questions that family might be coming in to ask me about.

Q. Is the bio -- I knew I was going to trip that up. Is the biopsychosocial assessment -- is that used to diagnosis any other conditions, in your experience?

A. Yeah. So I think that mental health professionals -- when I say "biopsychosocial assessment," I'm talking about bio meaning, you know, their medical and mental health history; psychosocial, more about how their mental health is interplaying with the world around them.

And so biopsychosocial assessment I think is really just a really careful and comprehensive assessment of a person for a variety of different reasons, right. So if there is a need for assessment for the potential diagnosis of a whole host of mental health disorders, the term "biopsychosocial assessment" is used to imply that a mental health professional is getting a thorough history and trying to determine if a person does meet a certain standard for a diagnosis.

Q. Something else that we talked about earlier today is the

idea of persistence and desistance with respect to gender dysphoria.

What is your experience with gender dysphoria persisting or desisting?

A. So I think this is a topic that requires sort of a review of what people are meaning by these terms, and also the literature, right.

So a person that's prepubertal, right, is -- a child is prepubertal all the way from birth until around, you know, 8, 9, 10, 11. It's normal for all children to explore the world around them, get to know who they are as a person, get a better understanding of lots of different aspects of their person, right, their gender identity, their likes and dislikes. Do they like to play sports? Do they prefer plays? Sexual orientation. Right. Childhood is a time of normal exploration and social learning.

And so it's quite normal for children to explore gender identity, even to, you know, go through phases of preferring this or that that may seem gender to parents. So exploring in that way is not gender dysphoria, right. It's just normal childhood.

If a child does meet clinical criteria for gender dysphoria of childhood, that -- that's something different, right, and that we do know that a child's gender identity isn't as predictive of their gender identity in adolescence and

adulthood, that there are some clues, certainly. And I think some of the work by Kristina Olson that was mentioned before, I think, and Diane Ehrinsaft's writing helps us to understand that there is a difference between "I feel like a girl" and "I am a girl," right.

Those are -- sound similar, but there's differences there is -- there's differences between "I feel like a girl" and "I want to change my name and I want you to call me she/her," differences between "I like dresses" versus "I'm not leaving the house without being in a dress," right.

So there's different levels of insistence, consistence, persistence through childhood of some of these things. So I would say that the kids that are very profoundly describing intense identification with the other gender, I do think that that is somewhat predictive of future gender identity. But kids that maybe are going through phases or trying on different hats when it comes to gender identity, I wouldn't say that's very predictive.

I think that, as has been pointed out, some of the desistance literature from the 1970s and '80s is using different denominators when we are thinking about, you know, rates of persistence and desistance.

But that being said, the nice thing is it actually doesn't really matter when it comes to making medical decisions, because regardless of what someone's gender identity is when they are 5,

6, 7 years old, there is no medical intervention that's being made at that time.

What's more important is what happens at the start of puberty, that a child's gender identity may become more intense, dysphoria become more intense, more debilitating as that adolescent now is starting to see physical manifestations of puberty: I know myself to be a girl, and I'm hearing my voice get deeper, and that's making me really upset.

You know, if you think about a -- someone assigned male at birth who is living their life as a little girl, you grow your hair; you wear stereotypical feminine clothes, and everyone sees you as a girl. Puberty starts; your voice gets deeper; your facial structure starts to change; your body shape starts to change. Those adolescents that now have intensification of gender dysphoria when those things are starting, that now is very predictive of continued persistent gender identity difference later on in adolescence and adulthood.

So, you know, we reference the Dutch. You know, the Dutch original papers were describing the onset of puberty not only as an important time because that would be the only time that you would need to start medication, right, because before puberty there is no hormones to suppress, but also a helpful diagnostic time, right. It's a time where maybe some of those feminine boys figure out that their feeling was a feeling of being gay, right.

But for those individuals, those adolescents that as puberty is starting, as those, for example, masculine features are emerging, they are feeling more and more distress and more and more certain of a female gender identity or, of course, vice versa, that that is very helpful and predictive of future gender identity persistence.

So the Dutch were still wanting to be cautious, right. Because, as we discussed, puberty does start when you are pretty young; 10, 11, 12 years old. And the Dutch were feeling like, okay, this is a time where we know we want to intervene medically, but ethically we also want to delay decision-making that has a more permanent on the body.

So that's where they came up with sort of the concept of using GnRH agonists -- which is a term that I use to describe puberty blockers, because that's the medical term -- and in so doing, preventing further development of an unwanted and dysphoria-inducing puberty, but also delaying decision-making about things like testosterone or estrogen until later adolescence when that adolescent has even more capacity for assent.

And so I think -- you know, when I think about the use of GnRH agonists, I think of it as sort of a conservative approach that we are saying, you know, even though your gender dysphoria is intensifying at the start of puberty, and even though that is a helpful predictor that this is your gender identity likely to

continue into adulthood, we still want some more time. And so GnRH agonists provide that time.

After several more years, gender dysphoria is still present. That person is still identifying -- no surprise, but still identifying as a gender identity different from their sex assigned at birth. Now the child is more capable of making a more informed decision, still with their parents, about the next potential step, which would be hormonal care.

Q. Dr. Shumer, you testified that you've provided gender-affirming care to hundreds of young people; is that right?

A. Yes.

Q. About how many of those -- to how many of those approximately have you provided GnRHa?

A. Probably about a quarter. Because I think that there's sort of two groups of patients primarily that are coming to pediatric gender clinics. One are patients who are coming in the peri-pubertal window, sort of at the cusp of puberty, or just after puberty has started, and then another relatively larger group of people that are not presenting to medical attention until later on in puberty.

So for those adolescents, if puberty has already happened, we are not really talking about GnRH agonists anymore. GnRH agonists are the most helpful for that age group where, you know, progression of puberty would potentially be devastating,

but we are at an age where we want to forestall decisions about hormones. I'd say about, you know, a quarter to a third of patients that I see are in that younger age group where the discussion of GnRH agonists is had.

Q. In your clinical experience with that population, what is your experience with your patients either persisting with their gender dysphoria or desisting?

A. So I think that -- first, I would say that there's a lot of people that are referred -- a wide variety of types of patients that are referred to pediatric gender clinics, right. There may be parents of young people who, you know, their child came to them, you know, relatively recently and is exploring gender identity, and they may see us, have an assessment, and don't meet criteria for having gender dysphoria, right.

There may be people who are adolescents who have more recently been thinking about their gender identity but were given more time to see where that gender identity goes.

However, I would say that patients that end up being diagnosed with gender dysphoria in that early puberty window who are eligible to receive GnRH agonists, the vast majority of them do persist with that gender identity into adolescence and adulthood.

Q. And you said the greater majority of your patient population are older adolescents, you know, transitioning into adulthood.

In your experience treating that population, what is your clinical experience with persistence and desistance?

A. Yeah. Again, I'm so fortunate to work with really smart mental health professionals who can get this really helpful assessment of these patients and families. But when that assessment yields a conclusion that someone does have gender dysphoria, that that gender identity is persisting across time and is causing that person significant distress or impairment, then persistence of that identity is by far the most likely outcome.

Q. I'm going to switch gears a little bit.

In your practice, Dr. Shumer, treating gender dysphoria, are there clinical guidelines you rely on?

A. Yes. So as has been mentioned, both the WPATH Standards of Care, Version 8, and the Endocrine Society Clinical Practice Guidelines, which has been discussed, don't disagree very much with each other, but, you know, were written in slightly different times, are primarily the -- sort of the guidelines that help you inform modern care.

Q. Do your colleagues rely on these guidelines as well, in your experience?

A. I'm sorry?

Q. In your experience, do your colleagues also rely on those two guidelines?

A. They do.

Q. When -- we've talked about this a little bit already here and there, but maybe we can be a little more systematic about it.

When you're treating patients with gender dysphoria, what is the course of treatment that you provide?

A. Yes, so as the endocrinologist, I'm primarily responsible for conversations about medical interventions. The rest of the team may also suggest interventions such as connecting with supportive therapists through transition, working with schools, you know, other supportive care.

But the conversations that I'm having have to do with, you know, medical options, including GnRH agonists, testosterone, estrogen, and discussing why those medications may be beneficial to a patient, what to expect if prescribed, what are some of the risks or side effects of taking these medications, and working with patients and families around those decisions.

Q. Is the care that you provide consistent with the Endocrine Society guidelines and the WPATH Standards of Care?

A. Yes.

Q. We've talked a little bit about GnRH agonists.

What are those exactly?

A. GnRH agonists are medications that suppress the hormones that come from the brain to tell the body to make puberty hormones.

So going -- taking a step back for a second, the

hypothalamus is a part of the brain that makes a signal called GnRH, gonadotropin-releasing hormone. GnRH is not produced in prepubertal years, and then as puberty starts, GnRH is now secreted in pulses from the hypothalamus. Those pulses tell the pituitary, another part of the brain, to make their hormones, called luteinizing hormone, LH, and follicular-stimulating hormone, FSH. Those hormones then tell the testicles or ovaries to make their hormones, testosterone or estrogen. So it turns out you need to make GnRH in pulses for the whole process to start.

So GnRH agonists are actually the same hormone, GnRH, that the hypothalamus is making, but instead of having it go in pulses, when you're giving it as a stable dose, you're messing up those pulses, right, and without the pulses, the pituitary doesn't make its hormones, LH and FSH. So GnRH basically is a hormone that's already in the body, just when giving it as a stable dose, instead of in pulses, the body no longer makes puberty hormones.

Withdrawing the medication takes away that stable dose of GnRH. The GnRH pulse generator then resumes and puberty continues.

Q. What are GnRH agonists used to treat?

A. It's actually several things that GnRH agonists are used to treat. Pediatric endocrinologists have been most involved using GnRH agonists both for gender dysphoria and also for precocious

puberty.

So precocious puberty refers to puberty that starts too young. If you're 4 years old and your body is starting puberty, you know, that's not good. There is something wrong there, and there's lots of reasons that you'd want to not continue to allow that child to go through puberty. They would go through a growth spurt but then stop growing and be very short, that -- they would have development of sexual characteristics well before all of their peers. So GnRH agonists have been a useful tool to treat precocious puberty for many decades.

GnRH agonists have also been used for other indications that you would want to reduce hormones, such as men with prostate cancer or women with endometriosis. These conditions, lowering the production of hormones in the body could help that particular condition.

So for all these conditions, GnRH agonists can be used to stop those signals and tell the body to stop making estrogen or testosterone.

Q. I think you said earlier that the effect of these medications are the same, the biological effects, whether they are used to treat precocious puberty or gender dysphoria.

Do I have that right?

A. That's correct.

Q. Are GnRH agonists considered medically necessary to treat gender dysphoria for adolescents?

A. They are. That's based on the body of evidence supporting the safety and efficacy of GnRH agonists in treatment of gender dysphoria as -- as sort of reviewed and summarized by the WPATH and the Endocrine Society, but also in my clinical experience seeing, you know, young people who are really suffering, adolescents that have debilitating gender dysphoria. Seeing the improvement in that gender dysphoria when provided the appropriate care informs me that GnRH agonists are part of medically necessary care for gender dysphoria.

Q. Are these medications considered experimental when they're used to treat gender dysphoria?

A. I do not consider GnRH agonists to be experimental based on the reasons that I just provided.

Q. What does the peer-reviewed literature say about these medications when they're used to treat gender dysphoria?

A. So there's a lot of ways to approach answering that question. I think that there's a lot of data that has been trying to understand how pubertal suppression works with regards to treating gender dysphoria.

Let's start with longitudinal data. So as has been previously referred to, the part of the world that has been using pubertal suppression as part of gender dysphoria management for the longest is The Netherlands, and in The Netherlands, they have documented the health and well-being of people -- of transgender individuals who are diagnosed with at

the time, you know, gender identity disorder, now would be referred to as gender dysphoria, and were treated with pubertal suppression followed by hormones and in many cases surgery and are now living as middle-aged adults.

And those people have been documented to have equal to or better-than-average quality of life compared to the general Dutch population, which is pretty remarkable, because we know how bleak the statistics can sound. When we're thinking about mental health outcomes for untreated gender dysphoria to have no differences between quality of life in these people that are now my age is quite powerful evidence.

There's other ways that investigators have approached these questions. So, for example, more short-term studies saying -- you know, comparing things like body satisfaction, quality of life, self-esteem, sort of before and after different elements of care, before and after pubertal suppression, before and after hormone provision. And those have also yielded in a variety of different documents reassuring results that, yes, in fact, there is -- these improvements that occur with this type of care.

Another way that you can approach this is by, you know, comparing different groups, right. So you can compare people that have had access to this care, people that for whatever reason have not, and there's a difference there with people having access to the care doing better in a whole host of these psychological parameters.

And then I think the final approach that I'd like to speak to is sort of a retrospective view of the question, so talking to adults who weren't being studied when they were first getting the care, but, you know, comparing adults who had access to, for example, GnRH agonists versus adults who when they were adolescents did not have access. And, you know, when comparing those people, you know, the ones that report that they did have access have better quality of life and mental health indicators, less suicidality, than people who did not have access to that care.

So the question you're asking has been approached from a whole host of different angles to compile sort of what we now consider the evidence base for the safety and efficacy of gender-affirming care, including GnRH agonists.

Q. We've heard a lot today about potential side effects that that these medications can have.

In your experience, what are side effects of GnRH agonists?

A. I would say the most common side effect of GnRH agonist is pain at the injection or insertion site, right. So primarily GnRH agonists are given as every-three-month injections, which can hurt, which can cause local irritation and pain similar to having your flu shot or any other vaccine, possibly based as an implant in the arm, so you can have pain from healing.

I think that one issue that has been brought up previously in this case -- in this trial has been, you know, this

discussion around bone health. So I think that deserves sort of a further explanation from an endocrinologist's perspective.

We know that every year a child's bones get stronger. From age 4, to age 5, to age 6, to age 7, every year the bones get stronger. An adolescent going through puberty, their bones get a lot stronger faster. It's those sex hormone, testosterone and estrogen, that cause the bones to get stronger even faster than they were before puberty started.

So if you take a 13-year-old, let's say, assigned male at birth and monitor their bone density, and then put them on -- measure their bone density, put them on a GnRH agonist, and measure bone density again at age 14, it will be stronger than it was at age 13, because they are one year older, but it wouldn't have gone through that spurt of getting stronger than it would have if puberty was going on, right.

Also, if you compare two 13-year-olds, one starting GnRH agonists and one not, and look at them when they're 14, the one that isn't is going to have a higher bone density score than the one that is on a GnRH agonist.

But the point here is that you don't continue GnRH agonists forever, that at some point you're going to go through puberty, whether it's because you're withdrawing the GnRH agonist and allowing the body to go through puberty itself or providing hormones for purposes of transition and treatment of gender dysphoria. In either one of those cases, you are going to have

that spurt of bone strengthening. And so we're delaying the growth -- the bone strength spurt, as I like to call it.

But, you know, if you compare people at age 22, now well past the phase where they may have been treated with GnRH agonists, there's very little difference in bone density at that point because now everyone has gone through puberty, some just a little later than others.

I think -- when I think about concerns about bone density, what are we really talking about here? We're talking about worrying that someone may develop osteoporosis as an older person and have a higher risk for fractures. So I've seen no reports of a whole bunch of transgender people walking around that have osteoporosis that were previously treated with GnRH agonists.

And so, you know, I think that it's, I think, appropriate to think about bone health when we're using medications to affect puberty, but I don't see GnRH agonists as having a significant risk for osteoporosis, which is really what it comes down to when we're talking about bone density.

I think another thing that -- that has been brought up previously is brain development, cognition, and, you know, I have trouble understanding this one myself, that -- you know, we know that people go through puberty at all different ages, right. So let's say someone naturally has delayed puberty. A 16-year-old assigned male at birth hasn't started puberty yet.

That 16-year-old is not going to score lower on an IQ test; they're not going to score lower on their exams or SATs compared to people that had early puberty or normally timed puberty. Puberty itself does not affect cognition in that way, and we don't have to test GnRH agonists to know that. We have examples because kids go through puberty at all different ages.

And so with that being said, you know, I haven't seen any literature sort of explaining why people would think GnRH agonists would affect cognition, nor have I seen any data to support that. And so I don't consider GnRH agonists as -- one of the side effects of GnRH agonists as affecting cognition.

Something that I think I've seen brought up in the expert reports from the defendants is something called pseudotumor cerebri, which is increased intracranial pressure. So pediatric endocrinologists are really used to talking about this topic because of one of the medications that we also use a lot called growth hormone. This is a side effect that is rare but can occur with the use of growth hormones.

So growth hormone seem to in some people, less than, I think, 1 percent, cause an increase in cerebrospinal fluid production, causing what we call spinal headaches. So this is something that happens for all sorts of reasons, but growth hormone can lead to an increase in intracranial pressure, which can cause headaches. The medical term for that is pseudotumor cerebri.

So I think last year there was a report from the FDA saying that six people have been recorded as having pseudotumor cerebri that were also taking GnRH agonists. I think five of them were given GnRH agonist treatments for treatment of precocious puberty and one for gender dysphoria. And so I think that that number six out of the many tens of thousands of people that have been receiving GnRH agonists seems very small, and I guess begs the question is it actually related to the GnRH agonist or is it not. Because you're allowed to have pseudotumor cerebri just for no good reason, so we would expect that maybe some people on GnRH agonists would have pseudotumor cerebri, true, true, but unrelated, right?

Subsequently, I think that Sweden is the country that reported their experience with their entire national database, but they did not have any patients with this side effect that were also being treated with GnRH agonists.

So it's something that I talk about with patients because the FDA put out this warning, but it's also something that I've never had the experience of a patient having myself, nor do I know any colleagues who have had that side effect in a patient that they've taken care of. It's also something that can be managed; right? You stop the medication; it gets better, just like pediatric endocrinologists are used to doing when that side effect happens with growth hormone treatment.

Q. You said you talk about that particular risk with your

patients.

Do you also talk to your patients about the potential bone density implications of GnRH agonists?

A. I do, sort of similarly to how I described it to you today, so they understand why there is discussion about this, sort of what the literature shows; yes, that someone on this medication will have continued bone strengthening to a less degree than people not on the medication. We expect catch-up.

So I have a very similar conversation with parents that I am -- and patients as how I described it to you today.

Q. And do you monitor the bone density of patients while they are taking GnRH agonists?

A. Yes. So patients that are at higher risk for fracture or that are known to have low bone density, we get serial DXA scans, or bone density scans. For everyone on GnRH agonists, just because this issue exists, or is being discussed, I monitor for vitamin D deficiency to make sure vitamin D and calcium intake are appropriate.

Q. We also talked about whether there are any effects of these medications on brain development or cognition.

Are those risks that you talk about with your patients?

A. You know, I think that I try to cover all the bases of what people may be hearing, especially recently in the media, that parents oftentimes come with really valid questions and maybe some misinformation. So in a very similar way to how I

described it to you today, I have that type of conversation with patients and families as well.

Q. Do you ever prescribe GnRH agonists to treat precocious puberty?

A. I do.

Q. Do you have these same kind of conversations when you use the medications for that purpose?

A. I do.

Q. Something else that has come up in this case is the potential for infertility.

Do GnRH agonists cause infertility?

A. GnRH agonists have no impact on fertility. That specifically turning off the signals in the brain to suppress puberty at this time, you know, don't have any direct impact on the ovaries or the testes.

So, no, GrNH agonists themselves don't have any impact on fertility.

That being said, I think fertility is a really important topic to talk about with patients and families, and something that I probably spend the majority of time discussing when I'm talking to patients and families, because it's probably the most complicated, that we do know that you do need to go through the puberty that your body makes, at least to a certain degree, to make sperm or make eggs, right.

So that if someone is coming to see me who is 16, right,

they have already presumably gone through puberty. And that person, let's say assigned male at birth, I talk to them about how -- you know, people that take estrogen, if they wanted to use their sperms later on, most of them would have to come off estrogen, wait for their sperm count to come back up, and they could try to use their sperm to make a baby. But for some people it might be harder.

Subsequent -- similarly, people that are postpubertal starting testosterone, we have many examples of people taking testosterone, deciding they want to become pregnant or use their eggs to make a baby, and they stop their testosterone and wait for their periods to resume, have the baby, go back on testosterone.

And so -- but there's maybe a subset that that's harder, that fertility becomes harder if someone is on long-term testosterone or estrogen. So for those postpubertal people there is a discussion we always have about, maybe, what are the options for fertility preservation, saving eggs, saving sperm, what that process looks like. So I talk to everyone about that.

For someone that is Tanner 2 at the beginning of puberty, it's not GnRH agonists that have any impact on fertility, but, at the same time, you need to go through at least some puberty to have that conversation about freezing eggs or freezing sperm.

So someone that went from GnRH agonists to testosterone, or GnRH agonists to estrogen, and never went further into puberty,

just sort of the idea, if someone does have persisting gender dysphoria, they wouldn't have had that opportunity to make that decision about preservation of sperm or eggs.

Now, presumably, even someone that went through that sort of -- that sequence of events -- pubertal suppression, hormones -- they still have testes or ovaries in their body. They could decide to come off of medication, allow their body to commence puberty, and try to use their body to make a baby. If that was unsuccessful, see a fertility doctor to get assistance with that. I think there is lots of options for trans people wanting to use their body to make a baby. As long as those gonads, testes, or ovaries are there, there's fertility potential, that only removal of the gonads makes someone permanently infertile.

So as a pediatric endocrinologist I'm not really discussing with anyone permanent infertility, because I don't do surgery. But I do talk about the fact that you do need to progress at least -- you know, a significant way into your own body's puberty in order to be able to produce those gametes that allow someone to produce biologic children.

Q. Have you ever prescribed GnRH agonists to people with other medical conditions beside gender dysphoria?

I'm sorry. That was a poorly worded question.

I just mean, you are prescribing the medication for the gender dysphoria, but the person also has other medical

conditions. Does that ever come up?
A. Oh, yes.
Q. Are there any other conditions that would contraindicate using GnRH agonists to treat gender dysphoria?
A. Well, I think -- as with any condition that I'm treating, I think it's really important to get a very complete medical history to understand what medical problems a person may have. But simply having another medical problem doesn't typically interfere with the decision to use GnRH agonists.

You know, I would say -- we talk about bone density. If someone already has osteopenia for whatever reason, for example, they had cancer and they needed chemotherapy and it made their bones week, you know, that would be a patient that I would maybe more concerned about really talking about what we know, what we don't know about the length of time that person would be on GnRH agonists.

But, you know, typically there's not, you know, hard-and-fast contraindications for GnRH agonists. But, again, knowing the complete medical history I think is just important in any discussion of medical decision-making.
Q. These medications are prescribed to minors. What is the informed consent process that you go through before you prescribe them?
A. So I think that in the course of this question and answer I've kind of gone through a lot of what I would talk about with

patients in that process. And I think as a pediatrician I'm sort of trained to explain these things, which are sometimes complicated, at an age-appropriate level and then ascertain whether the patient is understanding, what questions the patient may have, what questions the parents may have. And as I'm going into these conversations, you know, I know a lot about how the medications work; I know a lot about the risks and benefits as we've talked about, and I know a lot about that particular patient, but I'm not making that medical decision in a vacuum by myself, right. This is a relationship that I'm forming with the patient and their parents. We are working as a team.

And so at the end of that discussion, someone that would be prescribed GnRH agonists would meet the following criteria: That they would have a diagnosis of gender dysphoria, that my understanding of their gender identity and gender dysphoria would inform me that continuing into puberty would likely cause them significant distress, that the child understands why the medication is being prescribed and agrees that it would be helpful, and that the parents are making an informed consent decision with their adolescent's health in mind. And if all those criteria are met, then I would proceed to prescribing.

Q. And is that process you just described consistent with what's recommended in the Standards of Care?

A. It is.

Q. What is your own clinical experience prescribing GnRH

agonists to treat adolescents with gender dysphoria?

A. I mean, that's why I continue to wake up in the morning and smile to go into work, right, because, you know, I have the opportunity of meeting amazing kids and amazing parents every single day. Adolescence is a really challenging time in general, right, and that if you throw in gender dysphoria on top of that, then it can be really challenging. And when I have an adolescent coming to talk to me, they've also oftentimes been circling that appointment on their calendar for many, many, months. They are very nervous. They are expressing how they've been suffering, how they are not fitting in in the world because their body is changing in a way that is making them feel very uncomfortable.

And meeting parents that are there because they love and support their adolescent, and they're wanting to allow their adolescent to live the happiest, healthiest most fulfilling life that they can have.

But those stories are often quite painful. And one of the great things about my job is I get to see these patients back in follow-up and see them doing so well, and, you know, getting Christmas cards five years later from patients off at college and having that healthy, happy, productive life that they didn't think was possible when they first came. And it's because of gender-affirming care that that's the case. And I see that every day. And, you know, it makes -- makes me able to say

without hesitation that GnRH agonists are medically necessary, that it's complicated; we need to make sure we are performing assessments, really getting to know our patients and their families, really explaining these complicated things to them, but can have profound impact on the quality of the life of these adolescents.

Q. I'm going to turn know to ask you some questions about hormone therapy.

In the context of treatment for gender dysphoria, what is hormone therapy?

A. Hormone therapy is providing testosterone or estrogen in management of gender dysphoria for late adolescents or adults.

Q. Are these same medications used to treat any other medical conditions?

A. Yes. So many other medical conditions. But, you know, I would say maybe helpful in the context, there are patients with delayed puberty that would receive estrogen or testosterone to help start puberty, or patients that have a problem making testosterone or estrogen. So, for example, someone assigned female at birth may have ovarian failure and need estrogen in order to process through puberty normally. Or someone assigned male at birth may have testicle torsion where they lose their testicles and require testosterone to go through puberty normally. In those situations we're prescribing testosterone or estrogen in order to bring that testosterone or estrogen level

into the normal male or female range for that person's age so they are able to progress through puberty at an age-appropriate predictable path.

Q. In the context of using these medications to treat gender dysphoria, at what point in someone's development does that usually occur?

A. So I think that at early puberty we talk more about GnRH agonists, right. And then afterwards I think that there's been various discussions about when to discuss testosterone and estrogen.

You know, the very first Dutch clinics were using at age 16. That was the age that you're able to consent for care in The Netherlands in the 1990s, and I think that's why they chose that age.

I think subsequently providers understand that it's not so much an age that's important here, it's the individual case, right. So there could be patients that really need, you know, quite a long time on GnRH agonists before they're, you know, capable of making that informed decision with their families about testosterone or estrogen, and maybe the exploration of gender identity is more complicated. There's patients that are very straightforward, have been living as a boy for their whole life who are using GnRH agonists now, but as soon as I feel comfortable providing the testosterone, they are ready for it.

So really taking that individualized approach, understand

someone's needs, you want to provide hormones at an age that is appropriate for their understanding. Also, you wouldn't provide hormones at an age younger than their peers are going through puberty. So somewhere in that 13 to 16-year-old window is usually the time where we are having a discussion about whether someone might benefit from testosterone or estrogen.

And then, of course, people that present older than that, like in adulthood, we are not talking about GnRH agonists; we are talking about hormonal care.

Q. Are estrogen and testosterone considered medically necessary to treat gender dysphoria?

A. Yes.

Similarly to how I described GnRH agonists, the body of literature regarding testosterone and estrogen informs us that these medications are safe and efficacious. And then people in this field's clinical experience add to that, that without this intervention we understand that people with gender dysphoria would not improve and have worsening outcomes.

Q. Are these medications considered experimental when you treat gender dysphoria?

A. They are not.

Q. You mentioned that the literature suggests that these medications are safe. Do they have any side effects?

A. Testosterone and estrogen, because they are medicines, will have risks and benefits and side effects.

I'd like to first explain that whenever we are using -- let's take testosterone, for example. Whenever we are using testosterone as a medication, whether it's in someone assigned male at birth, someone assigned female at birth, we are trying to make that person's testosterone level normal for a male that age, right.

So if someone is 16 and lost their testicles in an accident, I'm using testosterone to bring that young man's testosterone level up to the normal range for a 16-year-old. If I'm using testosterone to treat a trans man who is 16, I'm bringing that testosterone up to what's normal for a young man that age in the same way.

And if we do that right, then some very predictable things happen. We call it the development of secondary sex characteristics: The voice gets deeper. Over more time the body gets more hairy, facial hair, body hair. Bones get stronger, muscles get stronger, maybe face becomes more masculine. All of those things are sort of the normal things that we would expect with any person going through a masculinizing puberty.

Are there side effects of going through puberty? Yes, right. I'd say the biggest complaint I get with testosterone is acne. That's because testosterone induces acne, both in people making their own testosterone, people given testosterone.

I'd also say that if you take more testosterone than you

need and have a testosterone level higher than normal for a man your age, then that's not good either, right. So think of the example of a baseball player who is abusing testosterone to hit more home runs, right. That person is giving themselves the whole bottle of testosterone instead of the right dose, and they are going to maybe hit more home runs, but they are going to have high blood pressure, put them at risk for diabetes. So more is not better.

But if I'm doing my job right and their testosterone level is normal, then we would really expect that person's risk for different medical problems to be very similar to other men, which might be different than other women. Men and women have different risks for different things. But if that risk is related to having a normal male hormone level, then I would expect that person to have the same risk for those medical problems as, say, brothers that they might have.

Q. You mentioned if you are doing your job right. Is there a monitoring that you engage in to ensure that those testosterone levels are appropriate?

A. There is. So prior to starting testosterone, it's recommended to -- and I do measure some baseline labs. So measure the testosterone level before we start. It's going to be low. Measure things like cholesterol and hematocrits, liver function to get a baseline, right. A patient then starts testosterone three months later.

At the follow-up appointment, I'm going to be first checking in on how things are going, right: What have they noticed on the testosterone? Does testosterone still feel like the right choice for them? Asking them very open-endedly -- right? -- because just like any other medical decision that needs to be reevaluated at each visit.

But then also are they noticing anything about the testosterone that they don't like or that they would consider side effects -- are they having bad acne, you know -- and then measuring the same labs that I got before they started to compare. I'm expecting the testosterone level to rise, but I'm expecting the other labs to be normal for a young man their age.

And I get the baseline labs because someone might have high cholesterol. Just because they have high cholesterol and if I only measured it after they started testosterone, I won't know if it was because of their own cholesterol problem or is the testosterone contributing.

So I'm using that lab and the clinical status and the patient's experience on testosterone then in potentially changing the dose or altering the plan in some way to continue to address the patient's gender dysphoria and continuing to do that in a safe way.

Q. We've talked about testosterone. What about estrogen? Does estrogen come with any side effects?

A. Yes, and I can explain it in kind of a similar way. With

use of estrogen, we're trying to raise the estrogen level to the normal female range for someone that age, and women have different risks for different things than men do simply because of estrogen, right? So woman are at higher risk for blood clotting problems. People with breasts are at higher risk for breast cancer. So -- and I would sort of expect that someone with a normal estrogen level for that age would have the same sort of risks as other women that age that are making the same amount of estrogen. So maybe they'd have the same medical risk as sisters that they might have.

So I think the examples that I tend to use with patients is, for testosterone, going bald, right. If you never started testosterone, the chances that you would go bald is very low, right. On testosterone your chance of going bald is probably very similar to all the other men in your family, right.

With people starting estrogen, while this topic isn't as maybe lighthearted as baldness, I think breast cancer is a good example. So if you take breast cancer as an example, women are at higher risk for breast cancer than men because women have breasts, and men typically don't. There are some breast glands in every person, and so some men have breast cancer but much, much lower than women. So that there's actually screening guidelines that women with breasts are supposed to have mammograms, I believe now, starting at 40. If there has been a history, it shifts to 35 or 30, and that men do not get

mammograms for a screening test because of the low incidents.

So someone on estrogen will develop breasts. Those glands will grow. And there is a study suggesting that transgender women that have been on estrogen have a higher risk for breast cancer than men and, it turns out, probably lower than cisgender women, so somewhere in the middle.

But I think that that kind of is a helpful example to point out that, yes, some medical problems are related to the hormones in our bodies, and that when we're using hormones to bring a person's hormone level up to what's normal for that gender's normal range that we expect that health problems might mirror women in their family more than men in their family, or vice versa.

Q. Do you do any monitoring when you prescribe estrogen to your patients?

A. I do, very similarly to testosterone: Get baseline labs, subsequent follow-up labs, and then as part of that assessment, in any return visit talking with the patient about her experience with being on estrogen, what is she noticing with regard to changes to her body, changes to her mood and mental health, any negative impacts that the medication may be having for her, and then measuring these labs to monitor for safety.

Q. Do testosterone and estrogen impair fertility?

A. So, again, that's a more complicated question and something that I do spend a lot of time talking to people about.

Let's think about testosterone first. So someone that is taking testosterone for an extended period of time, there's studies to suggest that if that person stops testosterone, say, in order to try to achieve a pregnancy, that 80 percent of people will have return of menses in six months. And so the -- then that person could then either try to become pregnant or see an OB/GYN doctor to retrieve eggs to use for a pregnancy. And there have been many, many babies born to trans men in a variety of those different contexts. And so, you know, I never think of testosterone as the end of the story for someone's fertility options.

Now, there may be a subset of people that being on long-term testosterone may make it harder for them to achieve a pregnancy and even a smaller subset that it may be impossible for them to achieve a pregnancy, just like there is a subset of cisgender woman that have a harder time becoming pregnant and a subset of cisgender women that are infertile naturally.

So I think that prior to starting testosterone, I make sure that the person knows that, yes, that there's still options, but that for some people, long-term testosterone may make it harder.

That for estrogen, right -- that taking estrogen lowers testosterone, lowers sperm count, and that people that would like to subsequently use sperm to make a baby would come off of estrogen. There would be an expected rise of sperm count and testosterone over time, and then they could try to use that

sperm to make a baby. But just like, vice versa, some trans women may have a longer time to return of fertility, and a subset may have failure to return to fertility, just like some cisgender men have infertility naturally.

So people assigned male at birth more than people assigned female at birth do opt for fertility preservation, saving sperm, because the process is more straightforward. But in both cases we counsel people that, you know, fertility preservation is an option.

Now, we don't think that either estrogen or testosterone has -- you know, it's not black and white, like everyone that takes it for a certain amount of time, there's no chance in even trying. There's studies, for example, of people who have had a hysterectomy and removal of their ovaries for gender-affirming reasons and their ovaries look healthy compared to -- they were comparing it to women with polycystic ovarian syndrome and hyperandrogenism, right. So some cisgender women have high testosterone levels just normally, naturally, and that's called PCOS. And when you look at the ovaries of women with PCOS who are -- tend to be -- have a hard time with fertility, their ovaries on the microscope look abnormal, but the ovaries of trans men look more normal. So that's, I guess, some evidence to suggest that there's not so much of this architectural change to the ovaries as a result of being on testosterone.

Q. Do you ever prescribe testosterone and estrogen for the

indication of gender dysphoria to people who have other co-occurring health conditions?

A. I do, yep.

Q. Are there any other medical conditions that would contraindicate prescribing these medications to treat gender dysphoria?

A. There's not many. I think that -- you know, just like our conversation with GnRH agonists, it's really important to get a complete medical history. You know, I think that sometimes that medical history may dictate differences in approaches.

So, for example, we think that -- you know, we talked a little bit about women have a higher clotting risk, right. So if a trans woman has a family history of blood clots, we might chose transdermal patches for estrogen rather than pills, because it seems like transdermal patches have an even lower risk for clotting problems.

You know, if someone is going through cancer treatment, for example, I might say, Okay. Well, you know what? Let's get through chemo first, and then let's talk about testosterone, right. So, you know, there's -- you know, I think putting -- putting this decision in context is what we're all supposed to be doing.

Q. When you prescribe these medications to minors, what informed consent process do you go through?

A. For testosterone and estrogen?

Q. Correct.
A. Yeah. So I think that -- sort of similar to my answer with GnRH agonists, basically it's a conversation very similar to what we're having right now, that we're going through what is known about why people might benefit from testosterone or estrogen, what to expect with taking testosterone and estrogen. I'm trying to get an understanding of what they understand with regards to those topics. I'm spending a lot of time talking about some of the risks and benefits, the side effects that we've talked about, and, similarly, assessing that person's capacity to understand that information, that they understand why the medication might be helpful for them, but they understand the risks of taking the medication, that they are then assenting to that decision, and their parents are providing the informed consent.
Q. Is that consistent with the Standards of Care?
A. Yes.
Q. And what is the informed consent process you go through when you're prescribing these medications to adults?
A. So it's very similar. That -- you know, I think the difference -- sort of the subtle difference in the WPATH Standards of Care is that the diagnosis of gender dysphoria in adolescents, it's recommended for that diagnosis to be made by a mental health professional with -- you know, with experience in gender dysphoria; that in adults, the diagnosis of gender

dysphoria may be made by a healthcare professional with experience with gender dysphoria, and that could be an adult endocrinologist.

Q. And is that process you described consistent with the Standards of Care?

A. Yes.

Q. What is your own clinical experience providing hormone therapy to treat gender dysphoria?

A. Maybe even more powerful than how I described the GnRH agonists, you know, one of my favorite types of visits is that three-month follow-up visit where patients are coming back after having been on testosterone or estrogen for the last three months, and, you know, my first question, which I've prepared them for as they left the first visit or the previous visit, was: The first thing I'm going to ask you after I ask you to verify what name and pronouns you're using is do you feel like the decision to be on testosterone or estrogen is still the right choice for you? Because like any medical decision, we need to reevaluate that at every visit.

But, you know, when I ask that question, I often see a light go off in these adolescents' faces: Oh, Dr. Shumer, absolutely. I can't believe, like, my grandma called me from California and she's like, your voice, your voice sounds different, and it made my day; right? And I'm feeling so much more comfortable doing X, Y, or Z, ordering a pizza -- I guess

people use an app for that now -- or going to school, or interacting with friends.

That -- that the -- that I have the privilege of watching adolescents who are withdrawing from life, failing school, not attending school, you know, having thoughts of self-harm, sort of unlocking the potential that I knew and their parents knew that they had inside of them, that they're now able to see a future where their life is happy and fulfilling.

And so I think that's my clinical experience in providing hormonal care for adolescents.

Q. Dr. Shumer, do you ever see patients seeking surgical interventions to treat gender dysphoria?

A. Yes. As a pediatric endocrinologist, I'm not really involved in decisions around surgery, but I certainly have patients that, you know -- and I ask patients, you know, what, if any, surgical goals they may have. You know, in the majority of cases, chest surgery and genital surgery are typically being reserved for patients that are over 18. In my hospital system, there isn't genital surgery offered for people younger than 18. But I -- I -- you know, I help to, you know, answer questions that they might have about what those surgical options are, but ultimately my job would be more to discuss, you know, the route that someone might go to pursue those services once they're 18 and ask the more specific questions to the surgeon.

MS. COURSOLLE: Your Honor, I know we're approaching

late in the day. I have maybe about 30 minutes left. Would you like me to finish up on direct?

THE COURT: It works if it works for everybody else. Yeah, let's see if we can't finish.

MS. COURSOLLE: Wonderful. Thank you.

THE COURT: If you get to a point where we're not making progress as fast as we could, we can start in the morning. It sounds like Dr. Shumer is going to be here in the morning either way, but if we can finish direct, that would be good.

MS. COURSOLLE: I appreciate that. Thank you, Your Honor.

BY MS. COURSOLLE:

Q. Dr. Shumer, in your opinion, other than the three types of treatment we've talked about -- GnRH agonists, hormone therapy, and surgery -- are there alternative treatments for gender dysphoria?

A. Yeah. So how I sort of described it at the beginning of my testimony, you know, I think that there's a variety of things that people do every day to help reduce gender dysphoria. They might not think about it as treatment, right?

You know, the clothes you pick out in the morning is treating gender dysphoria in some respects; right? But that -- you know, so there are some people that maybe have a difference in gender identity but, you know, are able to modify this or

that about their presentation to the world and don't require medical intervention.

Someone who has made a social transition and has experienced consistent, insistent, persistent distress that's impairing their life and is continuing to meet criteria for gender dysphoria, I don't see that degree of gender dysphoria resolving with alternative treatment besides the type of options that we've been talking about today.

Q. Dr. Shumer, are you familiar with the concept of watchful waiting?

A. I have heard that term before.

Q. What does it mean to you?

A. How I understand the term "watchful waiting" in this context is, you know, if someone has gender dysphoria even at the start of puberty, that allowing them to continue to go through puberty and continue to watch and wait and delay any medical decision-making until adulthood is an approach that some people advocate for.

Q. In your opinion, is that approach effective to treat gender dysphoria?

A. I don't find it to be effective, I think for a couple of reasons. One is that the process of continuing to go through a puberty that is causing distress seems to only exacerbate dysphoria for someone who clearly meets criteria for gender dysphoria.

But also, you know, not treating has risks and benefits as well; right? So a risk of not treating or, as you described it, watchful waiting is that you go through puberty and develop these secondary sex characteristics that do not align with your gender identity and likely never will.

All right. So let's say a trans woman who did watchful waiting throughout her whole adolescence and is now only, you know, embarking on treatment as an 18-year-old woman is going to have a very deep voice, is going to have large hands and a masculine face. All of that not only was very painful for her at the time it was developing but is now something that she's going to think about every morning: Are people going to, you know, see me as a woman because I don't -- I don't look as feminine as I feel inside? And that's because I went through puberty; right?

And so I think -- I think any medical decision, whether it's starting a medicine or not starting a medicine, has consequences.

Q. As you've described watchful waiting, Dr. Shumer, is that form of treatment safe to treat gender dysphoria?

A. So for the reason that I've just explained, I would not consider it safe.

Q. And you've defined watchful waiting as the waiting part of that to refer to waiting until someone has reached the age of majority to start treatment; is that right?

A. That's how I was referring to it. If you have a different definition, you know --

Q. I just wanted to make sure we're on the same page.

What is -- in your experience, what is the impact of not providing treatment, either hormone treatment or surgical treatment, to treat gender dysphoria for adults?

A. So I think that -- that someone with gender dysphoria is by definition struggling, right, and that -- that because we know that there's safe and effective treatment options that reduce that suffering, I think inability to provide that type of care leads to unnecessary suffering for that adult.

Q. A little earlier when you talked about sort of the range of interventions that people can use to treat gender dysphoria, you talked about mental health treatment psychotherapy that can be an appropriate treatment; is that right?

A. Yes. In fact, you know, I may have said I feel like every teenager could use a therapist, maybe every adult too.

And -- but certainly going through something like transition as an adolescent, I always recommend that you have sort of a non-parent, nonpartisan person to sort of, like, unload to every week or every other week is -- I think is helpful for anyone that -- that -- you know, I think that, for example, someone that isn't able to access gender-affirming care, working with a therapist to say, Okay, you know, here's what we know we might need, but we can't get it. How are we

going to cope? How are we are going to keep from killing ourself? Right.

So that type of therapy can be helpful, but it doesn't address the underlying issue of trying to reduce gender dysphoria.

So I think, for example, someone with gender dysphoria and depression and anxiety, right, you know, all of those things are allowed to coexist, right.

We think that -- an example that I like to use with patients and families is, you know, your depression and anxiety is like a loaf of bread, right, and this part of the loaf of bread is tied into your gender dysphoria. You know, this part of your anxiety and depression is really at the root of it because of this gender dysphoria that you are feeling. But you still got this part of the bread, right, that's totally separate anxiety and depression.

So if we are treating gender dysphoria effectively, this gets smaller, the loaf gets smaller; your anxiety and depression is now more manageable. And, you know, that -- that we can continue to work on with your therapist, right.

So -- but I think maybe in answer to your question, you know, monotherapy with psychotherapy in someone that has significant gender dysphoria, you know, may be helpful in keeping someone out of the psych ER, but really doesn't equate to a high quality of life.

Q. Dr. Shumer, are you familiar with the concept of conversion therapy?
A. Yes.
Q. And I should specify, conversion therapy relative to gender dysphoria?
A. Yes.
Q. What does that mean to you?
A. It means, you know, a mental health approach where the goal of the intervention is to help someone to change their gender identity.
Q. In your opinion, is conversion therapy an effective treatment for gender dysphoria?
A. You know, I'm not a mental health expert, but in my review of the literature on the subject, I would not consider conversion therapy to be an effective intervention strategy.
Q. Would you consider it a safe intervention?
A. You know, again, from my review of the literature, I have an understanding that many patients that have had attempts of that type of therapy have -- you know, have had poor outcomes. And so, no, I wouldn't consider it safe.
Q. I just have one more area of questions. I know we are all anxious to go home.

Dr. Shumer, in this case you have reviewed the medical records, or some of the medical records of our four plaintiffs, August Dekker, Brit Rothstein, Susan Doe, and K.F.; is that

right?
A. That's correct.
Q. And based on your review of those records, is the care that each of those plaintiffs received consistent with clinical guidelines?
A. Yes, it was.
Q. Do you have any concerns about the care that our plaintiffs received?
A. I don't.
MS. COURSOLLE: That's all my questions.
Thank you, Your Honor.
THE COURT: Mr. Jazil, I'll give you the option. You want to cross now or come back in the morning?
MR. JAZIL: Your Honor, I'll come back in the morning. It will be shorter.
THE COURT: And all the lawyers quickly figure out that by saying it will be shorter you always get to start tomorrow.
Thank you, Dr. Shumer. If you'd be back on the witness stand at 9:00 o'clock tomorrow morning.
Anything else we need to discuss before we break for the evening?
MR. GONZALEZ-PAGAN: Your Honor --
THE COURT: Dr. Shumer, you are welcome to step down. Thank you.

(Dr. Shumer exited the courtroom.)

MR. GONZALEZ-PAGAN: Your Honor, we can move some of the discussions to tomorrow, but we did want to have at one point a conversation with the Court, just an early conversation with the Court. Obviously, there was a bill that was signed -- that was passed by the legislature after our pretrial conference last Thursday that would establish the same rule in the statute. It is plaintiffs' intent to move to amend the complaint to include that into this case.

There really are no significant differences in what the trial would look like or -- but I think -- I just want to alert the Court about this conversation. The bill is not yet signed, and that's the trigger for us to have the conversation.

THE COURT: Well, I don't like making political projections, but my guess is that bill will be signed. And I'm not sure I know any of the details.

I know that -- I thought I knew that there was a bill signed that followed up on the rule that's at issue in the other case.

Did the -- does the bill also address Medicaid payment? Or by implication it would if it made it illegal to provide this service in the state, then the Medicaid issue kind of falls by the side.

But does the bill explicitly address Medicaid payment?

MR. JAZIL: Your Honor, it is Bill 254, Section 3.

Arguably addresses the Medicaid issues. There is a Subsection 2 that says a governmental entity or postsecondary educational institute, a state group health insurance program, a managing entity as defined in this particular statute, or a managed care plan providing services under Part 404.09, may not expend state funds as described in another statute for sex reassignment, prescriptions, or procedures, as defined in yet another statute.

So, Your Honor, the honest answer is I don't know what the prohibition on State funds necessarily applies to, because Medicaid funding is both state and federal funding. So I'm trying to get an answer to whether or not this is --

THE COURT: It's the state reimbursed by the fed, isn't it? But, whatever. Maybe not.

In any event, is there any reason -- nobody asked to consolidate this case with the other case, so I've started this trial as a Medicaid trial. It overlaps in a lot of respects. I'm not sure that there is going to be any evidence in the other case that's not already coming in in this case. But I'll be willing to listen to what either side says you want to do about the statute in the other case.

MR. GONZALEZ-PAGAN: Sure, Your Honor.

If I may, our -- for what it's worth, our intent is just to -- would be just to amend this case to have it be focused on public funding for reimbursement and stay within the Medicaid lane. It wouldn't be to attach the other parts of the

bill that affect the overlap of the BOM rule that are part of the Doe v. Lapado case.

THE COURT: I get it, but let me just tell you, there is a line of cases -- and this comes up, for example, in the billboard cases. You know, there's the billboard and there's the free speech problem, but there is some other regulation that you couldn't put that billboard up anyway. And that gets analyzed not as a same decision problem but as a standing problem.

And so you ought to think about and we should discuss the -- this problem.

We have this trial, and I make a ruling. And then the Eleventh Circuit says, All for not, because there's a separate statute that prohibits this service from being provided in the state of Florida anyway, so everything you addressed in that Medicaid trial didn't make any difference. And the way it would be articulated, at least on one view, is the plaintiffs aren't affected because they are not going to get care in Florida anyway.

And if it gets articulated that way, then the Circuit says that's a standing issue. And I haven't gone back and read it, but I think there is a case from maybe last week where I think a trial in a commercial case -- not anything to do with this -- they have a trial and the plaintiff doesn't prove damages. And the Circuit says there, Well, there was no

standing.

And, frankly, I kind of scratch my head and say, Wait a minute. There is a plaintiff putting on a whole lot of money and they had a trial before the issue was even resolved.

So let me just tell you, standing is a major issue in the Circuit, and we are spending a lot of time and a lot of effort and a lot of money to have this trial. And I've worked hard at it. And my plan is to work hard on it the next however many days we are in trial. But you may want to think about whether you really want to limit this trial to the Medicaid issue. And what's your answer going to be when you either win or lose and you're up in the Eleventh Circuit, and the first question the judge says is, How do we have jurisdiction? Why is there standing?

And if the answer is, Ah, shucks, because Hinkle worked really hard on this, that ain't going to get you there.

MR. GONZALEZ-PAGAN: No, of course, Your Honor.

So, first, I do want to address two quick points with regards to the standing and why we believe we should still move forward. But our intent is actually not to get to that, "ah, shucks" point and, in fact, to prevent that issue and situation.

So, first, we would posit that the statutory claim as to 1557 would still be live and standing. There has been care that has been denied in the past as a result of the rule, prior to the enactment of the statute. So that would still keep this

case as a live case or controversy.

But separate and apart from that, I would also note that --

(Reporter requests clarification.)

MR. GONZALEZ-PAGAN: 42 CFR 421.52.

While they're dire regulations under Medicaid, states do have to cover care that is not available within their state, if available elsewhere and actually pay for the travel of the Medicaid beneficiary to obtain that care.

All that said, however, our intent, actually, Your Honor, in raising this right now is that we would like to move to amend the complaint to include this statute, given that there would be really no difference in what the trial would look like if it were happening right now versus a month later, to avoid this issue going, "Ah, shucks," at the Eleventh Circuit, if you will.

THE COURT: But if I understood what you said earlier, what you want to amend is to challenge only the new part of the statute that prohibits payment of the care under Medicaid, not the part of my other case that challenges as unconstitutional the ban on doctors providing this care in the state.

MR. GONZALEZ-PAGAN: I'm happy to revisit with my team, Your Honor, but that is correct.

And the reason why is part A, the Medicaid aspect of this case, applies to both adults and minors. That other part

of the statute is only limited to minors. And even -- and as I mentioned under the Medicaid regulations, even if the care is not available in Florida, Medicaid does have to cover it when available elsewhere in the United States.

THE COURT: All right.

You object to the amendment?

MR. JAZIL: Your Honor, the bill hadn't been signed, so the amendment is premature, number one.

Number two, I think there is an added complication. If I understood it right, the plaintiffs have, in part, an animus claim. It's an animus claim rooted to how the rule was promulgated. If now the statute is the thing that is prohibiting the availability of care, I think the focus then shifts from the rule to the statute to look at the process.

THE COURT: Well, it does. I mean, I assume it's the same animus claim with respect to the statute now as opposed to the rule.

MR. JAZIL: The evidence was all, you know, directed at the rule with Jeff English, the process the State uses to promulgate the rule, et cetera.

THE COURT: Well, that was the evidence so far. The evidence is what's going to come in during the rest of this trial.

MR. JAZIL: Fair enough.

MR. GONZALEZ-PAGAN: For what it's worth, Your Honor,

if I may, I would just posit that when it comes to the animus prong of the claims that are at play, the trial is honestly focused on Your Honor's guidance on really the medical knowledge and *Rush v. Parham*.

The question of animus is really driven by, frankly, what would be considered more legislative fact finding by the Court. That is not -- it's not like we are calling in the Governor as a witness or anything like that in this case, nor do we intend to, nor would we in the other case, right?

And it wouldn't make any --

THE COURT: I never said animus wasn't an issue in the case. I addressed *Rush versus Parham* and the standards under the Medicaid statute. Your papers are full of references to animus.

MR. GONZALEZ-PAGAN: Yes.

THE COURT: Look, there's a -- I mean, I don't read the newspapers about this stuff with any care, but I see the headlines, and some of it just as it comes by. There was a legislator who on the -- was it a committee hearing that said, These people are mutants. I mean, animus is in the case.

MR. GONZALEZ-PAGAN: And again, a bit premature, but I would just posit that that doesn't prevent us from continuing with either the amendment or this trial. We could have separate truncated findings of fact of discovery with regards to just that question and proceed with the trial as is with regards to

the rest of the aspects, to the extent that my friend thinks that that question is different with regards to the bill.

We do -- I think we both agree that the trigger for us to amend has not yet come to pass. But once it does, we do intend to present the Court with a motion if -- for that effect. And we believe it would just be the most efficient way to deal with this, to meet the policies and the statutes of the State that deal with the same issue, one that has both come to pass, most likely during the pendency of this trial, and to preserve the resources, frankly, of all parties and the Court, given all the efforts that have been provided so far into this.

THE COURT: Well, I understand the amendment isn't timely until the new statute is signed. It seems likely to me that the statute will be signed.

I'm all for handling all of this in the most efficient way it can all be handled. I suspect that this case is not going to end in the district court. I will -- my ruling likely will make one side or the other, and perhaps both, dissatisfied in at least some respects. And one side or the other, or perhaps both, will wind up appealing. And so there will be a decision one day in the Eleventh Circuit, possibly in one of these cases, from one of the states where all this is going on, one day in the Supreme Court.

I view a major part of my job to compile a good record, at least as good as you folks bring and as well as I can

do it on this side. I'd like to do that as efficiently as I can. I'd rather not repeat stuff unnecessarily.

I mean, I don't know that Dr. Karasic would say anything different testifying in the other trial. I don't know that Dr. Shumer would say anything different in testifying in the other trial. By the other trial, I mean the trial of the new case, the one dealing with the medical profession -- or the prohibition in the new statute.

Now, there are all kinds of ways to deal with that. I may be wrong about that. There may be particular things they would say so that we need to have a trial in the other case and bring them back. But even there, to the extent we can treat testimony here as admissible and admitted there, that probably makes sense. But you should both be thinking about how best to get this presented.

I don't think it's a good answer just to say, Well, we're not going to amend the complaint. And so we just put things off, and we don't do any coordinating. Amending the complaint strikes me as fine. Mr. Jazil may persuade me otherwise, but it strikes me as probably just fine to amend the complaint, to go forward with the trial. If there really are new things that we can't get all presented -- one nice thing about a bench trial is you don't have to worry about bringing jurors back or whatever. If we just try this case as thoroughly as we can try it and keep the record open if we have to bring

back some other evidence a couple weeks or even a month or a couple of months down the road, that can be done. You've got everybody scheduled. So it seems to me that if we can make it work to keep on the schedule we have now and bring in all the witnesses on the schedule we have right now, that makes sense to do that.

And then you ought to talk about the other case and whether there is really anything different in the other case. I referred to a comment that I saw in the paper having been made, but the truth is those kind of comments really don't amount to much. What really matters is -- more is what was passed and if there's any history of what was introduced and how it got changed. That probably makes more difference than what one legislator said. You know the kind of things that go in and get properly considered on that kind of an issue and whatever else. There may be other testimony or other experts.

But if you can talk to each other about how much of this trial we can preserve for that other case, and then the possibility is to take the evidence we have now -- and if you want to wait and try the other case, it seems to me it shouldn't take very long because most of it is right here. But if we want to try the other case, consolidate the records, treat the two cases together and get a ruling at that point, that's the kind of thing we can do.

I'm very flexible on all of this. I'd like to do it

as efficiently as we can. If I can write one opinion instead of two, that's certainly okay with me. There will be a lot of overlap.

But you must have been thinking about this some because you knew this statute was in the works. We talked about it briefly at the pretrial, and everybody just wanted to keep marching as we are, and so that's why we're here.

MR. GONZALEZ-PAGAN: Yes, Your Honor, we're happy to have all of those conversations, and we do agree that efficiency here would be welcomed.

Just briefly, there's a small overlap between the team representing the plaintiffs in the other case and our team, but --

THE COURT: That's right. It's a different set of lawyers.

MR. GONZALEZ-PAGAN: It's a whole different set of attorneys, so -- but we're happy to talk to that -- plaintiffs' counsel in that case, and my colleague Simone Chriss is on both cases.

THE COURT: I'm sorry. I forgot that. I wouldn't have been talking about their case so much without them here if I had recalled.

You're in the other case?

MR. JAZIL: Yes, Your Honor. And the lead counsel for the plaintiffs in the other case is in the gallery as well.

THE COURT: All right. So I haven't talked too much behind your back.

All right. Well, all of you talk and see how you want to do, but the plan as of now is to just keep marching. So I'll be here at 9:00 in the morning, and we'll have Dr. Shumer on the stand, and we'll keep going with it.

MR. JAZIL: Your Honor, I just highlight for the Court -- I mean, if we're working through the *Arlington Heights, Greater Birmingham* factors, the sequence of events leading up to the passage of what -- the rule or the legislation, I think the focus does change a bit, the thing that we're looking at if we have a process claim. And, again, the State's position is under *Rush v. Parham* there is no process claim, but I understand --

THE COURT: Yeah, I have to tell you I find it -- curious may not be the right word. You're all up in arms because WPATH won't tell you how they adopted their standards, but you don't think the State of Florida ought to tell us how they adopted their rule. It seems to me that one can argue that how the State of Florida did it ought to be fair game, but how WPATH did it doesn't matter. But I think it's a whole lot harder to make the argument that how WPATH did it needs to be looked at under a microscope, but how the State of Florida did it doesn't matter. That seems to me to be a very hard argument.

MR. JAZIL: I understand, Your Honor. I'm simply making that argument under the *Rush* paradigm. Under the Equal

Protection paradigm, if we're using the *Arlington Heights* framework, that is all fair, and it is what it is.

THE COURT: It is what it is, yeah.

All right. Well, we've probably gone as much on this as we can. We'll keep going with it. But keep me posted. I'll go back and read the bill so that I've got a better idea of this, and we'll see where we go. My goal at least is not to have a trial that winds up being meaningless, so -- and that's probably everybody else's goal.

I'll see you at 9:00 in the morning.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

(Proceedings recessed at 5:26 PM on Tuesday, May 09, 2023.)

* * * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy is noted within the transcript.

/s/ Megan A. Hague 5/9/2023

Megan A. Hague, RPR, FCRR, CSR Date
Official U.S. Court Reporter

I N D E X

E X H I B I T S

EXHIBITS	OFFERED	RECEIVED
ECF NO. 219 -- All exhibits listed in ECF 219 are admitted	17	17

PLAINTIFFS' EXHIBITS	OFFERED	RECEIVED
359	22	22
360	178	178

PLAINTIFFS' WITNESSES

Doc. 224

Dekker v Weida: 4:22-cv-325

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
v.	)	Tallahassee, Florida
	)	May 10, 2023
JASON WEIDA, et al.,	)	
	)	9:01 AM
Defendants.	)	Volume II
_____	)	

TRANSCRIPT OF BENCH TRIAL PROCEEDINGS
BEFORE THE HONORABLE ROBERT L. HINKLE
UNITED STATES CHIEF DISTRICT JUDGE
(Pages 251 through 507)

Court Reporter: MEGAN A. HAGUE, RPR, FCRR, CSR
111 North Adams Street
Tallahassee, Florida 32301
megan.a.hague@gmail.com

Proceedings reported by stenotype reporter.
Transcript produced by Computer-Aided Transcription.

APPEARANCES:

For Plaintiffs:

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.com
120 Wall Street
19th Floor
New York, New York 10005

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JENNIFER ALTMAN
Attorney at Law
jennifer.altman@pillsburylaw.com
600 Brickell Avenue
Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall
Suite 1800
Sacramento, California 95814

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorney at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DEBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

APPEARANCES (continued):

For Plaintiffs (continued):

National Health Law Program
By: CATHERINE ANNE MCKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

For Defendants:

Holtzman Vogel Baren, et al.
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street
Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(Call to Order of the Court at 9:01 AM on Wednesday, May 10, 2023.)

THE COURT: Good morning. Please be seated.

Dr. Shumer, you are still under oath.

Mr. Jazil, you may proceed.

MR. JAZIL: Your Honor, a housekeeping matter before we get started.

THE COURT: Sure.

MR. JAZIL: I spoke to my friend Jennifer Levi who is the lead lawyer for the plaintiffs in the Doe v. Lapado case, and I spoke with my friend Omar Gonzalez-Pagan about the issues we raised yesterday. And my understanding, Your Honor, is in the second case, once the bill is signed, the plaintiffs will be moving for TRO. They will also be amending their complaint to list the various State's attorneys as defendants in the case, because of one of the provisions in the bill that deals with criminal liability.

So as we were working through the issues of can this be a trial that addresses both cases, one of the issues that came up is the State attorneys will have to decide for themselves whether or not they want to cross-examine certain witnesses, et cetera. So that's a complication we're working through.

Anything else?

MR. GONZALEZ-PAGAN: As I said for plaintiffs, Your Honor, we have no problem conceptually with consolidating the evidence for both cases, as the conversation was happening yesterday, keeping the record, if you will, open.

We do have conceptually issues about having to, like, bring back experts to be reexamined, if you will. The testimony is not really going to change. And, of course, our plaintiffs are not suing the State's attorneys.

So --

THE COURT: All right.

MR. GONZALEZ-PAGAN: -- we are trying to work through those issues. I don't think there's a proposal to present to the Court right now.

THE COURT: We can do that other than when we've got a witness ready to testify.

I will say I looked briefly -- we'll address it. I think you have a real standing issue in this case. I looked at your provision about the obligation to pay for care rendered out of the state. If the State, indeed, had an obligation to pay for service out of state when it's not available in state in circumstances like these, it seems to me that would solve the standing problem.

At least on first look, I don't think the pay out-of-state provision applies in these circumstances. So you need to look at that. We can take that up, but let's -- none of

that is going to affect Dr. Shumer's testimony or the cross-examination, so let's take that up not on Dr. Shumer's time.

I think we do have the preliminary injunction in the other case, and we talked about getting that set. I recall your responses may be due, what, later this week?

MR. JAZIL: The 15th, Your Honor, Monday.

THE COURT: So that must be next week.

MR. JAZIL: Yes, sir.

THE COURT: And then we were going to deal with it after that. And at least in that case -- there is standing for at least some of the plaintiffs certainly in that case. So we'll have issues to address. In the meanwhile, let's keep -- let's keep going.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good morning, Dr. Shumer.

A. Good morning.

Q. Yesterday you testified that you're an endocrinologist; right?

A. Yes.

Q. And as an endocrinologist, you follow the Endocrine Society's guidelines for treating gender dysphoria; right?

A. Yes, the Endocrine Society Clinical Practice Guidelines are certainly a tool that I rely on for providing this type of care.

Q. And, Doctor, you should have in front of you an exhibit that's marked DX24.

Would you mind grabbing ahold of that?

And are those the guidelines?

A. Yes.

Q. And, Doctor, yesterday when you were testifying, it was my understanding that you deal mostly with the adolescent population.

Did I get that right?

A. That's correct.

Q. Okay. So let's go ahead and take a look at the adolescent recommendations in the Endocrine Society guidelines. If we go to page 7 of the document -- and I'm going by the numbers on the bottom right -- now here Section 2 lays out the guidelines for the treatment of adolescents; right?

A. Yes.

Q. Okay. So after each recommendation, there is a cross-filled circle. Do you see that?

A. I do.

Q. And do you know what the cross-filled circles signify?

A. Yes. I believe in the beginning of this manuscript --

Q. Well, actually, let me help you out there. Let's go to page 8 of this document, bottom right.

A. Yep.

Q. Now, you'd agree with me that one cross-filled circle

signifies very low-quality evidence?
A. Yeah. So here they are outlining -- I think they're very transparently outlining how they came to these recommendations based on the evidence they reviewed, right. So they're talking about how much evidence they reviewed and what they are calling the quality of evidence that they reviewed for each one of these specific recommendations or suggestions that they're making throughout the article.
Q. Okay. And one cross-filled circle, according to this, signifies very low-quality evidence; right?
A. Yes.
Q. And two cross-filled circles signify low-quality evidence; right?
A. Yes.
Q. Three cross-filled circles signify moderate-quality evidence?
A. Yes.
Q. And four cross-filled circles signify high-quality evidence?
A. Yes.
Q. So let's go back to page 7 where the recommendations are.
Doctor, you'd agree with me that not one of these six recommendations is supported by high-quality evidence; right?
A. Yes. I think that deserves some explanation about how one would have high-quality evidence.

Q. Your counsel can ask you about the explanation. Let's go through some of these questions first.

And you'd agree that none of them are supported by moderate-quality evidence?

A. Yes, sir.

Q. And five of the six are supported by low-quality evidence; right?

A. Yes.

Q. And one is supported by very low-quality evidence?

A. Yes.

Q. So I'd like to focus on the one, 2.5, that's supported by very low-quality evidence.

If you would take a minute to read that, Doctor.

Now, there is a portion in there that says: *There are minimal published studies of gender-affirming hormone treatments administered before 13.5 to 14.6 [sic] years. As with the care of adolescents greater than or equal to 16 years age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment.*

Do you see that?

A. I do.

Q. Do you agree that there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years?

A. So I think this is a very specific question, right. The

question is is there evidence in this specific age group providing gender-affirming hormones -- so this is separate from GnRH agonist. So there is more evidence outlining the use of hormones in people 16 and older and less below 16 in 2017 at the time of this publication; that's correct.

Q. Is that still the case?

A. Gosh. I think there's literature being published all the time, and I wouldn't be able to tell you, if they rewrote this recommendation, if it would still get one hash mark or two.

Q. And it says here that an expert multidisciplinary team should manage care.

Do you see that?

A. Yes.

Q. Now, you work on an expert multidisciplinary team at the University of Michigan; right?

A. Yes.

Q. And you called it the biopsychosocial team, if I got that right?

A. No. The biopsychosocial assessment is what the social worker on our team performs as part of our multidisciplinary team.

Q. I got it. And your multidisciplinary team at Michigan includes an endocrinologist, you; right?

A. It includes two pediatric endocrinologists, three adolescent medicine pediatricians, two social workers, one

pediatric psychiatrist, one pediatric nurse practitioner, a pediatric nurse, and medical assistants.

Q. That's a pretty big team; right?

A. I don't know. It's our team.

Q. Okay. And all of these people were good enough to be hired at the University of Michigan children's hospital; right?

A. Yes.

Q. It's one of the best children's hospitals in the world?

A. Thank you.

Q. So you agree with me, I take it?

A. Well, I don't -- I'm not sure we are rated in the top ten, but I'm proud to work there.

Q. And would you agree with me that a small subset of the transgender population that is dealing with gender dysphoria has access to a multidisciplinary team like the one you're a part of?

A. I would not agree.

Q. Would you at least agree with me that the WPATH guidelines and the Endocrine Society guidelines suggest that multidisciplinary teams like yours be the ones at the forefront of providing gender-affirming care to patients. Right?

A. That's one of the Endocrine Society's recommendations.

Q. Okay. Doctor, I'd like to move on to another issue, fertility.

You testified yesterday that puberty blockers have no

affect on fertility; right?
A. Correct.
Q. But you still talk about fertility issues with your patients before putting them on puberty blockers; right?
A. Absolutely.
Q. And the Endocrine Society guidelines actually advise you to do just that; right?
A. Well, as I explained, you know, puberty blockers themselves have no impact on fertility. But I think it's helpful as a young person -- and their family -- who go on puberty blockers to be aware of subsequent decisions that -- and how those decisions may impact fertility in the future.
Q. Understood.
And so, Doctor, would you also agree with me that almost all of the patients that start off on puberty blockers go on to using cross-sex hormones?
A. I would say a vast majority of the patients that meet criteria for GnRH agonist who are having persistent gender dysphoria as puberty starts continue to have that gender identity in later adolescence and do qualify for -- for gender-affirming hormones, although not all, which is sort of the point of the GnRH agonists.
Q. And so for this vast majority, as you described it, who go from puberty blockers to cross-sex hormones, is there an effect on fertility for that population that goes from puberty blockers

to cross-sex hormones?
A. Well, as I tried to explain, the fact of the matter is you do need to go through puberty using your own body, at least partially, to achieve fertility. So someone assigned male at birth needs to progress through puberty enough, maybe to Tanner Stage 3 to make sperms currently, although there are investigations about taking, you know, premature sperm cells out, but that's not where we are at today in science.

So, yes, a person assigned male at birth needs to go partially through puberty to achieve the ability to make sperms. A person that is assigned female at birth, in order to participate in the pregnancy, needs to go through at least some puberty to produce eggs for fertility. The combination of puberty suppression using GnRH agonists, then hormones, you know, is intentionally, as part of treatment for gender dysphoria, forestalling the person from going through puberty using their own body. However, the only time I would say a person has no fertility potential is if the gonads are removed.
Q. So there is an effect on fertility? Did I understand that right?
A. Well, I would say, for example, if someone is assigned male at birth, right, and they are starting GnRH agonists at Tanner Stage 2, and then they're starting estrogen in later adolescence and never have started male puberty, that person, you know, has been, you know, treated for gender dysphoria, let's assume doing

well, and then later in adulthood says, You know what? I'd like to use my sperm to make a baby.

Okay. So what would that person do? They would stop their hormones and allow their body to go through some male puberty. And so anyone with testes in place, there is a chance that they could achieve fertility coming off of those hormones, allowing their body to go through a masculinizing puberty to some degree. You know, that would be the route that person would take if they wanted to achieve fertility.

Q. All right. I understood that. You said anyone with testes in place could potentially use those testes to have a kid later on in life?

A. Right. So how --

Q. Let me --

MS. COURSOLLE: Objection.

THE COURT: Overruled.

Here's what we are going to do. We are going to talk one at a time.

And, Dr. Shumer, it will help if you just answer his questions.

THE WITNESS: Sure.

THE COURT: And it will also help if things that have already been well established in the record, we just leave it alone and go on to the next thing.

MR. JAZIL: Understood.

BY MR. JAZIL:

Q. So, Doctor, someone with testes intact can still have a child, but the chances of that person having a child are lower after that person has gone through cross-sex hormones; right?

A. Yes. I think there's a couple parts to that. One is being on prolonged estrogen, how does that impact the testes, right?

If -- is the chance of fertility -- if someone were to be on estrogen for ten years and then discontinue, what is that person's fertility potential compared to if that person never went through that process in the first place?

I don't know the answer to that. It may be lower, but presumably not impossible.

Q. Are you aware of literature that supports the notion that withdrawal of hormones can allow a natal male to have a child?

A. I'm having a hard time thinking about a specific article, but I have patients that have done that successfully.

Q. Do you recall an article by Alexis Light that you cited in your expert report that deals with this issue?

A. Yes.

MR. JAZIL: Can we pull up Plaintiffs' Exhibit 188, please.

Can we go to the next page on this.

BY MR. JAZIL:

Q. Is this the article, Doctor?

A. Yes. So just to clarify, we were just talking about a

trans woman. So this article isn't necessarily about that. But I'm happy to review this article with you if you'd like.

Q. Okay. So what's this article about, a trans man?

A. Yes.

Q. Okay. And can trans men also become pregnant?

A. Yes.

Q. And this is one of the articles that supports that notion?

A. That's the -- sort of the topic of this article, yes.

Q. And this is one of the articles you relied on in forming your expert opinion in this case?

A. I don't exactly remember why I cited this article or what sentence I thought this article was helpful in citing, but I do recall citing this article in my expert report.

Q. And let's just quickly go through this article.

The first section, *MATERIALS AND METHODS*, it says that it was a web-based survey.

Do you see that, Doctor?

A. I do.

Q. Under *RESULTS*, it says: *Forty-one self-described transgender men completed the survey*.

Do you see that, Doctor?

A. I do.

Q. The *CONCLUSION* says: *Transgender men are achieving pregnancy after socially, medically, or both transitioned.*

Do you see that, Doctor?

A. Yes.
Q. Now, if we go to page 7 of this article, the second full paragraph -- page 7 on the bottom, the second full paragraph on the right, *Limitations to the study...*, do you see where it says: *Our eligibility criteria screened for transgender men who had a successful birth, impeding generalizable to those who attempt to get pregnant and cannot and those who do not carry to term.*

Do you see that, Doctor?
A. Uh-huh, yes.
Q. So you -- this study that you cited, you'd agree with me that it limited its eligibility criteria to transgender men who have had successful pregnancies; right?
A. Yes.
Q. And it concluded that transgender men can have successful pregnancies; right?
A. Yes.
Q. And it did so relying on a survey of 41 people; right?
A. So I think that the study is talking about the results of these pregnancies. I think the idea that trans men can have pregnancies is not controversial. This happens thousands of times across the country, you know, throughout the years. So I think the -- you know, just last week a person with an unexpected pregnancy who is a trans man currently on testosterone came to our emergency room. The fact that

transgender men can become pregnant is well known. So when I talk to my patients on testosterone, I always tell them, Even if you are not having periods, testosterone is not birth control, and that, You need another form of birth control, because transgender men get pregnant all the time.

So I think that that is not up for debate, necessarily. I think this article is interesting because it's explaining -- providing more detail about the results of those pregnancies.

Q. All right. Let's move on to another issue.

Dr. Shumer, bone mineral density, as I understood your testimony yesterday, you said the use of puberty blockers does have an affect on bone mineral density because we are suppressing natural puberty; right?

A. Yes.

Q. And you discuss issues related to bone mineral density with your patients; right?

A. Yes, similarly to how I discussed it with counsel.

Q. So as with the discussion with puberty blockers, is the idea that once you get off of the -- let me ask a better question.

If you are on puberty blockers, you discuss bone mineral density. And do you tell your patients that once you withdraw from the puberty blockers that bone mineral density will recover to where it should be for the natal sex at that age?

A. Well, how I talk about it is that puberty is an important

time for bone mineral density accrual, and everyone is going to go through puberty in some form or another, whether it's withdrawal from GnRH agonists or a provision of testosterone or estrogen.

You know, I think that the data that I discuss is having to do with the fact that, yes, when someone is on a GnRH agonist, as I said, you continue to accrue bone strength but not at the same speed as you would if you were going -- if you were continuing through puberty.

Upon starting puberty, in one way or the other, we would expect an increase in bone density relative to the speed that it's accruing prepubertally. And we do have evidence of catch-up. You know, there's an article demonstrating relative catch-up by 22. And as I also pointed out, we don't have data to suggest that there's a bunch of middle age trans people that took GnRH agonist that are now having the outcome that we really care about, which is fracture.

Q. Okay. When you're having these discussions, do you also order tests to get a baseline of what their bone density is before you put them on the puberty blockers?

A. My practice is to do a bone density scan in patients that have higher risk for low bone density. I don't -- I don't feel the evidence is compelling enough to require a bone density scan for every person that I prescribe GnRH agonists to.

Q. And do other endocrinologists in your practice have that

same practice of not taking a bone density scan to establish a baseline unless there is some other reason to do so?

A. I can't speak for all pediatric endocrinologists. I think perhaps some do DEXA scans on every patient starting GnRH agonists, and some use, you know, their professional judgment based on what the outcome of doing that bone density scan would be.

So sometimes I think about it like this. Anytime I order a test, I want to know what I'm going to do with the result, right. So if someone has lower bone mineral density than average prior to starting GnRH agonist, what would that mean?

It wouldn't change the fact that that person is eligible for GnRH agonist, but it would make me, as an endocrinologist, more cognizant of the fact that we need to keep this person's vitamin D in the normal range, talk about calcium intake, and that we would, you know, perhaps follow up with subsequent DEXA scans.

Someone without risk for low bone density, you know, the utility of that assessment, in my opinion, wouldn't change practice. So that's why personally I'd get a bone density scan if there is a history of fracture or low BMI, but not in someone that I'm not expecting to have a low bone mineral density for the reasons that sort of we discussed.

Q. What about your patients who go from puberty blockers to cross-sex hormones? How do you -- do you keep track of their

bone mineral density by taking a scan and then monitoring it over time?

A. No, I don't, because at the time that they start hormones, at that point we know that bone mineral density accrual increases, and watching that increase on a bone density scan wouldn't change the decisions that I would make with that particular patient.

Q. And, Doctor, you said that you reviewed the medical records of the plaintiffs in this case?

A. Yes.

MR. JAZIL: Your Honor, I'd like to discuss with the doctor some of the medical records. I was hoping we could not present the material on the larger screens.

THE COURT: Okay. The public screens are off, and the display will be shown there to the lawyers and to me and the witness but not to the public.

MR. JAZIL: Can we go to Plaintiffs' Exhibit 235, please.

BY MR. JAZIL:

Q. Now, Doctor, do you recognize the name of the institution on the top left?

A. I do.

Q. It's an institution that in your estimation provides world-class health care in this field; right?

A. I think that it's an institution I used to -- I was trained

at, and I have a high opinion of the care provided there, yes.

Q. Understood.

MR. JAZIL: Can we go to the page Bates labeled 43?

BY MR. JAZIL:

Q. Doctor, I'd like you to take a look at the second paragraph.

It says: *If the puberty blockade is discontinued, then the body would mature and the female puberty changes would occur. The potential risks include the effect on bone mineralization and fertility.*

Based on your review of the medical records for this patient, do you have any reason to disagree with this statement?

A. No.

MR. JAZIL: Let's go to the pages Bates labeled 45 and 46, please.

BY MR. JAZIL:

Q. Doctor, I'd like you to take a look at the very last sentence that begins on page 45 and then goes onto the next page.

Now, this says: *The risks of the procedure/treatment that have been discussed with me are*, and then the sentence goes on to say: *Studies of long-term side effects in this population* -- in this population here we are talking about a natal female who is in Tanner Stage 2 -- *is limited and may include a potential negative impact on bone health, growth, psychosocial development*

(including exploration of gender identity) and future fertility.

Do you see that, Doctor?

A. I do.

Q. First let me ask you this, Doctor: You disagree that puberty blockers may have an effect on future fertility if given long enough, right?

A. So as I have explained, GnRH agonists themselves do not have an impact on fertility. I think that this -- the verbiage here is obviously this provider's sort of boilerplate risks and benefits statement that they've discussed fertility with the patient.

She's not saying in this that the GnRH agonists themselves cause infertility, but she's saying that she had, presumably, a discussion around the same topics that we've been discussing in this trial.

Q. Do you disagree with anything that's listed there as the general verbiage from this physician?

A. Well, I think in previous testimony we talked a little bit about psychosocial development, to the extent that that may imply the topic we were talking about of cognition or brain development. So my answer to that one, you know, that I previously discussed may make me disagree with that part of the statement. Otherwise, you know, I don't have strong feelings about disagreeing with anything else.

Q. Understood.

MR. JAZIL: Can we take that down and go to Plaintiffs' Exhibit 236B.

Which is also medical records, Your Honor.

If we can go to the page Bates labeled 708.

BY MR. JAZIL:

Q. Now, Doctor, these are the medical records for a natal male who is almost a Tanner Stage 2.

If we go to the bottom of the page, the physician's notes, it says: *We have discussed that blocker therapy is reversible, but may have an affect on future fertility if given long enough. Furthermore, future fertility will almost definitely be compromised once cross-sex hormone with estrogen is ultimately started.*

That sentence, *Furthermore, future fertility will almost definitely be compromised once cross-sex hormone therapy with estrogen is ultimately started*, do you disagree with that statement?

A. I do. That's not how I would put it. I think the nuance of how I described it would be more accurate.

Q. And then it goes on to say: *For now, I have advised that we get a bone age and baseline labs below.*

So when the physician there is talking about bone age, is that the scan that you were mentioning?

A. It's not.

Q. It's not?

A. No.
Q. What would that be?
A. What is a bone age?
Q. Yes, sir.
A. Bone age is an X-ray of the hand. It's looking at the growth plates to help understand how much more height growth potential a patient has. So it's often used by pediatric endocrinologists when evaluating someone with short stature, for example.
Q. And then for someone who is being put on puberty blockers, would you be concerned about their bone age, and would you measure it before putting them on puberty blockers?
A. So a bone age itself isn't something to be concerned about. It's a test to assess how much taller someone is going to be.

So I don't know how tall this person was or if there was concerns about this person's final height. But I'd get a bone age frequently if I'm being asked a question about how tall someone is going to be. In gender clinic I get bone ages more rarely, only if there is a question or a concern about someone's final adult height.

Q. Understood.

Doctor, a few more questions.

THE COURT: Before you go on, let me just say for the record, I think you misread one of those scripts. There was a reference to the one in red on the screen now. *Furthermore,*

future fertility, it says, *will most definitely be compromise*d. You read it as will almost definitely be compromised. And I'm sure the transcript will have what you read and not what it says here.

MR. JAZIL: Understood, Your Honor. I apologize. It was inadvertent.

THE COURT: I understand. It's better for your side the way it's actually written than the way you read it, but I just didn't want there to be a confusion about the transcript.

BY MR. JAZIL:

Q. Doctor, yesterday you talked with my friend about the *DSM-5*.

Do you recall that testimony?

A. Yes.

Q. But you're not a psychiatrist; right?

A. That's correct.

Q. And you've never made a diagnosis for gender dysphoria using the *DSM-5*, have you?

A. Well, I'm very familiar with the *DSM-5*. And making a diagnosis using *DSM-5* isn't very complicated. So if you meet this criteria, this one and this one, you have a diagnosis of gender dysphoria.

That being said, my role on our multidisciplinary team is not to perform that assessment. It's -- that part is being done by a social worker.

Q. Understood.

And, Doctor, you're a member of a group called Stand with Trans; right?

A. I'm not a member of a group. I'm on the advisory committee of that organization.

Q. Okay. And that organization that you are on the advisory committee of, it's an advocacy organization for transgender issues; right?

A. Yeah.

Primarily they organize support groups for trans youth and for parents of trans youth in southeast Michigan.

Q. But they also put out literature critical of state efforts to regulate gender-affirming care; right?

A. Well, fortunately there aren't a lot of state efforts to eliminate transgender care in Michigan, so I don't think they have been very active in that regard.

Q. Have you written anything for that organization that criticizes, say, the State of Arkansas for it's gender-affirming care approach?

A. I have written about legal efforts in Arkansas, but I'm not sure that was related to the organization Stand with Trans.

Q. Okay. Fair enough.

MR. JAZIL: Your Honor, I have no further questions.

THE COURT: Redirect?

MS. COURSOLLE: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MS. COURSOLLE:

Q. Dr. Shumer, when my friend Mo was asking you questions just now, you mentioned that the quality of evidence related to the Endocrine Society guidelines reviewing deserves further explanation.

What is that explanation?

A. Yeah. So I can -- I can understand consternation when one line in a long report says, This is based on very low-quality evidence. And I think the previous witness talked about this a bit, but I wanted to elaborate from my perspective that -- that the Endocrine Society, for example, publishes Clinical Practice Guidelines on many, many, different topics; congenital adrenal hypoplasia, thyroid cancer, adrenal insufficiency.

When you read all of those Clinical Practice Guidelines, they all start very similarly with an explanation of these hash marks, and then the multitude of very many suggestions and recommendations are all assigned different markers of quality that the Endocrine Society Clinical Practice Guidelines in this arena reads very similarly to all of these other Clinical Practice Guidelines, where if you have, you know, 35 different things, some of them are going to be higher or lower quality. And that quality means what type of evidence is that recommendation specifically being relied on, right?

So if you were going to give something four hash marks,

presumably that would be something that, for example, was subjected to some sort of double-blinded randomized trials, which, as we discussed, is not feasible in complicated medical problems such as gender dysphoria, but also such as many other complicated medical problems.

That -- the one here that was with the lowest, the one hash mark, was referring to a very specific question providing gender-affirming hormone care in this narrow age group between, I think, 13 and a half and 16.

So there hasn't been -- while there is maybe some literature about that, that literature isn't it as robust as the literature regarding 16 and up, for example, which isn't surprising to me. When I -- if I'm evaluating a 14-year-old and thinking about hormonal care, what I'm doing is, first of all, thinking about that person as an individual, looking at the literature to suggest is there relevant literature related to this specific patient that I'm seeing today? Is there literature -- more literature about 16-year-olds? Can I -- how does that literature relate to the question that I have in front of me; hormone care for a 14-year-old? Is that totally irrelevant because it doesn't talk about 14-year-olds, it's talking about 16-year-olds? Probably not totally irrelevant.

That -- you know, for that particular line to be higher, you would need to conduct another study that was specific to that age group, for example. And presumably that type of work

is continuing to be done.

None of those will ever be four hash marks, right, because we can never do the type of research in this particular field that would result in that, similarly to other Endocrine Society recommendation manuscripts such as this that are talking about very complicated, multifaceted medical problems that will never have four hash marks, but at least as a way for the reader to understand why the Endocrine Society made that particular suggestion or recommendation.

I'd also say that one hash mark is saying that, All right. We aren't assigning this a higher level, but we did review all of the data and we could have come up with one of two statements. One statement is, We recommend this or suggest this, and the other statement is, We do not recommend or suggest this.

So based on the review of the entire body of work, you know, while they weren't able to assign that particular item a higher score, rather than say, After reviewing all this, we don't suggest it, they said, After reviewing this, we do suggest it.

You know, I think that with any area of medicine more study and more literature is welcome. What I'm concerned about, though, in this particular field is that it may never be enough, right, for people that oppose gender-affirming care, that if we, for example, were able to do a randomized controlled trial where

we have 13-year-olds or, let's say -- let's say people at Tanner Stage 2 that are going to be randomly assigned GnRH agonists or no treatment, and hypothetically we could find people that would participate, right, because we wouldn't be able to find people that would participate, but let's say we did -- that what would the end point be? Would it be one year later how are we doing comparing these people to these people? We can do that. We could publish that. But then they would say, Well, that doesn't answer the question about how they are doing when they are 20, okay.

So let's continue this randomized controlled trial. Let's continue to treat these people from age 10 all the way to age 20 and say, You guys, you are going to stay in the control group and not receive any care for the next ten years, okay. And then we can publish data about how those people are doing.

And then they would say, Well, that doesn't tell us on how -- let's compare them on how they are doing as 50-year-olds, because that's what we really want to know, okay. So we are going to say, All right. This group, we are going to continue your hormones. This group, because you were assigned to the control group when you were 10, you are going to receive no care for your gender dysphoria until you are 50, but then you'll be done with the study. Then that's published, right.

I think that it's clear that that could never happen, right. But even then I think that people would still say

there's not enough high-quality evidence to support gender-affirming care. Not because there's not enough evidence per se, but because they have a problem with the care.

Q. Dr. Shumer, the type of theoretical study you just described, could that kind of study be blinded?

A. Of course not, because puberty is something that you can tell if you are going through or not.

Q. So it would be impossible to have a -- a blinded randomized control study of the effect of puberty blockers for that reason --

A. Correct.

Q. -- is that right?

A. Correct.

Q. You spoke with my friend about the effect of hormones on fertility. Are there any studies that quantify the effect of hormone treatment on fertility for people who receive hormone treatment for gender dysphoria? To your knowledge, of course.

A. Not that I recall.

Q. So there's some evidence that hormone treatment may impact fertility. Do I have that right?

A. Yes. So I think some of that we've reviewed, but I would say, yes, there is some evidence that hormone treatment can impact fertility.

Q. But we don't know the extent of that impact, in other words?

A. Correct.
Q. And some people who never receive gender-affirming care also experience infertility; is that right?
A. That's correct.
Q. You mentioned that you have clinical experience with your own patients who have received hormone treatment and have been able to achieve fertility.

Can you tell us a little bit about that?

A. Yeah. So, actually, just last week I was talking to a patient on estrogen who impregnated someone. And so our conversation was about becoming a parent. It was not an intended pregnancy, but the person was excited. They were in a relationship with a cisgender woman, and she's delivered a healthy baby.

So, you know, I think another just example of the fact that, you know -- that you can't use hormones as birth control, right, so I keep plugging away on that one. But also that, you know, everyone has different levels of fertility and infertility. And that -- that it is quite a complicated topic, right. That is complicated because we all don't know our life story, how it's going to unfold, who we are going to fall in love with, how we want to create a family. Of course, there is many options to create a family. But, you know, talking about fertility, you know, is a really personal and individualized thing. On top of that, everyone's individual capacity for

fertility is different. And everyone's response to these medical interventions that we are talking about is likely different.

So it's something that I think deserves sort of the breadth and depth of the conversation that I try to have with each patient, but it is not a topic that very well lends itself to black-and-white answers.

Q. Thank you.

You also spoke with my friend about using DEXA scans to measure bone density for people who use GnRH agonists.

When you use GnRH agonists to treat precocious puberty, do you ever order DEXA scans?

A. No.

Q. When you prescribe other medications that could impact bone density, what is your practice regarding DEXA scans?

A. Well, I think a DEXA scan is a test, and so it's a tool that one would use if you feel like knowing someone's bone density would be helpful in medical decision-making.

So I'd say the times where I use DEXA scans the most is someone with frequent fractures, right. So, as an endocrinologist, I might see someone who has, let's say, juvenile arthritis, and they've been on chronic steroids during childhood, and they've had some fractures. And the question that they are asking me is does this person need treatment with bisphosphonates to strengthen their bones? I might order a DEXA

scan to assess bone density. And then the DEXA scan, you know, comes back with the result -- zero is average. Negative 2 and lower is below average. Plus 2 or higher is above average. So if that person had a DEXA score of less than .2, then that might be an indication to start bisphosphonates, for example.

Q. My friend showed you the medical records of our two child plaintiffs in this case -- or some of their medical records.

The medical records that you were shown reflected the informed consent process that those two plaintiffs went through; is that correct?

A. Yes.

Q. And was that the informed -- is your understanding that that was the informed consent that the provider prescribing those medications reviewed with those plaintiffs's parents?

A. Well, it's what was in the medical records, so there may have been additional information verbally discussed with the family that I'm not privy to. But yes, it seems like it was included in the medical record as sort of an overview of the informed consent conversation that was had with that particular patient.

Q. In your opinion was the discussion of risks in those informed consent -- in that reflection of the informed consent conservative?

A. Yes.

Q. Why?

A. Well, you know, I think that it's hard to -- you know, some of the discussions that we've had about each of these topics, you know, I've spent five, ten minutes talking about the nuance, right. So when you're putting something in a medical record in a sentence, it's hard to distill all that nuance.

But I think, you know, for documentation sake, you know, the inclusion of those things implies that those types of discussions were had. But, like, for example, with -- including things like cognitive development, or however it was put for the first example, I would consider that conservative because the evidence for that particular isn't there.

You know, in a second case when it says most definitely, or whatever, would impact fertility, you know, I hoped to have conveyed the nuance that I would convey to patients, which is, you know, I would -- we consider that example to be conservative.

MS. COURSOLLE: Thank you, Dr. Shumer.

I have no further questions, Your Honor.

THE COURT: Dr. Shumer, you told us you're in clinic a couple of times a week.

You're also a medical professor?

THE WITNESS: Yes.

THE COURT: So part of your week is spent teaching medical students?

THE WITNESS: That's right.

THE COURT: Mr. Jazil asked you about the University of Michigan and your clinic and its quality; it's one of the good medical schools.

There are also a couple of schools in Florida that folks think highly of. University of Florida, University of Miami both had, I understand, gender clinics.

Are you familiar with those clinics at all?

THE WITNESS: Yes.

THE COURT: My understanding is they are now shut down. Do you know whether that's so or not?

THE WITNESS: I'm not sure. I would say that I've had a few patients from Florida that have come to Michigan for care because their grandparents live in Michigan. Usually people's grandparents live here and they live there, but I guess this was the other way around.

THE COURT: Have you talked with anybody about how that will shake out now that Florida apparently has legislation that would allow taking children away from their parents if they go to Michigan to your clinic?

THE WITNESS: Well, that's -- that makes me sick to my stomach, to be honest, because, you know, I just am really worried about the health and well-being of those kids. But it's also saying, you know, not only do we disagree with this particular evidence, but parents that may agree with it we think are committing some sort of child abuse.

And so, yeah, it makes me very worried about the health and well-being of children and families in that sort of situation.

THE COURT: Now, I haven't seen evidence on exactly your clinic or of the Florida -- University of Florida clinic or Miami. But my guess is nobody is going to disagree with the proposition that these are all very high-quality institutions that provide high-quality medical care in general. There will be a lot of disagreement about the care in this particular area, but all good institutions.

Here's a concern, and tell me what you can about this. The concern is the quality of care that you are providing with the team you've described may be different from the quality of care that someone gets from a single doctor in a single city in Florida where there is not a major medical research institution, and so that's a concern.

If care is properly provided in the University of Michigan setting or University of Florida setting, how does that compare to what may be provided in an individual city by an individual provider?

THE WITNESS: Yeah. You know, I would say that it's -- I think it's different when you are thinking about pediatrics versus adult. So I think, in general, most solo practice pediatricians, for example, aren't deciding that they are going to start providing gender-affirming care, because they

recognize that that care may be better provided in more of a multidisciplinary center. On the other hand, there's more, you know, family practice docs or internal medicine docs that are providing care to adult trans people sort of across the country.

So, for example, in Michigan, we have patients coming from all corners of the state. Just like Florida, it's -- we've got two peninsulas, not just one, but people coming from, you know, the Upper Peninsula traveling six hours to Ann Arbor for care. Virtual visits have made that a little easier for follow-up.

But I would say, if not all, the vast majority of adolescents receiving gender-affirming care are getting that care at -- at not necessarily universities, but centers with experience and centers of excellence.

You know, so I think that -- I agree with you that, you know, if I had -- if I had a transgender child, I would want to them to be seen by someone that was an expert. And, you know, fortunately, in -- I would also not say that that's not so different than other endocrine problems, right. So if I had a child with hypophosphatemic rickets and I lived in Florida, I might travel to Gainesville for care. Because that's a rare condition, I want to see an expert pediatric endocrinologist.

And so I think that is an important topic, but I also think that most kids are getting seen by people that are in this field because they are passionate about it, but they have also

taken the time to really become experts in providing the care.

THE COURT: Questions just to follow up on my questions, Mr. Jazil?

FURTHER EXAMINATION

BY MR. JAZIL:

Q. Dr. Shumer, do you know of colleagues who provide the same care kind of services you provide to transgender youths at the University of Florida?

A. I can't say their names off the top of my head, but yes, I have interfaced with colleagues at the University of Florida before.

Q. Have you interfaced with anyone, who provides the services you provide, here in Tallahassee, Florida?

A. I don't recall.

MR. JAZIL: Thank you.

THE COURT: Thank you, Dr. Shumer. You may step down.

(Dr. Shumer exited the courtroom.)

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

MS. McKEE: Plaintiffs call Dr. Loren Schechter.

(Dr. Schechter entered the courtroom.)

MR. GONZALEZ-PAGAN: Your Honor, if it's okay, the witness has requested to take a two-minute -- five-minute bathroom break, if that's okay.

THE COURT: Surely. Let's go ahead and take the

morning break. Let's take ten minutes, and we'll start back at 10:10.

(Recess taken at 10:00 AM.)

(Resumed at 10:10 AM.)

THE COURT: Please be seated.

Please swear the witness.

THE COURTROOM DEPUTY: Please stand and raise your right hand.

DR. LOREN SCHECHTER, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: Loren Schechter, S-c-h-e-c-h-t-e-r.

DIRECT EXAMINATION

BY MS. McKEE:

Q. Dr. Schechter, what is your profession?

A. I'm a plastic surgeon.

Q. Are you a board-certified plastic surgeon?

A. I am.

Q. Would you please summarize for the Court your formal education and training?

A. Undergraduate degree at the University of Michigan, medical degree at the University of Chicago Pritzger School of Medicine, and training in general and plastic surgery at the University of Chicago, and a fellowship in reconstructive microsurgery at the

University of Chicago.
Q. What is your current position?
A. Professor of surgery and neurology at Rush University Medical Center, and director of gender affirmation surgery.
Q. Do you have any additional role within the division of plastic surgery at Rush?
A. I serve as the patient safety officer for the division of plastic surgery.
Q. You mentioned gender affirmation surgery. In basic terms, what is gender-affirming surgery?
A. Gender-affirming surgery represents a constellation of procedures that are designed to align a person's anatomy with their gender identity.
Q. Is gender-affirming surgery performed to treat particular condition or conditions?
A. Performed to treat gender dysphoria.
Q. How long have you been performing gender-affirming surgery?
A. As an attending physician, since 2000, and also during my medical school and residency as well.
Q. Over the course of your career how many gender-affirming procedures have you performed?
A. Over 1500.
Q. What percentage of your current practice consists of gender-affirming procedures?
A. Approximately 90 percent.

Q. And what percentage of your patients who undergo gender-affirming procedures are under age 18?
A. Currently under -- under 2 percent.
Q. And how many would you say -- or what percentage would you say are under age 21?
A. Under 5 to 10 percent.
Q. Have you published any articles in peer-reviewed publications?
A. I have.
Q. About how many articles?
A. Approximately 70, perhaps a bit more.
Q. And roughly what percentage of those articles are related to gender-affirming surgery?
A. Approximately 15 percent, maybe 20 percent.
Q. Have you written any medical textbooks on gender-affirming surgery?
A. I have.
Q. Could you tell us what those are?
A. I've written for *Surgical Atlas* on *Surgical Management of the Transgender Patient*, published perhaps 2006 or 2017. Edited textbooks similarly on gender-confirming surgery.
Q. Are you one of the authors of the WPATH Standards of Care?
A. I am.
Q. Which chapter did you contribute to?
A. I was the co-lead author on the surgery and aftercare

chapter, Chapter 13.
Q. Are you involved in training other surgeons to perform gender-affirming procedures?
A. I am. I started the first fellowship in the U.S. in 2017, and regularly work with surgical residents, medical students, fellows.
Q. Do you have a leadership role in any professional associations?
A. I do. I'm currently on the executive committee of WPATH. I serve as treasurer of WPATH. I chair the finance committee for the American Society of Plastic Surgeons.
Q. What is the American Society of Plastic Surgeons?
A. That's a professional organization. Membership requires certification by the American Board of Plastic Surgery and represents plastic surgeons, both nationally and as well as internationally, international members.
Q. When you submitted your expert report in this case, you provided a copy of your CV; correct?
A. I did.
(Reporter requested clarification.)
BY MS. McKEE:
Q. When you submitted your expert report in this case, you provided a copy of your CV; correct?
A. Yes.
Q. And does that CV present an accurate summary of your

qualifications and professional activities?
A. Yes. There's probably been some more publications since then, but yes.
MS. McKEE: Your Honor, Dr. Schechter's CV is Plaintiffs' Exhibit 362 and is included on our list of stipulated exhibits.
THE COURT: That is admitted.
MS. McKEE: Thank you.
At this time I move to have Dr. Schechter qualified as an expert in plastic surgery, and specifically the surgical treatment of gender dysphoria in adults and adolescents.
THE COURT: Mr. Jazil, questions at this time?
MR. PERKO: No questions, Your Honor.
THE COURT: You may proceed.
MS. McKEE: Thank you.
BY MS. McKEE:
Q. So you mention you're a member of the American Society of Plastic Surgeons.
Are you a member of the American Medical Association?
A. I am.
Q. What about the American College of Surgeons?
A. Yes.
Q. What about the American Burn Association?
A. Yes.
Q. Do any of those four professional medical associations I

asked about engage in advocacy?
A. Yes, to those four and many others.
Q. On behalf of what or whom do those organizations advocate?
A. Typically on behalf of the patients for whom we care, as well as members of the organization.
Q. And in your experience do most professional medical associations engage in advocacy?
A. Yes, they do.
Q. Would you summarize for the Court the various gender-affirming surgical procedures that are performed?
A. So there are procedures on the face, often referred to -- or maybe referred to as facial feminizing or masculinizing; procedures on the chest or breasts, typically either mastectomy or breast reconstruction, sometimes referred to as breast augmentation; procedures on the genitalia, and procedures on the body.
Q. Could you give an overview of gender-affirming genital surgeries that you mentioned?
A. Pardon me?
Q. Could you give an overview of gender-affirming genital surgeries?
A. Yes.
So for transfeminine people, vaginoplasty. For transmasculine people, either phalloplasty or what's referred to as metoidioplasty, m-e-t-o-i-d-i-o-p-l-a-s-t-y, which refers to

lengthening of the hormonally hypertrophied or virilized anatomy.

Q. And what surgical procedures do you perform in your own practice?

A. I perform all of those procedures, less so face now. I have colleagues who specialize in facial surgery and craniofacial surgery.

Q. Are the various surgical procedures that are performed to treat gender dysphoria performed to treat other conditions as well?

A. Yes, they can be.

Q. And what other conditions is mastectomy performed to treat?

A. A mastectomy may be performed to treat breast cancer, it may be performed as what we call risk reducing or prophylactic, to reduce the risk of a person having breast cancer, may be performed for gender-affirming purposes.

Q. So other than when performed for gender-affirming purposes, have you ever performed a mastectomy to prevent or treat cancer?

A. Yes.

Q. And other than gender dysphoria, what conditions is vaginoplasty performed to treat?

A. Vaginoplasty may be performed for congenital differences, for cisgender women either born without a vagina or incomplete formation of the vagina; may be performed for oncologic reconstruction, so for cisgender women who have had portions of

the vulva or vagina removed for cancer; may be performed to treat traumatic deformities, infection, and gender-affirming.

Q. So have you ever performed a vaginoplasty to treat any of those conditions other than gender dysphoria?

A. Yes.

Q. And other than gender dysphoria, what conditions is phalloplasty performed to treat?

A. Similarly, it may be performed for traumatic reconstruction, oncologic reconstruction, congenital differences, infection.

Q. Have you ever performed a phalloplasty for any of those reasons?

A. I have.

Q. How long have surgeons been performing gender-affirming procedures?

A. Well, in the modern surgical history, really dates back to the 1930s. The first modern reports of vaginoplasty performed in Germany in Berlin in the 1930s. Subsequent to that, really, the father of plastic surgery, Sir Harold Gillies, performed the first phalloplasty procedure on a World War II veteran in the mid-1940s, using a series of flaps, tissue we transfer from one area of the body to another.

Sir Harold Gillies, actually in association with Dr. Ralph Millard, who had served as chairman of plastic surgery at the University of Miami, was a world-renowned plastic surgeon, also

performed a vaginoplasty in the '40s or '50s, again on a World War II veteran.

Subsequent to that, a gynecologist practicing in Casa Blanca, really credited with developing much of the modern basis, the surgical techniques that we use today, really still form the basis of those procedures.

We move forward to the '80s or so, and many of the more sophisticated reconstructive and microsurgical procedures were then performed for how we now create -- perform a phalloplasty.

Q. How does a doctor become a board-certified plastic surgeon?

A. So following graduation from medical school, entering an accredited residency; following that, passing written examination, and then an oral examination. And then to maintain one's board certification, there is a ten-year cycle, that we now refer to as maintenance of certification, requiring a variety of ongoing education efforts and tests.

Q. Is gender-affirming surgery part of the core curriculum in residency for a plastic surgeon?

A. It is.

Q. Is gender-affirming surgery a component of the written or oral board exams in plastic surgery?

A. Yes.

Q. And can gender-affirming surgery be a component of the maintenance requirements of a plastic surgeon?

A. It can, yes.

Q. I want to turn to talk about clinical guidelines.

Are there clinical guidelines for the surgical treatment of patients with gender dysphoria?

A. Yes.

Q. What are those guidelines?

A. Those are the Standards of Care, currently Version 8.

Q. When you say "Standards of Care," are you referring to the WPATH Standards of Care?

A. I am.

Q. When were those Standards of Care first published?

A. The first version was published in 1979. Prior to the 8th version, the 7th version was published, I believe, in 2012. The 8th version was released in September of '22.

Q. And do you practice in accordance with the WPATH Standards of Care?

A. I do.

Q. Do you regularly talk with other surgeons who perform gender-affirming procedures about those procedures?

A. Yes.

Q. And roughly how many surgeon who perform gender-affirming procedures would you say you regularly talk with?

A. Over 100.

Q. In what context are you having those discussions?

A. A number of different contexts: Meetings, seminars, conferences, collaboration in various clinical research

programs, patient care.
Q. Are all of the surgeons you are talking with based in the United States?
A. No.
Q. Where are some of those other surgeons living and practicing?
A. Throughout Europe, South America, Canada, Asia.
Q. And do most of those surgeons consider the WPATH Standards of Care to be the prevailing clinical guidelines for gender-affirming surgery?
A. I believe so.
Q. And, to your knowledge, do most of those surgeons practice in accordance with the WPATH Standards of Care?
A. I believe so.
Q. Under those Standards of Care, is surgery indicated for every patient with gender dysphoria?
A. Well, not every patient who is transgender or who has gender dysphoria seeks surgical interventions. Not every person seeks every possible surgical intervention and not every person is a candidate for a surgical intervention.
Q. Under the WPATH Standards of Care, is gender-affirming surgery ever appropriate for treatment for an adolescent under age 18?
A. It can be.
Q. Which surgeries are considered appropriate treatment for an

adolescent?
A. Overwhelmingly, mastectomy.
Q. Is general surgery ever considered appropriate treatment for a patient under 18?
A. In extremely rare situations it can be.
Q. Does the number and sequence of surgical procedures vary --
(Reporter requested clarification.)
BY MS. McKEE:
Q. Does the number and sequence of surgical procedures vary from patient to patient?
A. Yes.
Q. And based on what factors?
A. Based on patient factors, patient goals, patient expectations -- any number of factors -- ability to have time off work, depending -- or school, depending on the complexity and the nature of the procedure.
Q. Do the WPATH Standards of Care envision the surgeon working in a multidisciplinary manner to decide if a particular patient is a candidate for surgery?
A. It does.
Q. What kinds of providers can be part of that multidisciplinary team?
A. It can be surgeons; it can be medical professionals; it can be mental health professionals.
Q. In your experience, are any of those providers working as

part of that team ever in private practice?
A. Yes. And I was in private practice for a number of years.
Q. And when you were in private practice, did you still work as part of a multidisciplinary team for patients undergoing gender-affirming surgery?
A. I did. And we regularly -- I regularly work with professionals from around the country and around the world. So multidisciplinary doesn't necessarily imply that all of the professionals are housed, so to speak, under one roof. We regularly communicate and interact with people outside of our own institution, and I have done that throughout my career.
Q. Can you explain for us how the multidisciplinary process works?
A. Sure.

And so it depends, of course, on the individual case. But, for example, in my practice when I see someone in consultation, we'll meet with them, obtain a history and physical, listen to what their goals are; we'll discuss possible treatment pathways, which may mean no intervention, but we also discuss, if appropriate, relative interventions.

Subsequent to that and before making a decision to proceed with surgery, we'll obtain assessments. Those are typically assessments from mental health professionals, typically medical professionals as well. Those assessments are reviewed. If additional information is required or warranted, or additional

consultations, we'll obtain or request that. And then we'll, if appropriate, move forward with surgery.

Q. And under the WPATH Standards of Care and in your practice, does the surgeon make the ultimate determination as to whether to proceed with surgery?

A. Yes. Ultimately it's the decision of the surgeon.

Q. What goes into making that determination?

A. Well, it's much like every decision we make, every surgical decision we make in many areas of surgery. We meet with the patient; we take a history and physical; we listen to them, listen to their goals, their expectations. We make an assessment as to whether a procedure is indicated; if so, what types. We discuss the options, the risks, the benefits. We obtain the consult -- the assessments that we just discussed and hopefully arrive at a treatment plan that is in mutual agreement through this shared decision-making process.

Q. And does the surgeon obtain informed consent from the patient?

A. Yes. And informed consent is very much a process. Just as we've described, it culminates with memorializing this typically in what we call the informed consent document, but typically involves this discussion between the surgeon and the patient. We encourage people. We provide written information. We review, for example, representative photographs of results. We encourage patients to go home, to consider, to discuss with

whoever is relevant in their decision-making process, to return to us, if needed, in person, by phone for additional information. And then, again, if the decision is to move forward, memorialize that with the documentation.

Q. Can a minor provide informed consent to surgery?

A. So minors, in order to proceed with surgery, need to assent to a surgical procedure, which is very much a parallel process to the informed consent which is provided by the parents or guardian.

Q. Can a patient with a mental health condition provide informed consent to surgery?

A. So patients with mental health conditions can provide informed consent. Now, if someone, of course, is actively psychotic or delusional, they cannot do that. But we do see patients not only in the realm of gender-affirming care, but many other areas of care -- oncologic care, traumatic reconstruction -- who may have mental health conditions and routinely provide informed consent.

Q. Are there other areas of surgery in which a similar kind of multidisciplinary approach is used?

A. Multidisciplinary care is common in cancer care, transplantation, bariatrics.

Q. What distinguishes a medically necessary surgery from a surgery that is not medically necessary?

A. So medically necessary procedures are typically done to

treat a medical condition or prevent progression of that condition.

Q. In plastic surgery is a medically necessary surgery generally referred to as reconstructive?

A. Generally, yes.

Q. And a surgery that is not medically necessary is generally referred to as cosmetic?

A. Correct.

Q. Are there any gender-affirming surgical procedures that you consider to be medically necessary?

A. Yes.

Q. And why do you consider them to be medically necessary?

A. Because -- excuse me -- they are used to treat the medical condition of gender dysphoria.

Q. Does the broader medically -- let me start over.

Does the broader medical community generally consider gender-affirming procedures to be medically necessary?

A. Yes.

Q. And how do you know that?

A. Well, I'm a member of professional organizations. I've spoken at a number of these professional organizations at various conferences, routinely work with other professionals who are members of these organizations.

Q. Does the American Society of Plastic Surgeons consider gender-affirming procedures to be medically necessary?

A. Yes, they consider many of these procedures to be reconstructive and, in fact, list that on their website under the description of these procedures.

Q. Are there other medical associations that agree with that, that these surgeries are reconstructive?

A. American Medical Association, WPATH.

Q. One of the experts for the defense, Dr. Lappert, contends that gender-affirming surgery is never medically necessary because the patient is healthy before the surgery.

What is your response to that?

A. I disagree with that. As we've discussed, we operate on people who are oftentimes, quote, otherwise healthy. So, for example, performing a risk reduction or prophylactic mastectomy where we remove a breast on a cisgender woman who may be seeking to reduce her risk of cancer who is otherwise healthy; a person with appendicitis, but for the appendicitis would be otherwise healthy.

So otherwise healthy is not a distinguishing criteria for medical necessity of a procedure.

Q. Dr. Lappert also contends that a gender-affirming mastectomy is not medically necessary because it causes a complete loss of function, specifically, the loss of the ability to breastfeed and a loss of erotic sensibility.

What is your response to that?

A. I also disagree with that.

So for many transgender men, the breast is not a source of erotic sensibility, and they do not desire the ability to breastfeed. And, in fact, romantic relationships are typically enhanced following the removal of the breasts, following the mastectomy.

But we perform other procedures on the breasts on cisgender women. The ability to lactate, for example, is not necessarily known to me. If we have a woman who is seeking breast reduction, we don't test her ability as to whether she can lactate. Many cisgender whom who seek breast reduction do not have erotic sensibility of the nipples. The breasts may be quite large; they stretch the nerves.

So neither of those, in my opinion, would determine medical necessity of the procedure.

Q. Is there peer-reviewed literature examining the effectiveness of gender-affirming surgery?

A. Yes.

Q. Do you keep up to date with that literature?

A. I do.

Q. Why do you do that?

A. Well, clinically for patient care. I teach -- routinely teach students, residents, fellows, present at meetings, conduct clinical research.

Q. And what does the peer-reviewed literature show about whether a surgery is effective in alleviating gender dysphoria?

A. Literature demonstrates both safety and efficacy.
Q. Do some of the studies look at whether surgery, when used to treat gender dysphoria, has any effect on patient quality of life?
A. Yes.
Q. And what do those studios show?
A. Improvements in quality of life.
Q. Is it common for researchers to examine the effect of a surgical procedure on patient quality of life?
A. Yes.
Q. In what other areas of surgery do researchers use patient quality of life as an outcome measure?
A. Many in plastic surgery, but certainly in breast cancer and breast reconstruction.
Q. And am I correct to say that surgeons generally agree that surgery to treat breast cancer is medically necessary as opposed to reconstructive -- as opposed to cosmetic?
A. Yes.
Q. Does any of the peer-reviewed literature look at the effectiveness of gender-affirming surgery in adolescents?
A. Yes.
Q. And what does that literature show?
A. Similar, both safe and effective.
Q. Are you familiar with the American Society of Plastic Surgeons's levels of evidence?

A. I am.
Q. Could you explain what the levels of evidence are?
A. The levels of evidence are listed I through V, I typically being randomized controlled trial, V typically being expert opinion, II, III, IV vary, for example, with case series, cohorts, et cetera.
Q. And are those levels of evidence similar to the levels of evidence used in other areas of medicine?
A. They are. They may have subtle variation, but generally speaking, yes.
Q. Is it possible to perform randomized controlled trials to evaluate gender-affirming surgery?
A. It's not. Number one, we can't blind people to a surgical procedure. Obviously, if you've had a procedure, you will know. There's no placebo in surgery. There's not a pill, that is, a sugar pill, versus a medication. Of course, it would be unethical to deny people medically necessary care. And so those are limitations not only in the realm of gender-affirming surgery, but in many other areas of plastic surgery.
Q. Are studies that are rated as a lower level of evidence ever used in clinical decision-making?
A. Yes.
Q. And how are they used?
A. Well, levels of -- studies of lower levels of evidence may be helpful in guiding treatment, understanding a condition. The

medical literature is one component that informs our clinical decision-making, but it's one component. Of course our experience -- not only our experience, our discussions with colleagues across the globe; speaking with our patients, listening to our patients, understanding their values, their preferences. Those are all some of the factors that guide and go into clinical decision-making.

Q. How does the level of evidence supporting gender-affirming surgical care compare to the level of evidence supporting other accepted plastic surgeries?

A. Similar. So, for example, in the area of cleft or cranial facial surgery, there are very few randomized controlled trials and for many of the same reasons: Small population size, vulnerable population, inability to blind, to have a placebo, can't deny people medically necessary care. And these are just inherent limitations we face in surgery.

Q. So you mentioned studies aren't the only way that you determine the appropriate course of treatment for a condition; that's right?

A. Correct.

Q. In your clinical experience, do patients benefit from gender-affirming procedures?

A. Yes.

Q. And how so?

A. Well, overwhelmingly, in terms of relief of dysphoria,

improved quality of life.
Q. Have you seen patients who have been unable to access gender-affirming procedures due to lack of insurance coverage or other financial barriers?
A. Yeah. That was really the natural history. Certainly, early in my practice when access to care was limited, people had to leave the country. People very tragically had a result of self-surgery, castration, autoamputation. So, unfortunately, I've seen the natural history of untreated gender dysphoria. And, unfortunately, that was the norm here in the United States until we were fortunate to have expansion of access to care.
Q. You testified earlier that various surgical procedures that are performed to treat gender dysphoria are also performed to treat other conditions; correct?
A. Yes.
Q. Are the procedures any more or less safe when performed to treat gender dysphoria as opposed to another condition?
A. Procedures we use in gender-affirming surgery are established techniques that are routinely used to treat other conditions.
Q. Are the complication rates for the procedures any different when performed to treat gender dysphoria as opposed to other conditions?
A. Complication rates are commensurate with those other procedures, other conditions.

Q. Okay. I want to switch gears to talk about regret among patients.

Is there peer-reviewed research looking at rates of regret among people who have had gender-affirming surgery?

A. Yes.

Q. What does that literature show?

A. Extremely low. The -- and regret may be subdivided into different types. Regret regarding one's identity -- I was wrong. I'm not who I am -- extremely low, probably .3; .6 percent, regret regarding external factors -- marginalization, stigmatization, loss of relationships, loss of professional opportunities.

But regret in -- regret also implies that someone would have made a different decision. And so regret occurs far more commonly, far more commonly in other areas of surgery and, in fact, is very low in gender-affirming surgery as compared to many other areas of surgery.

Q. And is there peer-reviewed research looking at rates of regret in other areas of surgery?

A. Yes.

Q. What kinds of surgery?

A. Breast cancer -- treatments for breast cancers, breast reconstruction, prostatectomy, orthopaedics.

Q. And you mentioned, I believe, that rates of regret are much higher in those areas of surgery.

Can you describe for us at all what magnitude we're talking about when we say they are higher?
A. On the order of exponential.
Q. In your clinical experience, have you seen many patients expressing regret after undergoing gender-affirming surgery?
A. Very few.
Q. In your opinion is gender-affirming surgery experimental?
A. No.
Q. What is that opinion based on?
A. Well, it's based on my knowledge of the procedures, the fact that they use established techniques that are widely used in other areas of surgery, that the procedures that we've discussed have been performed in the modern history since the 1930s. I've presented at numerous national and international conferences. I've never been required to identify any of these procedures as experimental in those conversations.
Q. Are you aware of any professional surgical societies that characterize gender-affirming surgery as experimental?
A. I am not.
Q. In your opinion is gender-affirming surgery an effective treatment for gender dysphoria?
A. Yes.
Q. And what is that opinion based on?
A. Again, my providing care for over two decades, my discussions with patients, discussions with colleagues, the

literature.
Q. In your opinion does denial of coverage for gender-affirming surgery harm patients?
A. Yes. I mean, we're going back to the days where there were no -- there was no access to care and see the, you know, regrettable consequences of people who lack access to medically necessary medical care.
Q. And in your experience what are some of those consequences?
A. Well, in the surgical arena for me it's autoamputation, self-castration, self-mutilation, worsened dysphoria.
MS. McKEE: That's all I have for this witness.
THE COURT: Cross-exam?

CROSS-EXAMINATION

BY MR. PERKO:
Q. Good morning, Dr. Schechter.
A. Good morning.
Q. Dr. Schechter, you went into a lot about the gender-affirming surgery that you perform. And that includes mastectomies on gender dysphoric patients?
A. Yes.
Q. And you have performed mastectomies on gender dysphoric patients as young as 14 years old; is that correct?
A. That is correct, on three occasions.
Q. Now, you also mentioned that you were a chapter -- co-author of chapter -- co-lead author of Chapter 13 of the

WPATH Version 8 Standards of Care?

A. Yes.

Q. Let me pull up Plaintiffs' Exhibit 34, please.

MR. PERKO: Your Honor, may I approach the witness?

THE COURT: You may.

BY MR. PERKO:

Q. Turning to Bates page 6268 in the back.

A. Okay.

MR. PERKO: Can you blow up 6268.

THE WITNESS: I'm sorry. 62?

BY MR. PERKO:

Q. I'm sorry. At the bottom, 6268. It's at the very end.

A. Oh, I'm sorry. I'm looking at the Bates --

Q. If we could look at the third paragraph under *Section 3.3, Selection of chapter members*.

A. Okay.

Q. It states that: *Each chapter also included stakeholders as members who bring perspectives of transgender health advocacy or work in the community, or as a member of a family that included a transgender child, sibling, partner, parent, et cetera.*

Did you seek out the perspectives of opponents of gender-affirming care?

A. I would say I didn't necessarily know the opinion before selecting the chapter member.

Q. So were any of the members opposed to gender-affirming

care?
A. I would say -- based on our discussions, I would not say people were opposed to gender-affirming care.
Q. I'd like to show you Exhibit DX24. I believe you have that with you. It's the Endocrine Society guidelines.
You have it there for you?
A. I do.
MR. PERKO: Can we bring that up, please.
BY MR. PERKO:
Q. I'd like to go to Bates page 29. And you -- in your expert report, you refer to the Endocrine Society guidelines, and you said it was a leading medical organization; is that correct?
A. It is a leading medical organization, yes.
Q. And are you familiar with the Endocrine Society guidelines?
A. I am.
Q. Okay. Referring to *Section 5.0, Surgery for Sex Reaassignment and Gender Confirmation*, do you see that?
A. I do.
Q. The second sentence says: *The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not.*
Do you see that?
A. I do.
Q. Do you agree with that statement?
A. I don't know that I would characterize -- when describing

procedures that I would use that characterization, but there are procedures that direct fertility -- that affect fertility and those that don't.

Q. Okay. Paragraph 3, the first full paragraph under Section 5, the first sentence says that: *Surgery that affects fertility is irreversible*.

Do you agree with that statement?

A. No. I guess I would need to know what the particular procedure they are referencing is. Orchiectomy, removal of testicles, would be sterilizing, yes.

Q. It actually goes down later in paragraph 4, *Gender-affirming* -- I'm sorry -- I apologize. Yeah, paragraph 4: *Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina.*

Do you agree with that statement?

A. Yes.

Q. Moving on to the next page, under the heading Evidence, first sentence says: *Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult.*

Do you agree with that statement?

A. This statement refers to the specific techniques. So in terms of a head-to-head comparison, there are a number of, for

example, vaginoplasty techniques, a number of phalloplasty techniques, a number of mastectomy techniques. So in terms of a head-to-head comparison between each of those techniques, I'm still not sure that I would agree with that statement. No, I don't think I would agree with that statement.

Q. Okay. If we could go up above that, there are a number of recommendations and ungraded good practice statements. Do you see that? They are labeled 5.1 to 5.6.

A. I see 5.1 to 5.6.

Q. Okay. And it shows the level of quality of evidence for each of those recommendations; is that correct?

A. I think that's referencing what I just heard in Dr. Shumer's deposition, the -- I think these hash marks after each of their statements.

Q. Do you understand what those hash marks represent?

A. I'd have to go look at their specific -- I don't recall by memory what each represents.

Q. Do you know what an ungraded good practice statement is under 5.2?

A. I don't know how they are using that term. I'd have to look at the definition.

Q. If we could go to the next page, 31, last sentence of the first paragraph, it states: *We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the*

long-term benefits of surgical treatment.

Do you disagree with that statement?

A. Well, I'm just going to take a look and see what paragraph it is. But, as a general rule, I would say I'm unaware of any area of medicine or surgery where we would say there's no need for further study or research.

But looking at this paragraph. So it seems to me this refers to the sentences before it: *Reversal surgery in regretful male-to-female transexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcome. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies.* That's the last sentence.

So I don't think I would disagree with any report saying we need continued study or ongoing understanding.

MR. PERKO: Your Honor, at this time I wanted to pull up some of the confidential medical records, so if we could turn off the big screen.

This would be Exhibit -- Plaintiffs' Exhibit 234A. And about ten pages down, Bates No. 000848, please.

BY MR. PERKO:

Q. And, Doctor, I think you can take a look at this. This is a record of a MD who met with one of the plaintiffs to discuss

chest masculinization surgery.

Do you see that?

A. I see this, yes.

Q. About three-quarters of the way down it states: *I discussed the risk of surgery, including but not limited to bleeding, infection, scarring, loss of nipple graft, asymmetry, contour irregularities, need for revision surgery, regret, sensory changes, and need for additional procedures.*

Do you agree that those are some of the risks associated with chest masculinization surgery?

A. I do agree.

Q. And you mentioned vaginoplasty. What are the risks associated with vaginoplasty?

A. So, as with any procedure, bleeding, infection, flow accumulations, wound disruptions, delayed healing, blood clots, stenosis of the vaginal canal, fistula, rectovaginal fistula, meaning a hole or abnormal communication between the rectum and the vagina, urinary stream abnormalities, unsatisfactory cosmetic outcome, loss of sensation.

Q. Is that it?

A. That may not be all inclusive, but representative.

Q. Thank you.

What are some of the risks associated with phalloplasty?

A. Similar: Bleeding, infection, tissue loss, blood clots, urethral stream abnormalities, urethral fistula, urethral

stricture, delayed healing, unsatisfactory outcome, appearance, sensory, injury to nerves, including sensory nerves.

Q. What are some of the risks associated with gonadectomy?

A. Well, orchiectomy, removal of the testicles, fairly low risk. Like any procedure, there are risks of bleeding or infection or wound disruption.

Q. And what about penectomy?

A. Similar.

MR. PERKO: I have nothing further, Your Honor.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MS. McKEE:

Q. Dr. Schechter, my friend asked you about the risks associated with various gender-affirming surgical procedures. Are those risks the same when a procedure is performed to treat gender dysphoria and when it's performed to treat another condition?

A. Yes.

MS. McKEE: No further questions.

THE COURT: Dr. Schechter, you talked about a time when care wasn't available; insurers didn't pay for it. What's the situation now? Do all the major insurers pay for this?

THE WITNESS: Much better than it was. Of course, it varies state to state. It varies by insurer. I would estimate now -- so in 2000, if it was 5 percent of cases that were

covered by insurance that would probably be a lot. I could say now 80-plus percent of my practice is covered by insurance.

THE COURT: You draw patients from all around the Midwest or nationally? What's your patient mix?

THE WITNESS: 38 -- as of this last year, 38 states and Canada.

THE COURT: Heavily centered, I take it, in the Midwest?

THE WITNESS: Primarily Midwest, but including Alaska, Hawaii, Florida, Southeast as well.

THE COURT: The lawyers will have evidence of this other places.

You see Medicaid patients?

THE WITNESS: I do.

THE COURT: And that gets reimbursed from many of those 38 states, I take it?

THE WITNESS: I can't speak on each state of reimbursement. In Illinois, yes.

And I don't want to speculate exactly on the back end, but to my knowledge we treat people -- Indiana, the surrounding states where it is covered, and we do receive reimbursement. But I don't want to -- I know they are not paying out of pocket, let me say that.

THE COURT: You are not the financial guy, I get it?

THE WITNESS: I'm not.

THE COURT: All right. Thank you.

Questions just to follow up on mine?

MR. PERKO: No, Your Honor.

MS. McKEE: No, Your Honor.

Thank you.

THE COURT: Thank you, Dr. Schechter. You may step down.

THE WITNESS: Thank you.

(Dr. Schechter exited the courtroom.)

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Your Honor, if we could have a couple of minutes. He's going through security right now.

THE COURT: All right. If he's going through security, he'll be here in just a minute. Let's just be at ease for just a minute.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

Mr. Charles will call him.

THE COURT: Who is the witness?

MR. CHARLES: Dr. Armand Antommaria.

THE COURT: Let me say this to the lawyers: The court reporter will be grateful if you provide a glossary. You've probably provided and she would have on her own some of the terms that are particularly related to this, but there have been times when the doctor has talked about procedures having nothing to do with gender-affirming care. If somebody on each side

would just make a note as those words come up, and then at the break provide it to the court reporter, she'd be grateful.

I do think DEXA, the DEXA studies, was D-E-X-A. That one we had.

Doctor, right up here.

(Dr. Antommaria entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

DR. ARMAND ANTOMMARIA, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: My full name is Armand Herbert Matheny Antommaria. Antommaria is spelled A-n-t-o-m-m-a-r-i-a.

Matheny is spelled M-a-t-h-e-n-y.

DIRECT EXAMINATION

BY MR. CHARLES:

Q. Good morning, Dr. Antommaria.

What is your profession?

A. I'm a pediatrician, a pediatric hospitalist and bioethicist.

Q. Please describe for the Court your formal education and training.

A. I hold a medical degree from Washington University in St. Louis, and completed my pediatric residency training at the

University of Utah. And I hold a Ph.D. in religious ethics from the University of Chicago Divinity School.

Q. Are you licensed to practice medicine?

A. I am licensed to practice medicine. I'm currently licensed in the state of Ohio.

Q. And are you board certified in any particular fields of medicine?

A. I'm board certified as a general pediatrician and also as a pediatric hospitalist.

Q. What does bioethics entail?

A. Bioethics entails an investigation of the ethical issues in medicine in the biological sciences.

Q. What professional positions do you currently hold?

A. I'm currently the director of the ethics center at Cincinnati Children's Hospital Medical Center. I hold the Leal Carter Chair in pediatric ethics. I'm an attending physician in the division of hospital medicine. And I'm a professional in the departments of pediatrics and surgery at the University of Cincinnati College of Medicine.

Q. What do you do as a professor of pediatrics in surgery?

A. So my primary academic appointment is in the Department of Pediatrics. My work in both bioethics and in hospital medicine is within the department of pediatrics, but my work in bioethics also addresses other departments within Cincinnati Children's. And I work extensively with our surgical colleagues, and in

recognition of that work I have a secondary appointment in the department of surgery.

Q. And what do you do as director of the ethics center?

A. So I oversee the activities of the ethics center, which has activities related to research, clinical and organizational ethics.

Q. How often are you involved with clinical ethics consults with patients?

A. So Cincinnati Children's has a relatively large volume for a children's hospital in clinical ethics consults, and we conduct 40 to 50 clinical ethics consults a year.

I share responsibility for conducting clinical ethics consults with my colleagues and take call for clinical ethics consultation approximately two weeks per month.

Q. When ethicists are involved in clinical practice decision-making, what expertise do they offer?

A. The expertise that we offer is to help identify ethical issues, and help the principal parties involved in medical decision-making think through those issues, potentially identifying risks and benefits of procedures or other considerations that should inform decision-making.

Q. In your role as director of the ethics center, do you work with transgender patients?

A. I do. I started at Cincinnati Children concurrently with the development of our transgender health program and have been

involved with the clinic through its duration of its existence. I help both at the program and policy level, for example, assisting the clinic in the development and in the revision of its informed consent documents. And then I'll consult on individual cases that raise unique ethical issues and participate in the clinic's monthly multidisciplinary team meetings.

Q. Have you taught classes on the subject of bioethics?

A. During my time at the University of Utah, I taught classes in medical ethics. In my current position I predominantly will guest lecture in courses in medical ethics, but frequently provide lectures in courses on medical ethics.

THE COURT: Dr. Antommaria, it will help us if you keep your volume up so that somebody even against the back wall would be able to hear you.

THE WITNESS: My apologies. I will try, sir.

THE COURT: Thank you.

BY MR. CHARLES:

Q. Dr. Antommaria, are you involved in any professional associations?

A. I'm a member of the American Academy of Pediatrics, the American Society of Bioethics and Humanities, the Association of Bioethics Program Directors, and the Society of Pediatric Research.

Q. And can you tell me briefly, please, what does the

committee of bioethics for the American Academy of Pediatrics do?

A. The Committee on Bioethics for the American Academy of Pediatrics contributes to the Academy's work through writing of policy statements and technical reports to address ethical issues in pediatrics.

Q. Dr. Antommaria, you mentioned that in your role as director of the ethics center, you work with transgender patients. Do you recall that?

A. Yes.

Q. In this role, do you keep up with the research and scholarly work on the treatment of gender dysphoria?

A. Yes, I do.

Q. Are you being compensated for your testimony today, Dr. Antommaria?

A. Yes, I am.

Q. Does your compensation depend on the content of your testimony?

A. No, it does not.

MR. CHARLES: Your Honor, at this time I move to have Dr. Antommaria qualified as an expert in bioethics and pediatrics.

MR. PERKO: No questions.

THE COURT: No questions at this time?

You may proceed.

MR. CHARLES: Thank you, Your Honor.

BY MR. CHARLES:

Q. Dr. Antommaria, what is the goal of medical research?

A. The goal of medical research is to contribute to generalizable knowledge.

Q. And how is medical research conducted?

A. Medical research is conducted according to protocols which describe the steps in a study.

Q. Are there different types of research studies?

A. Yes, there are a variety of different types of research studies.

Q. What are some of those types?

A. Within clinical research, two of the main categories would be observational studies and randomized controlled trials.

Q. What are observational studies?

A. Observational studies look at a group of individuals either at a single point in time or over a period of time.

Q. What is the meaning of the distinction longitudinal?

A. So longitudinal would be in distinction to cross-sectional. So cross-sectional would be a study that looked at a group of individuals at a single point in time, and longitudinal would be a study that looked at individuals over a period of time.

Q. What are randomized controlled trials?

A. A randomized controlled trial would be a trial in which the group of participants were separated into generally two, but

potentially multiple, groups through a process of randomization which is frequently analogized to flipping a coin. And frequently there is an intervention group that receives the intervention that's being studied and a control group which might be a placebo, an ineffective treatment, or the current standards of care.

Q. What are some of the factors that go into determining which type of study to utilize for a particular intervention?

A. So there would be multiple factors that go into choosing a study design. Some of those factors include what the objective of the study is. So if one was doing an epidemiologic study looking at the demographic characteristics of people with a particular condition, a cross-sectional study might be the best design to do so. Other factors would have to do with the available evidence that already exists. The resources that the investigator has available would all contribute to the choices in terms of study design.

Q. Is there a study design that is generally considered the best quality?

A. Within clinical research of interventions or tests, randomized controlled trials would generally be referred to colloquially as the gold standard.

Q. And why would that be?

A. There are certain benefits of randomized controlled trials, particularly in terms of the ability to have a higher certainty

that the intervention was responsible for the observed effects.
Q. Are randomized controlled trials always appropriate for medical research?
A. No, randomized controlled trials are not always appropriate. There might be either ethical limitations in which a randomized controlled trial would not be appropriate or methodological limitations restricting the use of randomized controlled trials.
Q. When might there be ethical reasons not to conduct a randomized controlled trial?
A. So in order for a randomized controlled trial to be ethical, the individuals must have what's referred to as clinical equipoise, meaning that they must have reason to have uncertainty about whether the intervention or the control is better. If there was reason to believe that one was superior to the other, it would be unethical to conduct that type of randomized controlled trial.
Q. Can you just clarify what you mean when you say if one is superior to the other, what you are referring to there?
A. That either the intervention or the control is superior to the other. So, for example, in asthma research there is evidence that individuals with more severe asthma do better if they are on a daily medication called an inhaled corticosteroid. So it would currently be unethical to conduct asthma research that took people off inhaled corticosteroids as part of a study

design because there is evidence that they are preferable in the treatment of those patients.

Q. And so is that an example of a study that might not have clinical equipoise?

A. Yes.

Q. When might there be logistical reasons that a randomized controlled study would not be possible?

A. So in designing the study, investigators would do something called a power analysis in order to determine how many individuals they would need to enroll in this study in order for it to be informative. If there was good reason for investigators to believe that they are not going to be able to recruit a sufficient number of participants, then it would be inappropriate to conduct that trial.

Q. Any other logistical reasons that might limit the ability to use a randomized controlled trial?

A. So inadequate staff in order to conduct the trial appropriately and other limitations in terms of resources. So there are a variety of different logistical potential barriers.

Q. Dr. Antommaria, what does it mean for a study to be double-blinded or double-masked?

A. So for a study to be double-masked would be that neither the investigators nor the participants know into which group they are assigned, whether they are in the intervention group or the control group.

Q. Why is masking important?
A. Masking is important because if there was a lack of masking and individuals had background beliefs about whether the intervention or the control was more effective, that might influence their interpretation of the results or their participation in the study.

So, for example, if a participant thought that the intervention was much more desirable than the control, and they were -- and they knew they were assigned to the intervention group, and they were filling out surveys about the effect of the intervention, they might inadvertently inflate the quality of the intervention in their reports.

Q. Are there times when it is impossible to mask a study?
A. Yes. There's ongoing debate, particularly in the surgical literature, about the appropriateness of controls and, in particular, sham surgeries in order to try to provide appropriate controls for surgical interventions. And there the concerns are about what is sufficient to try to mask the surgery to a participant as well as whether, in trying to mask a surgery, it's unethical in exposing someone to harm.
Q. Does -- backing up just a little bit, Dr. Antommaria, does -- do the individuals conducting the study -- does it -- does the ability to get participants affect whether or not a randomized controlled trial is appropriate?
A. So, as I said, it's necessary in order to have a sufficient

number of participants for a study to move forward. There would certainly be situations in which there would be a concern of -- in one's ability to recruit an adequate number of participants, whether that's an individual institution seeing enough patients with that condition or participants potentially not having equipoise between the intervention and the control and, therefore, being unwilling to enroll in the study.

Q. Dr. Antommaria, you mentioned that in some situations it would not be ethical or logistically possible to do a randomized controlled trial.

Are there additional barriers to using randomized controlled trials?

A. So conducting randomized controlled trials is less common in pediatrics than in adult medicine, and there are a variety of different reasons for that, including generally the lower frequency of illness in the pediatric population. Certain outcomes such as death or serious disability are less common in the pediatric population. There are reasons why both NIH funding and pharmaceutical company funding for randomized controlled trials in pediatrics are lesser.

And, again, you've asked questions about recruiting participants. It is more difficult to recruit participants into pediatric trials.

Q. Are there ethical concerns about utilizing randomized controlled trials in pediatrics in particular?

A. I think that the ethical concerns are fairly similar in adult and pediatric medicine in terms of needing to have clinical equipoise in conducting a trial.

Q. You stated earlier, Dr. Antommaria, that randomized controlled trials are generally considered the best quality clinical research.

Does that mean that observational studies should not be relied upon to evaluate medical treatments?

A. No, that would not be true. There are times in which an observational study is the optimal type of study in order to investigate a particular question in situations in which observational studies may provide what's referred to as high-quality evidence.

Q. Are all medical treatments supported by research utilizing randomized controlled trials?

A. No.

Q. And so do clinicians make treatment decisions that have not been researched using randomized controlled trials?

A. Unfortunately, that is the case, that clinicians frequently must make medical decisions without the benefit of randomized controlled trials.

Q. How common is that?

A. I don't know that I'm able to provide a particular percentage to you, but I would say that it's certainly not uncommon.

Q. Is that common in pediatrics as well as in adult medicine?
A. I would describe that it's more common in pediatrics than it is in adult medicine. The example that I would give you is during the COVID -- during the COVID pandemic, although children were less frequently affected with COVID than adults, there are children who were seriously ill with COVID either due to hyperinflammatory responses or to a specific condition in pediatrics called MISC, Multisystem Inflammatory Syndrome, in children. And, whereas, there were multiple or numerous randomized controlled trials which guided treatment of patients with COVID in adults, there were -- there are, unfortunately, no randomized controlled trials of treatments in the pediatric population.
Q. Does the absence of a certain type of study researching a treatment mean that there is not sufficient evidence to support the use of that treatment?
A. Can you repeat your question, please?
Q. Sure. Does the absence of a certain type of study for a particular treatment mean that there is not sufficient evidence to support the clinical use of that treatment?
A. So in making recommendations, the type or level of evidence is only one factor that's considered in making recommendations and so, no, there is not a requirement for an individual particular type of evidence to make a treatment recommendation.
Q. Dr. Antommaria, what would happen if in the medical field

treatment was limited to only those treatments that have been studied by randomized controlled trials?

MR. PERKO: Objection; speculation, Your Honor.

THE COURT: It's probably argumentive.

Overruled.

THE WITNESS: Many of the treatments that I use as a pediatric hospitalist would not be available to me and my patients would be harmed as a result.

BY MR. CHARLES:

Q. And would limiting treatments to only those treatments studied by randomized controlled trials have an impact on patient welfare?

A. Yes, it would.

Q. What do you think that effect would be?

A. I think that would be a negative effect that treatments that are effective would be unavailable to them.

Q. Dr. Antommaria, we've been discussing medical research. How do doctors use -- I think you've referred to it as clinical research, so I'll use that term.

How do doctors use clinical research to inform their clinical practice?

A. Clinicians should make their clinical decisions based on the best available research. Given the volume of the medical literature, clinicians frequently rely on Clinical Practice Guidelines to summarize the evidence for them and support them

in making clinical decisions.
Q. You just mentioned Clinical Practice Guidelines.
What are those?
A. Clinical Practice Guidelines generally are guidelines related to particular topics, generally particular disease states, that are frequently developed by medical -- professional medical associations that review the available evidence and make recommendations to guide clinical practice.
Q. Could you provide some examples of medical professional associations that publish Clinical Practice Guidelines?
A. So in my field the American Academy of Pediatrics publishes Clinical Practice Guidelines, as well as other medical professional associations, including NASPGHAN, which is the national organization for gastroenterologists, publishes Clinical Practice Guidelines relevant to their area of practice.
Q. How are Clinical Practice Guidelines generally developed?
A. So there would be the identification of an area in which a Clinical Practice Guideline would be beneficial. An organization would then seek to establish a group of individuals to develop the guideline. They would utilize processes to evaluate potential expert -- individuals who have appropriate expertise and exclude individuals who had inappropriate conflicts of interest. Those individuals would then review the literature, ideally developing systematic reviews of the literature to review relevant literature and then make

recommendations based on that evidence base.
Q. Are there other factors considered in developing Clinical Practice Guidelines?
A. Factors other than what?
Q. Than some of what you just described.
A. It's not a comprehensive description, so yes, I would imagine there would be other factors.
Q. Is the quality of the evidence the only factor involved in making a recommendation in a Clinical Practice Guideline?
A. No. The quality of the evidence is only one of the factors involved in making a recommendation. So a recommendation would be -- a recommendation for or against an intervention is an evaluation of the potential benefits compared to the risks of the intervention. So it would be based, in part, on that balance as well as information about patients' preferences that inform that. And then as a secondary consideration, recommendations are also at times based on resource utilization.
Q. Dr. Antommaria, what is a systematic review of the literature?
A. A systematic review of the literature is a process through which all of the evidence relevant to a particular topic is ascertained through a search of, ideally, multiple databases. The relevant articles are identified initially by examining titles in abstracts and then the full text of articles. Data is then abstracted from each of the individual articles and

summarized, and ideally then the quality of the evidence is evaluated.

Q. What is the difference between a systematic review of the literature and a Clinical Practice Guideline?

A. So a systematic review of the literature will rate the quality of the evidence, whereas, a Clinical Practice Guideline will make recommendations and both ideally rate the quality of the evidence and the strength of the recommendations.

Q. Do systematic reviews of the literature make clinical recommendations?

A. They do not.

Q. Why is it generally useful for clinicians to have recommendations in Clinical Practice Guidelines?

A. The volume of the medical literature is enormous and continues to increase over time. The amount of effort that's required to conduct a single systematic review of the literature would be, you know, hundreds of person hours. And so for practicing clinicians, it's exceptionally beneficial to have that literature summarized for them in a useful manner in order to not have to go through that process themselves for each clinical decision that they're making.

Q. Are there specific methodologies used in developing Clinical Practice Guidelines?

A. There are, in particular, methodologies for grading the quality of the evidence and the strength of recommendations.

Q. Are you familiar, Dr. Antommaria, with the GRADE methodology?
A. I am.
Q. Do you know what GRADE stands for?
A. Yes. GRADE stands for Grading of Recommendations Assessment, Development and Evaluation. And it's a widely used method for grading the quality of evidence and the strength of recommendations.
Q. And I just want to make sure you said this. Is it widely -- is it a widely used methodology in Clinical Practice Guidelines?
A. Yes, it is.
Q. And what does the GRADE methodology do?
A. So it provides recommendations about how one describes the quality of the evidence and then -- and how one goes through a process of grading the quality of the evidence, including what factors should be considered in doing so.

And then in terms of recommendations, it has suggestions about how the strength of a recommendation should be described and the factors that should be considered in characterizing the strength of a recommendation.

Q. Why is it important to know the strength of a recommendation?
A. The -- as a -- for me, as a clinician, the strength of the recommendation is likely to influence how I approach the

informed consent process. I may have a longer or a more detailed conversation with a patient about what's referred to as a weak recommendation than a strong recommendation.

Q. And why is it important to know the quality of the evidence?

A. So the quality of the evidence is related to the certainty of an effect, so that the intervention will have a particular effect. And so, again, in counseling a patient, I'm -- knowing the quality of evidence will inform how I describe that certainty.

Q. In using the GRADE methodology, is an entire Clinical Practice Guideline given a single grade?

A. No. Individual recommendations are given -- the evidence supporting them is given a grade and the individual recommendation is given a particular strength.

Q. And so do guidelines typically have multiple recommendations?

A. They do.

Q. Within the GRADE system, what are the quality levels of evidence?

A. They would be high, moderate, low, or very low.

Q. You said that --

THE WITNESS: Your Honor, am I loud enough?

THE COURT: I'm sorry?

THE WITNESS: Am I loud enough?

THE COURT: Yes, yes, you are doing well. Thank you. All except the question whether you were loud enough.

BY MR. CHARLES:

Q. Dr. Antommaria, how does the study design inform the quality of the evidence grade?

A. So, in general, randomized controlled trials are initially assigned to the category of high-quality evidence, and observational studies are initially assigned to the category of low-quality evidence.

Q. Then are there other factors utilized to give a grade to the quality of the evidence besides study design?

A. Yes. There are five additional factors that could decrease the quality and three additional factors that can increase the quality in terms of the final evaluation of the quality of the evidence.

Q. So is it possible that a randomized controlled trial could start as a high-quality grade but then be impacted by some of those other factors?

A. Yes, it's possible for a randomized controlled trial to, in the end, be low or very low-quality evidence.

Q. And, similarly, could an observational study be impacted in its ultimate grade by those other factors?

A. Yes. And in the end, then, an observational study might move from low- to high-quality evidence.

MR. CHARLES: Your Honor, I would like to show the

witness that's been marked as Plaintiffs' Exhibit 157.

THE COURT: Is this something that can be on the public board?

MR. CHARLES: It can, Your Honor.

THE COURT: All right.

BY MR. CHARLES:

Q. Dr. Antommaria, do you recognize this document?

A. Yes, I do.

MR. CHARLES: Right there. Actually, no -- I'm sorry -- keep going down.

Okay. Right there.

You got it.

BY MR. CHARLES:

Q. Okay. Dr. Antommaria, do you see on your screen page 404, Table 2?

A. I do.

Q. Looking at this table, how does GRADE define low-quality evidence?

A. So just to say that this paper -- so that the group who have developed the GRADE approach have published a variety of different descriptions of that approach as it has developed over time.

In this table in the far right-hand column, we see the definition from their initial publication, and in the left hand -- and in the middle column, the definition from the

current manuscript, which reflects this evolution. And so low-quality evidence in the current definition is that the confidence in the effect estimate is limited.

Q. And what do you understand that to mean?

A. So in reviewing the evidence, they're looking at the evidence -- looking for evidence that an intervention has a particular effect, and the quality evidence reflects the certainty or the level of confidence in that reported effect, and that a high-quality evidence provides a very high degree of confidence that the effect is accurate, and that other levels of quality provide less confidence in the effect. And for low-quality evidence, there may be a difference -- a substantial difference between the true effect and the effect that's currently reported in the literature.

Q. You mentioned in response to that question, Dr. Antommaria, what was reflected about high-quality evidence.

What do you understand the current definition to mean?

A. That there's a very high degree of confidence that the true effect is the effect that's currently represented in the evidence.

Q. So does low-quality evidence mean there is a likelihood that treatment will be determined to not be effective in the future?

A. Not necessarily.

Q. And does low-quality evidence mean there is a likelihood

that treatment will be determined to not be safe in the future?
A. It does not.
Q. What quality levels of evidence may a Clinical Practice Guideline base recommendations upon?
A. On any of those levels of quality.
Q. In general, Dr. Antommaria, does the GRADE system indicate the strength of the recommendations that are being made?
A. So a Clinical Practice Guideline makes recommendations, and the GRADE approach provides guidance for individuals creating the guidelines to rate the strength of the recommendations that they're making.
Q. How is the strength of a recommendation evaluated?
A. So the GRADE approach identifies recommendations as either being recommendations for or against an intervention as well as recommendations being strong or weak so that there is potentially a spectrum from strong recommendations for, weak recommendations for, weak recommendations against, and strong recommendations against a potential intervention.
Q. What are the levels of recommendations?
A. The levels of recommendation would be either a strong recommendation or a weak recommendation, although the GRADE group acknowledges that the term "weak recommendation" may have misleading connotations and uses other potential terminology, including "interim recommendations."
Q. What does it mean for a recommendation to be strong?

A. So the GRADE approach describes the difference between strong recommendations and weak recommendations in two different ways, one related to certainty. So a strong recommendation has a high degree of certainly that the benefits outweigh the risks, and a weak recommendation has a lesser degree of certainty.

And then the other way that they describe it is related to how many patients would agree with the recommendation. So in regard to any recommendations, that the majority of individuals would agree with the recommendation, but that with a strong recommendation, it would be the vast majority, whereas, with a weak recommendation, there might be a larger minority of individuals who would disagree with a recommendation, patients being those individuals.

Q. Are there other considerations in making a recommendation beside the quality of the evidence?

A. Yes. The balance between the risks and the benefits because those -- because patients might perceive those risks and benefits differently, the certainty of the knowledge of how patients would evaluate the risks and the benefits is a factor. And then in some circumstances resource utilization would also be considered in making recommendations.

Q. Is it common for Clinical Practice Guidelines to make recommendations based on evidence that is graded low?

A. Yes.

Q. And is it common for Clinical Practice Guidelines to make

recommendations based on evidence that is graded very low?
A. Yes, particularly in pediatrics.
Q. And why are recommendations made based on low or very low-quality evidence?
A. Clinicians are faced with treating patients based on the best available evidence, and sometimes the best available evidence is low or very low-quality evidence. But it's not possible for providers to tell patients to come back later in the future when better quality evidence is available. They have to make the best judgment possible at that particular point in time.
Q. Is it common for pediatric Clinical Practice Guidelines to make recommendations based on evidence that is graded low or very low quality?
A. It is.
Q. Why is it common?
A. Because of the lack of randomized controlled trials in pediatrics.
Q. Are there any other reasons why it is more common?
A. That would be the predominant reason.
Q. Does the Endocrine Society publish Clinical Practice Guideline in pediatrics?
A. It does.
Q. What are some that you are aware of?
A. There's a Clinical Practice Guideline for the treatment of

pediatric obesity, one for a condition called congenital adrenal hyperplasia, and one that includes pediatric patients related to the treatment of individuals with gender dysphoria.

Q. And what quality of evidence are the recommendations in those guidelines based upon?

A. In all three of those guidelines, the majority of the recommendations are based on low or very low-quality evidence.

Q. Do any of those recommendations utilize ungraded good practice statements?

A. In addition, there are ungraded good practice statements which account for across the guidelines, you know, approximately 20 percent of the recommendations.

Q. Do any of the Clinical Practice Guideline that you just listed have high-quality evidence supporting the recommendations?

A. To the best of my recall, they do, but only in a very small minority of the recommendations.

Q. Do Clinical Practice Guidelines require a threshold amount of evidence or a certain type of study to make a recommendation?

A. They do not.

Q. Dr. Antommaria, is not providing medical treatment an affirmative clinical decision?

A. Yes, it is.

So when -- in seeking informed consent, one discusses risks, benefits, and alternatives. One of the alternatives is

frequently not to undergo the procedure or the treatment, but that there would be particular risks or benefits of not receiving the intervention or the treatment.

Q. If a Clinical Practice Guideline were to recommend not providing medical treatment, would that recommendation need to rely on evidence?

A. It would.

So within the GRADE system we talked about recommendations for or recommendations against. Recommendations against are also graded in terms of their strength, and they would have a evidence -- ideally have a evidence quality assigned to them.

Q. Switching gears a little bit here, Dr. Antommaria.

Are there established ethical principles around medical decision-making?

A. There are.

Q. Under principles of medical ethics, how does decision-making around Medicare -- excuse me -- around medical care for adults generally work?

A. In general, adults informed consent would be required for treatment. There certainly are exemptions, but an adult who has medical decision-making capacity, their consent is generally required for medical treatment.

Q. Is there a term used to describe the process you were just discussing?

A. So historically the terminology would be the informed

consent process. Increasingly the language of shared decision-making is utilized. But both are common in the medical literature.

Q. Does the treatment decision ultimately lie with the doctor or with the patient?

A. With the patient.

Q. Under principles of medical ethics, how does decision-making around medical care for minors generally work?

A. So in general, for minors, parental or guardian consent is required and that pediatric patients should participate in medical decision-making to the extent that it is developmentally appropriate. So as children mature and are able to participate in decisions, they should participate in decisions. And that's described in the literature as seeking their assent. But in general, parental consent is still required.

Q. And with whom does the treatment decision ultimately lie for minors?

A. Generally their parents or legal guardians.

Q. What should a healthcare provider disclose to a patient, and for a minor their parent or guardian, to enable them to make an informed decision?

A. They should disclose the indications and the nature of the intervention, its potential risks and benefits, and the alternatives. And there are different standards for disclosure of the risks and benefits, because there are frequently more

risks and benefits than can be meaningfully conveyed. And frequently providers then will convey the common risks and benefits as well as the most serious risks and benefits.

Q. Should a healthcare provider disclose the risks and benefits of not undergoing an intervention?

A. As part of the description of the alternatives, yes.

Q. When the patient is an adolescent, does the patient have a role in the informed consent process?

A. Yes, they do. They should participate in the informed consent process, and their assent should generally be sought, although it's not necessarily determinative in decision-making.

Q. You've used the term "assent" when referencing minors and adolescents in the shared decision-making process.

What does it mean to assent to treatment?

A. It would be their verbal agreement to participate in treatment in contradiction to dissent or disagreement to participate.

Q. Can you describe the difference between assent and consent?

A. In some ways the distinction is a legal distinction, and in some ways it's a distinction about medical decision-making capacity.

So certainly there are older adolescents who have comparable medical decision-making capacity to adults but aren't legally authorized to provide informed consent. Whereas, substantially younger adolescents might have some degree of

understanding, and it's important for them to participate, but not a full understanding that's comparable to an adult's.

Q. In general, are adolescents who possess adequate decision-making capacity able to understand the benefits and risks of treatment?

A. Yes.

Q. Does adolescent decision-making capacity change over time?

A. So decision-making capacity is both relative to an individual's skills and abilities in making decisions, as well as the particular intervention. But, yes, as an individual's decision-making skills and abilities change over time, their decision-making capacity increases.

So an average 10-year-old has greater decision-making capacity than a 6-year-old but potentially less so than an 16-year-old.

Q. So, Dr. Antommaria, are you familiar with what the Rule of 7 is?

A. It's a rule of thumb that's used to help people understand an individual's decision-making capacity.

Q. Can you describe the general rule of thumb?

A. It would be that individuals who are less than 7 are incapable of assent; individuals between 7 and 14 are capable of assent, and individuals who are older than 14 are capable of consent.

Q. For adolescents who have the ability to assent to

treatment, must their parents or guardians still provide informed consent?

A. So in general, yes.

Q. In general, Dr. Antommaria, does having a mental health diagnosis impair medical decision-making capacity?

A. No, not in and of itself.

Q. Does the fact that a patient experiences depression mean they can't assent or consent to treatment?

A. Not intrinsically.

Q. Does the fact that a patient experiences anxiety mean that they cannot assent or consent to treatment?

A. Again, not intrinsically.

Q. Dr. Antommaria, have you read the regulation at issue in this case?

A. I have.

Q. And have you read the generally accepted medical standards determination on the treatment of gender dysphoria and all related attachments?

A. I have.

Q. The regulation and the document that I will refer to as the GAPMS memo refers to treatment for gender dysphoria. But if in my questions I refer to the range of care falling within that definition as gender-affirming medical care, will you understand what I mean?

A. Yes, I will.

Q. Is gender-affirming medical care as it is being used by doctors to treat gender dysphoria experimental?
A. No, it is not.
Q. Are there any Clinical Practice Guidelines regarding gender-affirming medical care?
A. Yes, there are.
Q. What are they?
A. There's a Clinical Practice Guideline produced by the Endocrine Society and one that's been produced by the World Professional Association for Transgender Health.
Q. If I refer to the World Professional Association for Transgender Health as WPATH, will you know what I'm referring to?
A. Yes, I will.
Q. And if I refer to those Standards of Care as SOC, will you know what I'm referring to?
A. Yes, I will.
Q. Dr. Antommaria, what is your understanding of what the Endocrine Society is?
A. The Endocrine Society is an international medical professional association of approximately 18,000 endocrinology clinicians and researchers.
Q. Does the Clinical Practice Guideline published by the Endocrine Society you just mentioned for the treatment of gender dysphoria make recommendations with regard to gender-affirming

medical care for adolescents?
A. Yes, it does.
MR. CHARLES: Your Honor, I'd like to show Dr. Antommaria an exhibit from the stipulated exhibits list, Defendants' Exhibit 24.
BY MR. CHARLES:
Q. Dr. Antommaria, if it's easier for access, there may be a copy in front of you of this document as well.
Do you recognize this document, Dr. Antommaria?
A. Yes, I do.
Q. And do you rely on it in your professional capacity?
A. I do.
MR. CHARLES: Your Honor, I believe this has previously been entered.
THE COURT: All the stipulated exhibits have been, yes.
MR. CHARLES: Okay. Thank you.
BY MR. CHARLES:
Q. Dr. Antommaria, what methodology does the Endocrine Society Guideline use?
A. They utilize the GRADE methodology.
Q. And so does the clinical guideline grade the quality of the evidence and the strength of the recommendations?
A. It does.
Q. So I'm now going to direct you to page 3872.

A. Yes.
Q. And looking at the bottom of page 3872.
What does the Endocrine Society guidelines say about strong recommendations?
It's going to be --
A. So they are utilizing the GRADE methodology. They describe that they are going to use the language of "we recommend," and the number 1 to indicate a strong recommendation.
Q. Does it define the meaning of "strong recommendation" in that section?
It's at the third-to-last sentence at the bottom of that section, beginning with "The task force has confidence..."
A. So they describe that if they've made a strong recommendation that they have confidence that an individual will derive, on average, more benefit than harm.
Q. Is that consistent with the GRADE concepts we discussed earlier?
A. It is.
Q. And looking at that same section, what does -- what does the Endocrine Society guidelines say a weak recommendation means?
A. They indicate that if a weak recommendation is given that there needs to be more careful consideration of the person's circumstances, values, and preferences in decision-making.
Q. And does that mean that a weak recommendation means that

the benefits of treatment do not outweigh the harms of treatment?

A. In general, no.

Q. Is the Endocrine Society guidelines supported by scientific evidence?

A. It is.

Q. What kind of evidence?

A. So depending on the individual recommendation, controlled trials, or, more commonly, observational studies.

Q. Do those include longitudinal observational studies?

A. They do.

Q. As you discussed before, does low quality in rating the evidence have a meaning under the GRADE system that is different from how that term is colloquially used?

A. I think that low quality might colloquially be interpreted as inadequate or insufficient, which is not the case, in that low-quality evidence may be sufficient to justify a recommendation.

Q. Dr. Antommaria, can I ask you to just speak up just a little bit, only because you're looking down?

A. I apologize.

Q. No, no, nothing to apologize for. Thank you.

Do the studies discussed in the Endocrine Society guideline demonstrate the safety and efficacy of gender-affirming medical care for adolescents?

A. They do.
Q. Would randomized controlled trials comparing the current treatment recommendation, that is, gender-affirming medical care and mental health care, to mental health care alone be ethical?
A. Not currently.
Q. Why would that be?
A. Because both investigators and participants are unlikely to have clinical equipoise between those two options, believing that gender-affirming medical care is superior to mental health care alone, based on the currently available evidence.
Q. Was there a time in the past where a randomized controlled trial comparing gender-affirming medical care to not receiving gender-affirming medical care would have had clinical equipoise?
A. Yes. There was likely to have been a time in the past when that was the case, but not currently.
Q. Can you think of other examples of treatments where the window of clinical equipoise closed before randomized controlled trials were able to be conducted?
A. So there are circumstances in which the observational studies are sufficient evidence that clinical equipoise no longer exists.
Q. Are there other challenges that a randomized controlled trial comparing gender-affirming medical care to not receiving gender-affirming medical care would be likely to face?
A. There would likely to be intrinsic methodological

limitation related to masking, in that if one is on a puberty blocker or is on gender-affirming hormone therapy, both the participant and the investigators would likely know if one was assigned to an intervention arm or a placebo arm based on physical changes in the participant over time. And that would likely create methodological limitations that decrease the quality of the study.

Q. Do you think such a study would be likely to collect sufficient participant numbers?

A. So that's returning to the issue of clinical equipoise because potential participants are unlikely to have clinical equipoise. They are unlikely to be willing to enroll, or they would enroll and if they realized that they were in the control arm would likely drop out of the study, so that there would be issues that were both about feasibility, and, in the long run, about ethics in terms of conducting that type of study.

MR. CHARLES: Your Honor, plaintiffs would request a recess for lunch break at this time if the Court is amenable.

I can also continue.

THE COURT: Are you not close to done, or you are just telling me this is a good breaking point, or somebody needs a break? What --

MR. CHARLES: I received a note.

MR. GONZALEZ-PAGAN: Your Honor, if I may? We think this may be a natural breaking point. I believe there may be

approximately 45 minutes --

MR. CHARLES: Half hour, 40 minutes.

THE COURT: Okay. All right. And we took an early morning break anyway.

Let's take an hour and we will start back at 1:15.

MR. CHARLES: Thank you, Your Honor.

THE COURT: Dr. Antommaria, if you would be back on that stand at 1:15, please.

Thank you.

(Recess taken at 12:14 PM.)

(Resumed at 1:15 PM.)

THE COURT: Please be seated.

Dr. Antommaria, you are still under oath.

You may proceed.

MR. CHARLES: Thank you, Your Honor.

BY MR. CHARLES:

Q. Dr. Antommaria, are you familiar with the WPATH Standards of Care?

A. Yes, I am.

Q. What are the WPATH Standards of Care?

A. They're a Clinical Practice Guideline for, among other things, the treatment of individuals with gender dysphoria.

Q. Do you know what the current version of the WPATH Standards of Care is?

A. It's currently in its 8th version.

Q. And if I refer to the WPATH -- I'm sorry. If I refer to WPATH SOC8, will you understand that I mean the 8th current version?
A. Yes, I will.
Q. Do the WPATH SOC8 recommendations for gender-affirming medical care for adolescents rely on scientific studies?
A. Yes, they do.
Q. What kinds?
A. Comparable studies to those relied on by the Endocrine Society, which are premeditatedly prospective observational studies or longitudinal observational studies.
Q. Are the WPATH SOC8 recommendations for gender-affirming medical care for adolescents consistent with the Endocrine Society guideline recommendations for the treatment of gender dysphoria?
A. Yes, they are generally comparable.
Q. Are you aware of any randomized controlled trials studying whether mental health services alone is effective to treat gender dysphoria?
A. No, I'm not.
Q. What about observational studies?
A. I'm aware of individual case reports, but no longitudinal observational studies.
Q. Some of defendants' experts rely on systematic reviews of the literature for some of their positions.

Do systematic reviews of the literature recommend banning gender-affirming medical care?
A. They do not, but as we noted earlier, systematic reviews do not make recommendations.
Q. And do those two Clinical Practice Guidelines we've discussed, the Endocrine Society guidelines and the WPATH SOC8, recommend gender-affirming care --
A. They do.
Q. -- for the treatment of gender dysphoria?
A. Yes.
Q. Dr. Antommaria, how does the evidence base supporting gender-affirming medical care for adolescents compare to the evidence base for other medical treatments for minors?
A. It is generally comparable. We discuss the Endocrine Society's guidelines for other pediatric conditions and the quality of the evidence that supports those recommendations are fairly similar to the quality of the evidence that supports the recommendations related to gender-affirming medical care.
Q. What are some of those Clinical Practice Guideline -- what are some of the recommendations within Clinical Practice Guidelines that are comparable?
A. The specific recommendations or that --
Q. I'm sorry. The Clinical Practice Guidelines.
A. Oh. The guidelines for pediatric obesity and for congenital adrenal hyperplasia.

Q. So do those Clinical Practice Guidelines include recommendations based on low or very low-quality evidence under the GRADE system?
A. They do.
Q. Are there any other pediatric Clinical Practice Guidelines that you can think of that are, again, similar in the reliance on low or very low-quality evidence?
A. Another specific one would be the American Heart Association's guidelines for cardiopulmonary resuscitation, which predominantly rely on low or very low-quality evidence in support of their recommendations.
Q. The defendants and some of their exerts raise the issue of potential risks associated with gender-affirming medical treatments.

Are you familiar with the risks associated with gender-affirming medical care?
A. I am.
Q. What are some of the more significant risks of which you are aware?
A. So the risks somewhat vary by the treatment, but for what are colloquially referred to as puberty blockers, the predominant risk would be the -- a decreased rate of development of bone mineral density while on treatment, which might be compensated for through the use of gender-affirming hormone therapy.

And then for testosterone, there would be cardiovascular risks, including the risk of heart attack, as well as potentially the risk of stroke, secondary to changes in lipids or in terms of having an increased production of red blood cells.

And for estrogen therapy, risks would include, again, the risks of blood clots, including clots in the veins and the legs, clots that go to the lungs, or clots that would cause heart attack or stroke.

And for any of the -- for the use of testosterone or estrogen, there would be risks of infertility.

Q. How do the risks of gender-affirming medical care compare to the risks associated with other medical treatments that adolescents may undergo?

A. There are other treatments that adolescents undergo that have comparable uncertainty or risk.

Q. Can you think of any examples?

A. So there are treatments for kidney diseases or blood diseases in adolescents that would also entail the risk of infertility.

Q. Are there chest surgeries that adolescents may undergo besides chest surgery for gender dysphoria?

A. There are.

Q. Can you think of any examples?

A. Chest surgeries that adolescents may undergo include

surgery for gynecomastia, which would be the proliferation of glandular ductal tissue in the chests of individuals who are assigned male at birth; chest surgeries for pectus excavatum or carinatum, which would be where the chest protrudes or goes inward; and individuals who are assigned female at birth might undergo either breast reduction or breast augmentation surgery.

Q. And are those surgeries you just mentioned premeditatedly about appearance or physiologic function?

A. Predominately about appearance.

Q. How do the surgical risks of breast reduction for cisgender girls and gynecomastia surgery for cisgender boys compare to the surgical risks of chest surgeries to treat gender dysphoria?

A. There would be comparable risks in kind.

Q. And specifically how do the surgical risks of pectus excavatum compare to chest surgery for gender dysphoria?

A. Pectus excavatum surgery potentially has greater risk in that there have been fatalities as a result of pectus excavatum surgery.

Q. You've talked some about the evidence supporting gender-affirming medical care for adolescents.

Is it unusual for adolescent patients and their parents or guardians to make decisions to undergo treatments supported by comparable levels of evidence?

A. No, it is not.

Q. Why is it not uncommon?

A. Because there are multiple other medical conditions for which adolescents are treated that have comparable risks, benefits, and levels of uncertainty or levels of evidence related to those treatments.

Q. Is it unusual for adolescent patients and their parents or legal guardians to make decisions to undergo treatments with greater risks than those associated with gender-affirming medical care?

A. There are certainly medical conditions whose treatment entails greater risk.

Q. For medical treatments where there is evidence of safety and efficacy, how should the medical community respond to concerns about limitations of the evidence?

A. In general, it's preferable to generate additional evidence on which to base decisions through further research.

Q. In response to concerns about limitations of the evidence, should the medical community refuse to provide a particular treatment?

A. If there is available evidence that supports safety and efficacy, no.

Q. If Florida Medicaid does not provide coverage for gender-affirming medical care for transgender beneficiaries, is it possible to conduct more research on this treatment for this population?

A. It would be possible, but it would likely impede the

development of additional evidence.
Q. Why?
A. One of the potential ways to gather that evidence is through prospective observational trials of individuals who are receiving treatment, and if fewer individuals are receiving treatment because of restrictions on funding, that would impede the development of that type of evidence.
Q. Do research trials typically cover the cost of the treatment in addition to the cost of conducting the research?
A. If there is evidence of safety and efficacy, then the treatment itself is generally covered in whatever way the treatment would be covered, and the trial itself would only cover the additional expenses entailed in the research.
Q. So if the cost of the medical treatment is not covered and patients cannot access it, would the research trial typically cover the cost of the treatment for those patients involved in the research?
A. It might be very difficult to identify funders who were willing to cover both the research expenditures as well as the cost of the treatment.
Q. Why might it be difficult?
A. Because of the significant incremental additional expense.
Q. Dr. Antommaria, what does it mean to say that a medication is FDA approved?
A. That the FDA has reviewed evidence demonstrating that the

treatment -- the medication is safe and effective for a particular indication.

Q. I apologize. Let me back up.

Can you tell me what FDA stands for?

A. The U.S. Food and Drug Administration.

Q. And if I use FDA, will you understand what I'm referring to?

A. Yes, I will.

Q. And, Dr. Antommaria, what is meant by an indication as you just mentioned in the context of FDA approval?

A. When the FDA grants approval for a medication, it is for a particular indication, which would be a particular disease, whether it is being used for diagnosis, curative treatment, or palliative treatment, and for a particular population, frequently specified in terms of an age group.

Q. And if a medication receives FDA approval for an indication, is that medication only allowed to be used for that indication?

A. No. The FDA does not regulate the practice of medicine, and so healthcare providers are generally free to use that medication for other indications. The primary restriction would be that the pharmaceutical company can't advertise that medication for what are referred to as off-label uses.

Q. So what does it mean for -- I'm sorry.

What does it mean to use an FDA-approved medication

off-label?
A. That it's used for an indication other than the indication for which it was approved.
Q. So we've been discussing all the terms that comprise several sentences I've been asking you about related to indication.
Can you explain what it could look like to use an FDA medication off-label?
A. So using a medication off-label would be for another purpose other than what it's approved for, which might be simply using it for an age group in which it's unapproved. So, for example, as a pediatric hospitalist, I take care of children with bone and joint infections. Frequently I -- I frequently would utilize an antibiotic called nafcillin. It's not FDA approved for use in individuals under the age of 18, and so my using it to treat a 6-year-old would be an off-label use of that antibiotic.
Q. And as you said, indication can mean treating for a different condition?
A. Yes, it can.
Q. Or a different age group?
A. Yes. So an example of a different condition would be magnesium, for example, is FDA approved for preventing seizures in women with high blood pressure in pregnancy, but, again, as a pediatric hospitalist, I use it in children with severe asthma,

and there is evidence of safety and efficacy in those children, although its use is off-label.

Q. And does using a medication off-label mean that there is not evidence supporting that use?

A. No, it does not intrinsically mean that there is a lack of evidence.

Q. Could there be substantial evidence for the safety and efficacy of a medication when used off-label?

A. Yes, and in many cases there is. There are reasons why the manufacturer might not seek to have an additional indication added in spite of that evidence, but frequently there is evidence of safety and efficacy for off-label uses.

Q. Does using medication off-label mean that treatment is experimental?

A. No, it does not.

Q. Why not?

A. As I've stated, there may be evidence of safety and efficacy supporting the use of that medication.

Q. Is it unusual for a medication to be prescribed for indications other than the one it was approved for in pediatrics?

A. No. In fact, it's very common for medications to be used off-label in pediatrics. So there's a study that looked at off-label uses using a very restrictive definition of off-label for children that had encounters in children's hospitals, and

approximately 30 percent of encounters involved an off-label use. And in particular populations or settings, the rate of off-label use may go up significantly. So, for example, in a cardiac intensive care unit, the vast majority of medications may be used off-label in that setting.

Q. And if there's evidence that an off-label use of a medication is safe and effective, are there reasons a manufacturer might not seek additional approval for additional indications?

A. Yes, there are. Because of the time and expenditure that it takes to get an additional indication added, it might not be in a manufacturer's economic interest to seek to have that indication added to the label.

Q. Dr. Antommaria, can adolescents assent to gender-affirming medical care?

A. Yes, in general adolescents have sufficient medical decision-making capacity to assent to gender-affirming medical care.

Q. Why do you believe that?

A. So both based on my individual experience as a clinician, as well as evidence in the literature. So there's general evidence related to individual adolescents' medical decision-making capacity, as well as at least one study that's looked at adolescents' ability to assent to the use of what's colloquially referred to as puberty-blocking medications which

show that adolescents in general have adequate medical decision-making capacity to assent.

Q. And can parents and legal guardians provide informed consent for gender-affirming medical care?

A. Yes, they can.

Q. And why do you believe that?

A. Based on adults' general decision-making capacity and the comparable nature of decisions about gender-affirming medical care compared to the other types of medical care to which they're asked to consent on behalf of their adolescent children.

Q. Can you describe for me, please, the process at Cincinnati Children's Hospital of establishing informed consent?

A. So informed consent generally refers to a process of decision-making, although some individuals may have that misapprehension that it is about the signing of a form, and that there are multiple conversations held over time to discuss the potential benefits, risks, and alternatives to gender-affirming medical care, and to be able to answer parents' and their adolescent children's questions before they consent to treatment.

Q. Is there anything inherent to gender-affirming medical care that present -- prevents assent by minors and informed consent by their parents and legal guardians?

A. No, there is not.

Q. And why not?

A. So the requirements for having medical decision-making capacity are that you understand the risk benefits, alternatives; that you appreciate what those mean in your individual circumstance, and that you're able to evaluate and weigh the risks and the benefits.

And adolescents and their parents are generally capable -- or the average adult or adolescent is capable of understanding the risks, benefits, and alternatives of gender-affirming medical care, contextualizing that information in their own individual circumstance, and then weighing the potential risks and benefits in order to reach a decision; and that the risks, benefits and alternatives of gender-affirming medical care are not categorically different than the risks, benefits, and alternatives of other treatments to which parents and adolescents consent and assent.

Q. Are there other medical interventions in pediatrics that have similar levels of uncertainty or outcomes to which minor parents -- minor patients -- excuse me -- and their parents can provide assent and informed consent?

A. Yes, there are.

Q. Can you think of any examples?

A. So I had the occasion to perform an ethics consult for a 12- or 13-year-old young woman who had Turner syndrome, which is a genetic condition, and she had premature ovarian failure, meaning that her ovaries were not functioning properly, and they

were considering starting her on estrogen therapy to replace the estrogen that her ovaries were not making.

She also had a bleeding disorder and had multiple episodes of gastrointestinal bleeding which were severe, and they were contemplating performing a hysterectomy prior to estrogen therapy because of the potential risk of serious, if not life-threatening, bleeding from menses.

Because she was a minor and they were considering a hysterectomy, they requested an ethics consult. I met with the patient and her mother. The patient understood what a hysterectomy was and the implications it had in her life. She planned to go to college and to get married and to have children. She understood that as a result of having a hysterectomy, she wouldn't be able to become pregnant. She had family members who had adopted children, and she very much wanted to have children and saw adoption as a way to have her own children and believed that the benefits of having the hysterectomy outweighed the risks and assented to that procedure.

And so I think that in that clinical situation there were, you know, comparable benefits and risks, and even at 12 she had sufficient medical decision-making capacity to assent to that course of treatment.

Q. And so that -- is that a treatment, other than gender-affirming medical care, which would have impacted the

patient's fertility?
A. Yes. She was assigned female at birth, and her gender identity was female.
Q. Is the current standard of care for treating gender dysphoria consistent with general ethical principles instantiated in the practice of informed consent and shared decision-making?
A. Yes, it is. The Clinical Practice Guidelines, including the Endocrine Society's, are particularly attentive to informed consent and emphasize, for example, the importance of making individuals who are considering undergoing gender-affirming medical care aware of options for fertility preservation and make in general recommendations about the timing of different forms of gender-affirming medical care related to the development of medical decision-making capacity as individuals grow older.
Q. We've talked today about the Endocrine Society guideline for treatment of gender dysphoric persons and the WPATH SOC8.
Do these Clinical Practice Guidelines provide that doctors inform families of the potential risks and benefits of treatment?
A. Yes, they do.
Q. And in particular, do the guidelines emphasize the importance of adequate informed consent as related to fertility?
A. Yes, they do, specifically making recommendations that

individuals considering gender-affirming medical care are advised of the opportunities for fertility preservation.

Q. Dr. Antommaria, you testified earlier that generally in the practice of medicine the decision of whether to undergo treatment ultimately rests with the patient and in the instance of an adolescent with the parent or guardian.

Are the Endocrine Society guidelines and the WPATH SOC8 consistent with that?

A. Yes, they are.

Q. In your view, is there anything about gender-affirming medical care that makes the informed consent process inadequate to enable patients to make decisions about medical treatment?

A. No, there's nothing about gender-affirming medical care that makes the general principles of informed consent inapplicable or the process of informed consent inadequate.

Q. Dr. Antommaria, in your review, does the regulation at issue in this case have implications for clinicians' ability to comply with their ethical obligations as physicians?

A. It does.

Q. How so?

A. It would -- although they may still be able to recommend what they see as medically indicated treatment, it would significantly limit some patients' access to that medically indicated treatment.

Q. Some of the defendants' experts have asserted that some

doctors are providing gender-affirming medical care to adolescents without appropriate psychological assessments and without properly informing families of risks.

If an individual doctor provides treatment in an inappropriate manner or without informed consent, how might that be addressed?

A. There are multiple levels of oversight within the healthcare system to address inadequate performance, be that at the individual hospital level, at the individual patient level, or at the state level. So at my institution, there is what is called the PPEC, Professional Practice Evaluation Committee, and if there are complaints about inadequate practice or inappropriate practice, the PPEC committee would evaluate those concerns, might recommend remediation, and if that was ineffective, the provider could lose their privileges at our institution in providing care.

There's certainly mechanisms to address inadequate performance through the malpractice system, as well as at the licensing level. So state licensing boards would consider, again, concerns about unprofessional conduct and might effect remediation plans or remove a provider's license to practice.

Q. And as you understand it, those are all systems that are currently in place to regulate medical providers to ensure appropriate care, including gender-affirming care?

A. Yes.

Q. Dr. Antommaria, are you aware of any empirical studies showing that providers are providing gender-affirming medical care without appropriately informed consent?
A. No, I am not.
Q. Dr. Antommaria, are you familiar with utilization rates of gender-affirming medical care?
A. I am.
Q. What do you know about the utilization trends of gender-affirming care in the last 30 years?
A. That, in general, the utilization rates have increased over that period of time.
Q. How would you account for the increased utilization of those treatments over time?
A. So there would be a variety of potential reasons for that increased utilization over time. In part the increase in the available treatment, in terms of the numbers of centers that are available that provide that care, has increased over time.

And then there have been broader social changes which have decreased the stigma of identifying as transgender or seeking a diagnosis of gender dysphoria, which may increase individual's willingness to seek treatment.

Q. Have utilization rates for treatments for other medical conditions also seen increases over the last 30 years?
A. So in the way that there have been increases in the diagnosis of gender dysphoria, there have also been increases in

other diagnoses including autism as well as Type 1 diabetes over comparable time periods.

Q. And are increased utilization rates inherently a bad thing?

A. No. If there are increasing numbers of individuals who have a particular diagnosis having increased utilization rates as a result of them seeking and obtaining treatment would be intrinsically a good thing.

Q. Where utilization rates increase over time, is it a common response for the medical community's use of those treatments to diminish?

A. No. There might be questions -- so I'll use an example from my area of practice in hospital medicine.

So I treat children with bronchiolitis, which is a respiratory infection in children under two. There has been the development of a new technology called high-flow nasal cannula which is an alternative way to provide ventilatory support to help them get rid of carbon dioxide.

The utilization rates of high-flow nasal cannula have significantly increased in the last ten years. That's been a good thing because, in part, it allows us to treat these patients without having to intubate them -- put a breathing tube in them -- and over time allow them to be treated on the general hospital floor instead of the Intensive Care Unit.

So the increase in utilization has, in general, been a very positive thing for patients and their families.

There is a minor concern, potentially, now that high-flow nasal cannula is being over-utilized. And so wanting to make sure that the utilization is correct, but that's at the margins of the overall utilization being a positive thing for patients and their families.

Q. Dr. Antommaria, some of the states -- some of defendants' experts have attempted to discredit WPATH by asserting that they are not a scientific organization because their membership includes members of the patient community who are not medical professionals.

Is the inclusion of other stakeholder groups atypical for research or the development of Clinical Practice Guidelines?

A. So it is my general understanding that WPATH requires professional credentials in order to be a full member of the organization.

In developing of its standards of care, it incorporated stakeholder groups who were a minority of the participants who developed the standards of care, but that would be consistent with general trends in the development of Clinical Practice Guidelines.

So as we talked about in the development of recommendations it's important in considering the risks -- the balance of the risks and benefits that that balance reflects the evaluation of the risks and benefits of the patient groups. And so incorporating them in guideline development is a beneficial

change that has occurred over time rather than being problematic.

Q. Some of defendants' experts point to systematic reviews of the literature that describe the evidence base for gender-affirming medical care as being limited. What's your response to that?

A. That those systematic reviews are not Clinical Practice Guidelines. They do not make recommendations. And so the fact that they are evaluating the quality of the evidence has implications for recommendations, but do not intrinsically entail a specific recommendation.

Q. Dr. Antommaria, some of defendants' experts reference a systematic review of Clinical Practice Guidelines by Dolan, et al, in support of claim that the Endocrine Society Guidelines and the WPATH Standards of Care are of low quality.

What's your response to that?

A. The methodology that's used by Dolan, et al does not provide cut offs for assigning a quality grade to Clinical Practice Guidelines.

Q. Do you know what methodology that review used?

A. I apologize. I don't recall off the top of my head.

Q. Some of defendants' experts cite to treatment recommendations from government authorities in other countries.

Are you familiar with that reference?

A. I'm familiar with some decisions of some European

countries. Yes.

Q. What's your response to the assertion that countries in Europe are banning access to gender-affirming medical care, in particular for adolescents?

A. I'm not aware of any European country that has either banned or withdrawn coverage for gender-affirming medical care.

My general understanding of the recommendations are that the United Kingdom, Finland and Sweden are moving to providing gender-affirming medical care in the setting of multidisciplinary clinics, which is the type of care that is typically provided in the United States. And that those countries are also emphasizing the importance of ongoing research in the field. But, in particular, Sweden disclaims that that research will necessarily involve randomized controlled trials.

Q. And so to your knowledge, do the Sweden or Finland treatment recommendations evaluate the strength of the underlying evidence?

A. To the -- so the difficulty with the Swedish and Finnish guidelines are that I don't read Swedish or Finnish and that very limited parts of their reports are available in official English translation. So to the best of my knowledge, based on the limited information available, none of those reports constitute what I would consider a Clinical Practice Guideline that both grades the quality of the evidence and the strength of

recommendations.

Q. Are you familiar with the report from the UK known as the Cass Interim Report?

A. I am.

Q. Can you briefly describe with that is?

A. So a group that is chaired by Dr. Cass, who is an imminent British pediatrician, has been chartered to review the provision of gender-affirming medical care in the United Kingdom.

They have commissioned systematic reviews of the literature and have issued an interim report in the process of issuing a final report.

The interim report has recommended the development of regional multidisciplinary teams to provide gender-affirming medical care and building an infrastructure in order to provide research in the field. But the interim report makes no specific recommendations relative to the use of medications relative to gender-affirming medical care.

Q. Some people have characterized that report as shutting down gender-affirming care for adolescents in the UK. Is that a correct assertion?

A. That would not be my characterization. The Cass Commission has recommended the closure of a clinic that historically had provided evaluation for individuals with gender dysphoria, but rather than closing down the provision of gender-affirming medical care it is trying to address a substantial problem with

a large wait list and make evaluation and treatment more readily available to adolescents in the United Kingdom.

Q. Dr. Antommaria, some of defendants' experts rely on other organizations' views about gender-affirming medical care, such as the Society for Evidence-Based Gender Medicine, rather than the Endocrine Society and WPATH.

What's your reaction to that?

A. I'm not aware that the Society for Evidence-Based Gender Medicine has produced a Clinical Practice Guideline for gender-affirming medical care.

Q. And to your knowledge -- sorry. Strike that.

Dr. Antommaria, defendants claim that patients with gender dysphoria engage in self-diagnosis. Is that accurate in your view?

A. I would not consider it accurate, or to the extent that it is accurate it's not dissimilar to other medical conditions. So it's not uncommon when I see patients for them, based on their symptoms, to have a sense of what they have.

If they have a fever and a cough and shortness of breath they might reasonably suspect that they have pneumonia. It would, however, be up to the healthcare provider to confirm that diagnosis and make a treatment recommendation.

I would say that individuals with gender dysphoria might have reason to believe that they have gender dysphoria, but it would be up to their healthcare providers to appropriately

evaluate and diagnose them as to whether they, in fact, have gender dysphoria.

Q. So in your view, do medical diagnoses commonly rely on patient's self-report of their symptoms to medical providers?

A. Yes. When I see a patient the process that we undergo would be obtaining a history performing a physical exam. The history is about obtaining the report of their symptoms.

There are other medical conditions that rely on individual's self-report of their symptoms. Many other -- the one nonmental health condition that readily comes to mind would be migraine headaches.

Migraine headaches are exclusively diagnosed based on patient's report of their symptoms; the duration, frequency, characteristics of their headaches. And there are, in fact, no laboratory or radiographic studies that allow one to confirm a diagnosis of a migraine headache. Laboratory and radiographic studies are only used in those instances in which one is attempting to exclude other diagnoses.

Q. Dr. Antommaria, are clinicians who perform research in their clinical specialty inherently biased?

A. No, they are not.

Q. Why not?

A. So having heard that claim in the past, it's hard for me to understand who individuals making that claim envision doing that research, if not individuals within their own medical specialty

because they're the individuals who have the knowledge and expertise to frame the research questions and the access to the patients, or potential participants, in order to conduct the studies. And that there are multiple mechanisms in the profession to review potential conflicts of interest and to appropriately address them, including at the level of grant submission, so that if there was a particular individual who had a specific conflict of interest, that would be addressed either in not funding that individual to perform the research, or potentially not publishing the results of their research.

Q. And similarly are clinicians who develop Clinical Practice Guidelines in their clinical specialty inherently biased?

A. They are not.

And medical professional associations generally have robust mechanisms to screen candidates for guideline development committees for potential conflicts of interest and exclude them from potentially participating in the development of such guidelines.

Q. So are clinicians who prescribe treatment for gender-affirming medical care inherently biased, or do they have an inherent conflict of interest in performing research or developing guidelines about that care?

A. No, they are not. They do not have intrinsic conflicts of interest.

Q. And why would that be?

A. Their recommendations are generally based on their knowledge of evidence in the literature and their clinical experience. And that knowledge and experience in and of itself doesn't constitute bias in the negative or pejorative sense of the term. It is, in fact, what patients would be seeking their care for.

Q. Dr. Antommaria, does a condition's cause being unknown mean that there can be no established treatments for it?

A. No. It's not necessary to know the cause of a condition in order to have effective treatments.

Again, I'll rely on my experience as a pediatric hospitalist. So there is a condition called Kawasaki disease which is common to me as a pediatric hospitalist and not uncommon in the general population. And it's an inflammatory disease in younger children. And we do not know what causes it. But we have effective treatments that have been demonstrated to be effective, based on studies. And so our lack of knowledge of what causes the condition does not prevent us from having effective treatments for that condition.

Q. Do the adverse effects of a treatment not being fully elucidated make the treatment experimental?

A. No, it does not.

Q. Why is that?

A. It is not uncommon for the potential side effects of the treatment to not fully be elucidated, say, for example at the

time the FDA approves a medication.

So the FDA reviews evidence of safety and efficacy typically to trials, which may have several hundred individuals, and that that is adequate evidence of safety and efficacy, that there might be uncommon side effects that are identified when that treatment is used in a larger population, or side effects that only become apparent over a longer time frame.

Again, I'll use a COVID example. So the COVID vaccines were approved, but there was post-marketing surveillance, as there are with other approved treatments, in order to potentially identify side effects in larger groups or over longer periods of time. But the FDA, none the less, approved those vaccines as safe and effective.

Q. And has -- excuse me. Has medicine identified a definitive cause of gender dysphoria that you are aware of?

A. It's my understanding that medicine has identified contributing factors of gender dysphoria, including potential genetic influences, but not a definitive cause.

Q. And does that undermine the existence of well-established evidence-based treatments for gender dysphoria?

A. No, it does not.

MR. CHARLES: Your Honor, I'd like to show the witness a stipulated exhibit labeled Defendants' Exhibit 28.

BY MR. CHARLES:

Q. Dr. Antommaria, can you see this document on your screen?

A. I can.
Q. Are you familiar with it?
A. I am.
THE COURT: Is this -- this can be shown to the public, can it not?
MR. CHARLES: Oh, I'm sorry, Your Honor. Yes.
BY MR. CHARLES:
Q. Dr. Antommaria, what is this document?
A. It's a systematic review that was conducted, in part, to support -- I believe it was Swedish recommendations related to gender-affirming medical care, in this case specifically hormone treatment.
Q. I'm going to take you to a section here.
Can you just read that highlighted paragraph to yourself, please, Dr. Antommaria?
(Pause in proceedings.)
THE WITNESS: I've read it, sir.
BY MR. CHARLES:
Q. Okay. And can you -- I'm looking at the sentence that starts, "Given the current lack of..."
Do you see that about halfway through the paragraph?
A. I do.
Q. Okay. And it states: *Another ethically feasible option would be to randomize individuals to hormone therapy with all study participants, independent of intervention status,*

receiving psychological and psychosocial support.

Do you understand what kind of study design that is suggesting?

A. So I will note that this is an accepted article, which means that it is not in its final published form and has yet to undergo copy editing.

The sentence is hard for me to understand and appears in some ways to not be well formed. But in particular I would say it's hard for me to envision the study design, because they talk about randomizing individuals to hormone therapy, but they are suggesting that that would be the intervention. But they don't suggest in the sentence what they would be randomized in terms of what the control is.

So it would be at least incomplete in terms of the type of study design that they are envisioning.

Q. Based on what you can understand from that suggestion, would that be an ethical study design for gender-affirming medical care?

A. So I don't -- so their claim about it being ethically feasible is simply an assertion. They don't -- so I'll say this as an ethicist, they don't provide an argument for why it would be ethically feasible. So I have both difficulty understanding what design they envision and why they think it would be ethically feasible because they don't provide specific reasons to justify that assertion.

I would have concerns about their subsequent sentence that said: *Controlled trials do not necessarily require placebo treatment, but could for example build on the date or time of starting hormonal therapy to generate comparison groups*, which might suggest that they envision a study design that required -- that is dependent on there being a waiting list in randomizing people, for example, to initiate treatment versus continue on the waiting list. But that would strike me as ethically problematic, because it would seem that the primary ethical thing would be to decrease the waiting list as opposed to utilizing the waiting list as a mechanism to generate a clinical trial.

Q. Dr. Antommaria, we discussed earlier today the Florida Medicaid GAPMS memo.

Do you believe the GAPMS memo properly characteristics gender-affirming medical care and the evidence base for it?

A. I do not.

Q. Why is that?

A. Because I believe that there is evidence of the safety and efficacy of gender-affirming medical care and that there are appropriate mechanisms to obtain informed consent for gender-affirming medical care, and that it is a medically indicated treatment.

Q. And, Dr. Antommaria, is gender-affirming medical care experimental?

A. It is not.
Q. Or investigational?
A. So it is possible for gender-affirming medical care to be part of a trial or for research to be conducted on gender-affirming medical care. But as a broad category, as it is used in clinical practice, is it a medically indicated clinical treatment and is not experimental except in those specialized circumstances in which research is being conducted.
MR. CHARLES: Finished, Your Honor.
THE COURT: All right. Before we start cross, let me note, the last exhibit I think you used was Defendants' Exhibit 28. I think you said it was stipulated. I don't think it was. I don't know if you wanted it admitted.
MR. CHARLES: I'm sorry, Your Honor.
THE COURT: It doesn't matter. I'm just noting it -- I think it has not been admitted. If somebody wants it admitted, you need to offer it.
MR. PERKO: We'd like it to be admitted, Your Honor.
THE COURT: You would like it admitted?
MR. PERKO: Yes, sir.
THE COURT: Is there --
MR. CHARLES: No, we don't want it to be admitted, Your Honor.
THE COURT: All right. We'll wait until it's authenticated and a foundation is established.

CROSS-EXAMINATION

BY MR. PERKO:

Q. Good afternoon, Dr. Antommaria.

Dr. Antommaria, you're a pediatrician and a bioethicist; right?

A. Correct.

Q. You are not a psychiatrist?

A. No, I am not.

Q. And you're not an endocrinologist?

A. No, sir, I am not.

Q. And you are not a surgeon?

A. No, I am not.

Q. And you do not diagnose patients with gender dysphoria?

A. I do not provide the initial diagnosis of gender dysphoria to patients, no.

Q. And you talked at length about the GRADE methodology.

MR. PERKO: And if you could bring up Plaintiffs' 157, please.

IT STAFF: I'm sorry?

MR. PERKO: 157.

IT STAFF: Thank you.

BY MR. PERKO:

Q. Now, this is the article that you talked about in direct examination.

The last author listed here is Gordon H. Guyatt. Do you

understand him to be the father of the GRADE system?
A. Sir, you'd have to explain to me which what you mean by father --
MR. CHARLES: Objection.
BY MR. PERKO:
Q. Was he the original author of the GRADE system?
A. The GRADE approach was developed by a multi-author group. He was among the authors of the original paper and an author on the subsequent publications.
Q. You've never heard him acknowledged as the father of the GRADE system?
MR. CHARLES: Objection, Your Honor.
THE COURT: Overruled.
THE WITNESS: I'm to answer the question?
THE COURT: Yes, you are.
THE WITNESS: Not until you've used the term today, sir.
MR. PERKO: Okay. If we could turn to that Table 2 on Bates number 6349 that you previously testified about.
BY MR. PERKO:
Q. Now, Dr. Antommaria, you previously testified about the low evidence -- or quality of evidence in this table. And I believe you said it meant our confidence is the effect estimate -- in the effect estimate is limited. But you did not read the second sentence.

Can you tell me what that says?

A. The rest of the sentence after the colon states: *The true effect may be substantially different from the estimate of the effect.*

Q. And what is very low quality of evidence defined as?

A. Would you like me to read that sentence?

Q. Yes, sir.

A. *We have very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.*

Q. And you talk a lot about --

MR. PERKO: You can take that down now.

BY MR. PERKO:

Q. You talked a lot about the Endocrine Society's Clinical Practice Guidelines.

In your expert report, you state that the Endocrine Society Clinical Practice Guidelines make 28 recommendations, and that 10 are strong, 12 are weak, and 6 are ungraded good practice statements.

Do you recall that?

A. So I don't have a copy of the report in front of me, sir.

MR. PERKO: Could we bring up -- I'm sorry. I have too much paper here.

Bring up Plaintiffs' 5.

May I approach, Your Honor?

THE COURT: You may.

IT STAFF: Plaintiffs' 5?

MR. PERKO: If we could turn to page 11.

BY MR. PERKO:

Q. In the paragraph 23 that starts on page 11, you state: *The Society's clinical practice guideline for the endocrine treatment of gender-dysphoric/gender-incongruent persons makes 28 recommendations.*

Is that an accurate statement?

A. Yes, sir.

Q. You go on to say: *Ten are strong, 12 are weak, and six are ungraded good practice statements.*

Is that a correct statement?

A. Yes, sir.

Q. Now, you mentioned ungraded good practice statements on your direct. Can you tell me what that is?

A. Those are recommendations for which there is not substantial evidence available, and they are made as recommendations for practice without a specific grading of evidence in support of them.

Q. You are saying they are recommendations?

A. I'm sorry?

Q. You are saying that they are recommendations?

A. They are not recommendations in the sense of strong or weak recommendations, but I would say that I think that they're

broadly understood as recommendations in the sense of directing provider performance.

MR. PERKO: Can we bring up page 39?

Which is exhibit C to your expert report.

It's the very last page. It's Appendix C to his report -- Exhibit C. It's the very last page. It should be, at least.

There we go.

BY MR. PERKO:

Q. So this is Exhibit C to your expert report, and it does -- in footnote 3 it says: *Upgraded Good Practice Statement.* And then, quote: *Direct evidence for these statements was either unavailable or not systemically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.*

Is that a correct understanding of what ungraded good practice statements are?

A. Yes, sir.

Q. Going back to -- on page 11, again, paragraph 23. Page 11.

After you say that: *Ten are strong, 12 are weak, and six are ungraded good practice statements,* you say that: *Three are based on moderate, 14 on low, and five on very low-quality evidence.*

Is that a correct statement?

A. Yes, sir.

Q. You also mention that the Endocrine Society has guidelines on pediatric obesity. Do you recall that?
A. Yes, sir.
Q. Those guidelines don't recommend the use of hormone therapy for pediatric obesity, do they?
A. I don't believe that they do, sir.
Q. You'd agree with me that there is no confirmatory laboratory or radiographic study for the diagnosis of gender dysphoria, wouldn't you?
A. Can you repeat your question, sir?
Q. Yes.
There is no confirmatory laboratory or radiologic -- radiographic study for the diagnosis of gender dysphoria?
A. That's correct, sir.
Q. You talked about migraine headaches as having similar quality evidence to support it as gender dysphoria.
What's the treatment for migraine headaches?
A. So, sir, I don't believe that I talked about the quality of the evidence related to migraine headaches. I believe that I discussed that migraine headaches are diagnosed based on patients' reports of their symptoms.
Q. Thank you for that clarification.
What's the treatment for migraine headache?
A. This is a pharmacotherapy for migraine headaches, sir.
Q. There is what?

A. There are medications that are used to either prevent or treat migraine headaches, sir.
Q. Is hormone therapy used to treat migraines?
A. Not to the best of my knowledge, sir.
Q. And you're a member of the American Academy of Pediatricians; right?
A. The American Academy of Pediatrics.
Q. Pediatrics.
A. Yes, sir.
Q. Are you aware that -- and I'll refer to it as the APA; is that all right?
A. The AAP, sir.
Q. I'm sorry. The AAP.
Are you aware that the AAP endorsed WPATH's Standards of Care?
A. So the AAP endorsing another medical professional organization's Clinical Practice Guideline has a very specific meaning. And no, I'm not aware that the AAP has endorsed WPATH's SOC 8.
Q. Has the AAP taken a position on the WPATH Standards of Care?
A. The AAP has taken positions on gender-affirming medical care.
Q. Have they taken a position on the WPATH's Standards of Care?

A. On the recently published 8th version?
Q. I believe it was the 7th.
A. So I don't recall a specific statement by the Academy on SOC 7 or SOC 8.
Q. But you did say that the Academy did endorse gender-affirming care? Did I hear you correctly?
A. So the American Academy of Pediatrics has not published a Clinical Practice Guideline on gender-affirming medical care, but has published other documents in support of gender-affirming medical care.
Q. Okay. Were you and your fellow members asked to vote on the AAP's endorse -- or position on gender-affirming care?
A. No, sir, I wasn't. But I was also not asked as a member of the Academy to vote on its Clinical Practice Guideline for the treatment of febrile infants.
Q. So it's possible that not all members of the AAP agreed with the AAP's position on gender-affirming care, isn't it?
A. Yes, that is possible, sir.
Q. It's possible that the majority of the members didn't agree with that position statement, isn't it?
A. As a theoretical possibility, sir?
Q. Is it possible that a majority of the members did not agree with that position statement?
A. It would theoretically be possible, but I would believe it to be highly unlikely.

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023 /s/ Mohammad O. Jazil

No. 23-12159

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME VI OF XIII

Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
(850) 274-1690

Counsel for Defendants-Appellants Florida Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

Ashley Moody
Attorney General of Florida

Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
(850) 414-3300

Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

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11	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
11	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
11	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
11-12	Doc.193-16, DX16	WPATH Standards of Care, Version 8
12-13	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
13	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: September 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
Phone: (850) 391-0503
Facsimile: (850) 741-1023
mjazil@holtzmanvogel.com
mbeato@holtzmanvogel.com
Counsel for Defendants-Appellants Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

/s/Joseph E. Hart
Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
Phone: (850) 414-3300
henry.whitaker@myfloridalegal.com
joseph.hart@myfloridalegal.com
Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

Q. You talked about the Swedish -- I don't know if you used the phrase, but the Swedish National Board of Health and Welfare coming out with a new position.

Do you recall that testimony?

A. Yes, sir.

MR. PERKO: Could we bring up Defendants' 8?

BY MR. PERKO:

Q. Do you see it on your screen?

A. I do, sir.

Q. Is this the official translation that you're referring to about the Swedish physician paper?

MR. CHARLES: Objection, Your Honor.

THE COURT: What's the objection?

MR. CHARLES: It lacks an authentication certificate -- an official translation certificate.

THE COURT: Well, he's asking. Let's find out if Dr. Antommaria knows what it is.

THE WITNESS: Can you scroll through several of the pages, sir?

BY MR. PERKO:

Q. Sure.

A. Can you keep going, please?

To the best of my understanding, this is the official translation of the summary of their document. It is not an official translation of the entire guideline.

Q. You referred to official translation (indiscernible) --

(Reporter requested clarification.)

THE COURT: Slow down.

Look, here -- everybody speak up, speak one at a time. It's getting late in the afternoon. Everybody is slowing down, but we need to keep going. So speak up and make it clear.

We're going to be reading some papers back and forth. When you're reading, read slowly and loudly. We can all read faster than we need to read in the courtroom.

So let's get back on track.

You had an objection?

MR. CHARLES: Yes, Your Honor. Lacks authentication.

THE COURT: He just authenticated it. The objection is overruled.

MR. PERKO: Can we go to page 3, the first paragraph under "Caution in the use of hormonal and surgical treatment"?

THE COURT: And I guess, before you ask the question, I can ask: Do you think this is not what it purports to be?

MR. CHARLES: Your Honor, it appears to be a document online. We don't know anything else about it.

THE COURT: Well, your witness just said what it is, so I overrule the objection.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. Do you see this paragraph? It says: *At group level (i.e.*

for the group of adolescents with gender dysphoria, as a whole) the National Board of Health and Welfare currently assesses that the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments. The National Board of Health and Welfare therefore gives the following weak, negative recommendations as guidance to the healthcare system.

And those include *treatment with GnRH analogues, gender-affirming hormones, and mastectomy can be administered in exceptional cases.*

Is that your understanding of what the Swedish National Board of Health and Welfare concluded?

A. So, sir, this is a different document than the one with which I am familiar.

THE COURT: All right. Let's back up.

Where did this come from?

MR. PERKO: It came from the Internet, Your Honor.

THE COURT: I sustain the objection.

If you find somebody that knows what this is, you can put it in, but I take what the doctor has just told me to be that when he first said this is what he thought he had seen, now having seen more of it, he does not think it is what he has seen.

So if all you've done is pull some document off the Internet without anybody who can say what it is, it's not coming

in.

MR. PERKO: Fair enough, Your Honor.

THE COURT: You've got an expert -- I assume you've got experts on your side, and somebody will know what this is.

But, look, you -- on both sides, don't go pulling preliminary drafts and bringing them in here as if they're some official document. So I assume that this is really the official document and you have somebody that's going to say it is, and when you do that, I'll admit it.

MR. PERKO: Fair enough, Your Honor.

Thank you, Your Honor. I think that's all I have.

THE COURT: Redirect?

MR. CHARLES: Nothing further, Your Honor.

THE COURT: There was some discussion, I think on your direct examination, about the increase in the number of -- I think it was adolescents seeking treatment, and you said if -- in effect, as I grasped it, you said, in effect, if these are people who need treatment, the increase in people seeking treatment is a good thing. I get it.

Is there any way to know whether the increase in the number of people seeking treatment is an increase in the number of people seeking treatment out of a population of people who need treatment that's unchanged or instead is reflective of an increase in the number of people who need treatment?

I asked that very badly. I hope it came across. The

idea is are we looking at an increase in the number of people with gender dysphoria, or are we looking at a situation where it's the same percentage of people who have gender dysphoria, it's just that more of them are seeking treatment?

THE WITNESS: I don't think that we have that information available to us. I think going forward -- but even know there are not broad in the U.S. population-based estimates of the measures of the number of individuals with gender dysphoria, and certainly that information wasn't available in the past. So we don't -- we are not able to make those comparisons.

THE COURT: I take it it would be very difficult even now to find out what percentage of people in the population are trans.

THE WITNESS: So there are people who are working in order to be able to do that, both in terms of developing robust questions in surveys in order to do that, as well as being able to field those surveys to a representative group of people. But those are still barriers to being able to answer the question that you are asking, sir.

THE COURT: Very hard survey to get honest answers to, I take it?

THE WITNESS: Well --

THE COURT: Sociological research is always difficult. This one has got to be one of the harder problems, isn't it?

THE WITNESS: Somewhat outside of my field, sir. I might not say -- certainly there might be individuals who, again, because of the social stigma, might have hesitance to answer honestly, but some of the issue is just how do you ask the question at all and in a way that people respond consistently.

THE COURT: One of the other discussions that you had, I think on the direct examination, was about this assertion that the people who are providing care in this field are biased. And, frankly, I understand the concern. There's the old statement when the only tool you have is a hammer, everything looks like a nail. On the other hand, if we're going to study a cardiology problem, we're not going to get pediatricians to do the research. We're going to get the cardiologists to do the research. That's why you'd do it.

So I've heard from you and the other experts about clinics where this kind of work is done, so, for example, the University of Michigan clinic where people come.

Are there any successful practices treating gender identity in other ways, under other paradigms, successful practices that -- by "successful" I mean that have attracted people who wind up satisfied with the outcomes. Is that going on anywhere?

THE WITNESS: I'm not aware of what you refer to as successful practices using a different paradigm for postpubertal

children, sir.

THE COURT: Thank you.

Questions just to follow up on mine?

MR. CHARLES: No, Your Honor.

MR. PERKO: No, Your Honor.

THE COURT: Thank you, Doctor. You may step down.

(Dr. Antommaria exited the courtroom.)

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Thank you, Your Honor. I believe Ms. Altman will be calling our next witness, but we're wondering if we could take a brief afternoon break for just --

THE COURT: I mean, if someone needs a break, we can take it, but, look, what I'd like to do is take one more break this afternoon. If we take it now, it's going to be a long afternoon.

MR. GONZALEZ-PAGAN: I understand. It's been requested of me, so I defer.

We're okay.

THE COURT: So let's keep going.

Who is the next witness?

MS. ALTMAN: Your Honor, the plaintiffs call Jeffrey English.

(Mr. English entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

JEFFREY ENGLISH, **PLAINTIFFS WITNESS, DULY SWORN**

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: My name is Jeffrey A. English. My last name is spelled E-n-g-l-i-s-h.

MS. ALTMAN: Your Honor, may I approach?

THE COURT: You may.

MS. ALTMAN: I have put the exhibits -- we're going to call them up electronically, but I also have paper copies here, and I have a copy for the Court.

THE COURT: I've got the one electronically and the one you're going to call up, so thank you.

MS. ALTMAN: All right.

DIRECT EXAMINATION

BY MS. ALTMAN:

Q. Good afternoon, sir.

We've met before?

A. We have.

Q. And can you introduce yourself to the Court, please?

A. My name is Jeff English.

Q. Were you previously employed by the Agency for Health Care Administration?

A. Yes.

Q. And if I say AHCA, will you agree with me that that's going

to refer to the Agency of Health Care Administration?
A. Yes.
Q. For what period of time were you employed by AHCA?
A. I believe I started in September of 2019, and -- until February of 2023, so --
Q. And --
A. Yeah.
Q. -- what positions did you hold while employed there?
A. I was a Government Analyst II. Initially in that role I was responsible for the generally accepted medical standards process, and then ultimately I transferred out of that position and into the position as the Medicaid state planning coordinator.
Q. In the Government Analyst II position -- the Generally Accepted Professional Medical Standards --
A. Uh-huh.
Q. -- we can call that GAPMS; is that correct?
A. Correct.
Q. And you were the GAPMS guy?
A. Yes, I was.
Q. And how long did you hold that position?
A. Three years.
Q. How long did you hold the state planning coordinator position?
A. Several months.

Q. When did you leave AHCA?
A. I left in February of 2023.
Q. Did you leave voluntarily?
A. I did.
Q. When you decided to leave AHCA, did you have another job?
A. I did not.
Q. But you chose to leave anyway?
A. I did.
Q. Are you working today?
A. I am not.
Q. Are you being compensated for your time?
A. I am not.
Q. Why did you choose to leave AHCA?
A. It was a combination of personal reasons and professional reasons, some family considerations, and just the direction that the agency seemed to be going. There were a lot of morale problems, and I just didn't feel like -- I no longer wanted to be associated with a position that I didn't feel had any more integrity.
Q. Is the position that you're referring to your position as the GAPMS guy?
A. It is.
Q. And is that the position for which you felt the GAPMS no longer had any integrity?
A. It is.

Q. Can you describe for the Court what you did while you held the title of Government Analyst II, the GAPMS guy, meaning what were your specific roles and responsibilities?
A. Any GAPMS request that came in, I was responsible for researching and writing those reports and routing them through leadership. I also worked quite a bit with regards to things going on with session. I was the liaison with the agency for the Centers for Medicaid & Medicare Services, the National Association of Medicaid Directors, and some other organizations that pertain to the work we did.
Q. Who was your supervisor when you were in the GAPMS role?
A. When I was hired, it was a woman named Christina Vracar, and ultimately it was Jesse Bottcher.
Q. Who is Jesse Bottcher's supervisor?
A. The bureau chief, which would be Ann Dalton.
Q. Why did you transition to the state planning coordinator position?
A. I had -- I had wanted to switch positions. I didn't want to be involved in the GAPMS position anymore. I had tried to leave, and Jesse explained to me that he really wanted to keep me and offered me my choice of a couple of different Government Analyst II positions in order to try and get me to stay.
Q. And the period you're talking about where you no longer wanted to be associated with the GAPMS role, was that after the June 2, 2022, GAPMS report on gender dysphoria was issued?

A. It was.
Q. And prior to that, you were not looking to leave that role, were you?
A. No.
Q. Did you resign after the June 2, 2022, GAPMS report on gender dysphoria was issued?
A. I did. I sent a two-week notice to the bureau chief and my supervisor.
Q. The bureau chief being Ann Dalton?
A. Yes.
Q. Did you end up resigning?
A. No. That was when Jessie came to me and convinced me to stick around a little longer.
Q. And you stuck along, I guess, about six more months; is that fair?
A. That's fair.
Q. When you tendered your resignation in the summer of 2022, did you explain to them why -- why you were resigning?
A. I didn't lay that out in the email to Ann, but Jesse was well aware of the circumstances of why I wanted to leave the position.
Q. And when you say the circumstances of why you wanted to leave the position, did it relate to the June 2, 2022, GAPMS report?
A. And its impact on the process as a whole.

Q. What do you mean by that?
A. Part of the process -- when you get a request, you end up kind of having a working relationship, so to speak, with the requester. They trust you to see the report through. There were multiple reports that had been written that were lying around that had not been reviewed. There were people who mistakenly believed that I had written the June 2 report. There were a host of reasons why I didn't want to stay in that position.
Q. Did you write the June 2, 2022, GAPMS report on gender dysphoria?
A. I did not.
Q. What is the purpose of a GAPMS report?
A. It's a request for coverage. It's a coverage determination document that's prepared in response to a request for coverage for something that Florida Medicaid doesn't already provide coverage for.
Q. Does it also determine medical necessity?
A. It does.
Q. So it determines both coverage and medical necessity; is that correct?
A. Yes.
Q. While you held the title of Government Analyst II, did anyone else work on GAPMS reports with you?
A. Yes. And you'll have to forgive me. There was a woman

that worked in Medicaid policy briefly who was brought in to help take some longer form -- some longer reports and condense them down to something called a short form GAPMS. And there was a gentleman named Nick who we -- when I accepted the job there was a big backlog, a big queue of requests that had not been addressed, and we had Nick -- we tasked Nick with going through those requests and applying the GAPMS checklist to make sure that every request that was in the queue was truly a GAPMS.

Q. Sir, if you could turn to Tab 1 in your binder.

MS. ALTMAN: For the Court's indulgence, it's Exhibit 18.

THE WITNESS: Okay.

MS. ALTMAN: Plaintiffs' Trial Exhibit 18.

BY MS. ALTMAN:

Q. Do you recognize this document, sir?

A. I do.

Q. What is it?

A. It's the Florida Medicaid GAPMS report on gender dysphoria.

Q. Who created this document?

A. Matt Brackett.

Q. Did you have any involvement in the preparation of this document?

A. None whatsoever.

Q. Does this GAPMS report set out the basis for AHCA's determination to not cover treatments for those diagnosed with

gender dysphoria, including treatment such as puberty-suppressing medications and cross-sex hormones?
A. It does.
Q. Is the June 2nd, 2022 GAPMS report the basis for AHCA to establish Florida Administrative Code Rule 59G-1.050, which bans medical treatments for gender-affirming care?
A. Yes.
Q. Was this GAPMS report created while you were still employed by AHCA as a Government Analyst II, as the GAPMS guy?
A. Yes.
Q. And is this a business record of AHCA maintained in the ordinary course of business that you had access to while you were employed by AHCA?
A. Yes.
Q. Where was this record maintained?
A. On AHCA's website.
Q. Was there a slogan associated with it?
A. I believe it was Let Kids be Kids.
Q. And at the time this GAPMS report was created, who was responsible for preparing GAPMS reports?
A. Myself.
Q. Did you have any role in drafting this report?
A. I did not.
Q. Were you asked to participate in the drafting of this GAPMS report?

A. I was not.
Q. Other than this GAPMS report, meaning what's been marked as Plaintiffs' Trial Exhibit 18 for identification, are you aware of any other GAPMS report while you were employed there that was created by someone other than you while you were in the Government Analyst II position handling the drafting of GAPMS reports?
A. I am not.
Q. Prior to the June 2022 GAPMS report, are you aware of any other instance where a GAPMS report was drafted and issued without your direct involvement?
A. I am not.
Q. At the time of the June 2022 GAPMS report, were there other GAPMS reports in queue?
A. Yes.
MS. ALTMAN: And, Your Honor, we'd ask that Plaintiffs' Trial Exhibit 18 be moved into evidence.
MR. PERKO: Your Honor, our only objection is it's not complete. It doesn't have the attachments to it. We'd offered that into evidence.
THE COURT: The one in this book has some attachments. Is that not all of them?
MR. PERKO: I don't believe it does, Your Honor.
MS. ALTMAN: Your Honor, Plaintiffs' Trial Exhibit 18 is just the report, which is what we are using with Mr. English.

The attachments are the -- I'll use air quotes -- assessments of the experts, for lack of a better word, that they attached to the report.

THE COURT: Does the whole thing have a different number? Is there a defense number?

MR. PERKO: DX6.

THE COURT: DX6?

MR. PERKO: 6.

THE COURT: DX6 is admitted.

(DEFENDANT EXHIBIT DX6: Received in evidence.)

THE COURT: And I'll admit Plaintiffs' 18 as well. It won't hurt to have the two versions.

MS. ALTMAN: Thank you, Your Honor.

THE COURT: And if you are going to work with him on this one, I don't want to have to worry about whether the page numbers are the same or whatever, so I'll admit both exhibits.

(PLAINTIFFS EXHIBIT 18: Received in evidence.)

MS. ALTMAN: Thank you, Your Honor.

And just for the Court's edification, we are not going to go through the attachments with this witness.

Thank you.

BY MS. ALTMAN:

Q. Why was the June 2022 GAPMS report pushed in front of other GAPMS reports that were in process before this one?

A. Because the request for it came in from the executive.
Q. And who is that?
A. The Governor.
Q. What type of information is in a GAPMS report?
A. Everything from recognized relevant Clinical Practice Guidelines.

There's usually -- there is always a literature section pertaining to the most relevant studies on the subject.

There's coverage considerations, both from other state Medicaid programs and major insurance companies.

There is -- and if need be for a particular report, there can be a fiscal analysis included as well.

Q. Is there more than one type of GAPMS report?
A. There's what I call a traditional GAPMS report, which is a traditional request that comes in and goes through the normal process and routing process. And then there is something that's called an expedited GAPMS that is an internal memo between a health plan and Medicaid policy when the health plan denies coverage for something as experimental and investigational.
Q. Is a request from the Governor a traditional request for a GAPMS report? Is that how they traditionally come in?
A. That's what this report would most closely -- would most closely resemble.
Q. And I'm sorry. My question probably wasn't clear.

When you talk about the requests for how a GAPMS is

requested, do they usually come from the Governor? The request?
A. No, they come in through an email address called Health Service Research, and it's typically either providers who are seeking treatment for a patient, or, say, a manufacturer who has invented a new medical device or some type of company that has treatment that they want Florida Medicaid to cover.
Q. While you were the GAPMS guy, were there any requests that came in to you from the Governor?
A. No.
Q. Just this one?
A. Well, this one didn't come to me, but, yes, just this request, as far as I know.
Q. And do you know who it came to, meaning the request from the Governor?
A. Ultimately it went to Matt Brackett.
Q. Is the GAPMS process used to ask for treatment or service to be excluded?
A. No, it's a request for coverage; it's not a request for exclusion.
Q. Sir, if you could turn to tab 2.
Do you recognize this email exchange?
A. I do.
Q. And what is it?
A. That is an exchange between myself and DeDe Pickle pertaining to, I believe, an expedited GAPMS.

Q. And you said DeDe Pickle. This says Devona. Does Devona go by DeDe?
A. Yeah. I knew her as DeDe.
Q. Who is she?
A. She is, I believe, now the -- I believe she's the head or senior person on the Canadian drug import team. And at the time of this email, she was -- in situations where Ann Dalton, the bureau chief, was unavailable in the office, then DeDe would frequently be put in place to cover for her while Ann was gone.
Q. At the time of this email exchange, were both you and Ms. Pickle employees of AHCA?
A. We were.
Q. Was this written and exchanged while you were performing your role as Government Analyst II, meaning while you were the GAPMS guy?
A. I was.
Q. When you were employed by AHCA, was it part of your regularly conducted business to write emails to other employees of AHCA about the business and affairs of AHCA, and, in particular, matters within the scope of your employment related to GAPMS?
A. It was.
Q. And was this email retained as a business record of AHCA?
A. Yes.
MS. ALTMAN: Your Honor, we would ask that Plaintiffs'

Trial Exhibit 30 be moved into evidence.

MR. PERKO: No objection, Your Honor.

THE COURT: Plaintiffs' 30 is admitted.

(PLAINTIFFS EXHIBIT 30: Received in evidence.)

BY MS. ALTMAN:

Q. Sir, in this email, Ms. Pickle says to you: *Interesting. I went back to read the GAPMS rule. It's for requesting coverage -- not disputing it.*

Did I read that right?

A. You did.

Q. And Ms. Pickle is telling you -- she's citing to a rule there; is that correct?

A. Yes.

Q. What rule is that?

A. That's the GAPMS rule.

Q. And she's indicating that that GAPMS rule provides only for coverage requests, not disputing or excluding coverage; correct?

A. Correct.

Q. The exhibit we were looking at, the June 2022 GAPMS for gender dysphoria, is that a GAPMS for coverage or a GAPMS to exclude coverage?

A. It reads like a document to exclude coverage.

Q. And that's not what the GAPMS rule was designed to do, according to Ms. Pickle and yourself; is that correct?

A. That's correct.

Q. Sir, if you can turn to Tab 3 in your binder.

MS. ALTMAN: And, Your Honor, this is a stipulated exhibit, Exhibit 23. Plaintiffs' Exhibit 23.

BY MS. ALTMAN:

Q. Do you recognize this document, sir?

A. I do. That's the GAPMS rule.

Q. And that's what Ms. Pickle was discussing with you in the email we were just talking about?

A. It is.

Q. Now, sir, looking at (4), (4) seems to outline the areas that AHCA must consider when determining whether something meets with Generally Accepted Professional Medical Standards; is that correct?

A. It is.

Q. When you held the position of Government Analyst II, did you rely on this rule when preparing GAPMS reports?

A. It was the foundation for every report.

Q. Under the rule, one of the things that AHCA must consider is whether there are evidence-based Clinical Practice Guidelines; is that correct?

A. Correct.

Q. And did you do that when you held that position?

A. I did.

Q. And the rule, 59G-1.035, also requires AHCA to consider the effectiveness of the health service in improving the

individual's health prognosis or health outcomes; is that right?
A. Yes.
Q. And AHCA is also required to consider the recommendations of clinical or technical experts in the field; is that right?
A. Correct.
Q. And these are some of the criteria that AHCA is required to look at as part of the GAPMS process; correct?
A. Correct.
Q. And, again, the purpose of this rule and the GAPMS rule is to establish coverage and medical necessity; correct?
A. Correct.
Q. Not to exclude it; correct?
A. Correct.
Q. Sir, based on your review of the June 2022 GAPMS report on the treatment of gender dysphoria, do you believe AHCA considered the factors outlined in this rule, which is Plaintiffs' Trial Exhibit 23?
A. Not adequately.
Q. What factors do you believe that AHCA failed to consider?
A. I believe they just outright dismissed the evidence-based Clinical Practice Guideline. Quite a bit of the literature that's included and referenced in the work cited is not peer-reviewed scientific literature; it's opinion pieces.
There is no inclusion in the report of coverage policies by major insurance companies, which is a standard part of the

report.

They're dismissive of the effectiveness of the health service in improving health outcomes. And -- yeah -- not well.

Q. Are those things that you would have considered if you had been asked to write the GAPMS report on gender dysphoria?

A. Those are things that my duties and my job required to me to consider.

Q. And the rule requires; correct?

A. Correct.

Q. Are there any examples of evidence-based Clinical Practice Guidelines that AHCA disregarded?

A. Sure. You know, everything from the Endocrine Society to the American Academy of Pediatrics, the American Psychological Association, and there are a host of them, actually.

Q. Okay. Can you describe for the Court the normal timing of the process for the preparations of a GAPMS memo? So, by example, how long would you normally take to research and draft a report from the point at which a request comes in?

A. It can vary depending on the topic and the context of when the request is received. I was generally working on about a six-to-eight-month turnaround time. But I inherited a very large queue when I started, so it was a lot of backtracking to begin with.

Q. And just to make sure I understood you, six to eight months just for the drafting process; is that right?

A. The research and drafting.
Q. Sir, can you look at (4) and just briefly talk through for the Court's edification what you would look at for subparts (a), (b), (c), (d), (e) and (f). What kinds of evidence and information you would look at and just identify the subpart and then some examples for the Court?
A. Well, for instance, with evidence-based Clinical Practice Guidelines, if I was reviewing a treatment for wound healing, there are organizations like the Wound Healing Society and other professional organizations, that have released Clinical Practice Guidelines for the treatment of those types of wounds that might be considered in the report.

The published reports and articles and the authoritative medical and scientific literature published in peer-reviewed scientific literature, it's -- the way we regard it, if it wasn't peer-reviewed, it was opinion and opinion didn't go in the reports.

Utilization trends; we would look at, you know, how many patients have a particular diagnosis or, you know, that would obviously factor into a cost analysis if we were to add the service for coverage.

Coverage policies by other credible insurance payor sources; we look at what other state Medicaid programs cover. And we also look at what the major insurance companies cover.

And then recommendations or assessments by clinical or

technical experts on the subject or field; that could be a subject matter expert that I consult within AHCA, or it could be something like maybe a well-respected researcher or related person to the subject, to the topic, who maybe has written -- is engaged in like a journal letter discussion or something like that. But we didn't typically hire people from outside the agency.

Q. A couple of follow-up questions.

On subsection (f), recommendations or assessments by clinical or technical experts that you were just discussing, would you rely on a practitioner that doesn't treat the area of medicine that was at issue? So, by example, in the area of gender dysphoria, would you rely on or would they be considered subject matter experts if they didn't practice in that area or treat patients of that nature?

A. I don't believe it would occur to me to do so.

Q. And under -- I think you skipped subsection (c).

A. Yes. The effectiveness of the health service; you know, is there a -- does this treatment produce an improvement? And that's -- that's essential to coverage.

Q. Did AHCA consider these factors in issuing the June 2022 GAPMS report?

A. It's a mixed bag. I would describe it as inconsistent. So no.

Q. Did AHCA, while you were the GAPMS guy, hire outside

consultants for this process?
A. No.
Q. Did AHCA ever contract with non-AHCA employees to write assessments in support of a GAPMS report while you held that position?
A. No.
Q. Did AHCA ever pay experts to consult with you and give you a list of sources?
A. Absolutely not.
Q. Sir, if you can turn to Tab 4.
MS. ALTMAN: For the Court, it's Plaintiffs' Trial Exhibit 238. And I believe this is stipulated, Your Honor.
BY MS. ALTMAN:
Q. Can you identify this document, sir?
A. That's the GAPMS checklist.
Q. What is this?
A. That's a required element of the position. When a request comes in, as stipulated in the requirements for the position, the job description, whenever a request would come in, I would have five days to have -- to apply this to the request and then to review it with my supervisor.
Q. Did this document exist before you worked at AHCA?
A. Not that I'm aware of. My -- my initial supervisor, Christina Vracar, and I made this.
Q. You made it together, yourself with your supervisor; is

that correct?
A. Yes.
Q. Why was it prepared?
A. Well, for a couple of reasons. One, as I said, when I started the position there were anywhere from 40 to 50 requests that had come in, most of which had not even been looked at.
What we started to understand when we were looking through the queue was that some of those weren't actual GAPMS requests; they were other types of coverage requests. And so we fashioned this checklist to weed out -- both to weed out non-GAPMS assignments in the queue and also to apply to all the requests, new requests, that came in going forward so that we made sure -- to make things more efficient and to get things into the GAPMS process, when they belong there, as quickly as possible.
Q. Did you utilize this checklist when you issued GAPMS reports?
A. I had to.
Q. Was this part of the basis on which your annual reviews would be conducted? Were you sort of graded, for lack of a better word, on how well and how often you use this document?
A. I was. It's stipulated five days from the request.
Q. Was another thing that you did when you came on as the GAPMS guy -- was part of what you understood AHCA required was to shorten the actual reports?
A. Initially they were -- they were traditional long-form

reports, the ones I wrote. And then -- I kind of outran the coverage, so to speak, and there were more reports than management was able to -- basically I was told we were moving to the short-form reports in order to provide shorter documents for management to read in the hopes of speeding up the process.

So I took long-form reports and condensed them down into, quote/unquote, short-form reports.

Q. How long were those short-form reports supposed to be?

A. They were supposed to be four pages, but a page and a half of that four pages is nonnegotiable template. So what they ended up getting were -- primarily were six- to seven-page reports.

Q. And the June 2022 GAPMS report doesn't comport with the short-form report; correct?

A. That's a 45-page report that was written at a time when I was being asked to submit six- to seven-page reports.

Q. Are there multiple checklists used in connection with preparing GAPMS reports?

A. There are not.

Q. If someone said that there were, would that be truthful?

A. No.

Q. If you could look at the top of the checklist and explain to the Court -- and I'll read the language I'm referring to at the very top of the document. And it says: *If any item on the list is yes, discuss with your manager for the potential to move*

towards a coverage determination (decision point) instead of a GAPMS report.

Did I read that right?

A. You did.

Q. What does that mean?

A. It's basically -- one of the purposes, as I said, of this checklist is to weed out the requests that come in. Some of them are not actual GAPMS reports, but they are just more simplified coverage determination reports, which we referred to as decision points. So we would run the request through this checklist, and depending on what and how many of these things they checked off, it was highly likely that it would not be a GAPMS report.

Q. So, by example, sir, if you look at No. 5, it says: *Does any Medicaid state cover the service?*

If the answer was yes, what would you do?

A. Well, that would be -- you know, it can vary. If it's a situation where, you know, I look it up and I find four states that cover, then that's -- that's something. If I find, you know, 40 states or, you know, a whole lot of states that cover something, then that's going to be a big feather in the cap for the requester, and that will be a clue that perhaps this isn't considered experimental/investigational.

Q. And the same for No. 6, would it be the same analysis: Does any private insurance cover the service?

A. Yes.
Q. And what about No. 7: Does the agency cover a similar device, service, or product?
A. Yes.
Q. The same analysis? So, by example, if AHCA already covered the procedure or service or treatment at issue -- if they were already covering it, what would you do?
A. If AHCA already covered the service, then it wouldn't be a GAPMS. It would just go back -- the requester would be notified that, Hey, this is on our fee schedule. This is what we pay for it, and that's that, and move on to the next project.
Q. So there would be no need for a GAPMS report?
A. No.
Q. To your knowledge, did Medicaid cover puberty-suppressing medications prior to the June 2022 GAPMS report?
A. Yes.
Q. To your knowledge, were puberty-suppressing medications covered for the treatment of gender dysphoria prior to the issuance of the June 2022 GAPMS report?
A. Yes.
Q. To your knowledge, did Medicaid cover cross-sex hormones prior to the June 2022 GAPMS report?
A. Yes.
Q. To your knowledge, were cross-sex hormones covered for the treatment of gender dysphoria prior to the issuance of the

June 2nd, 2022, GAPMS report?
A. Yes.
Q. And the same question, sir: To your knowledge, was gender-affirming medical care covered by Medicaid prior to the June 2022 GAPMS report?
A. Yes.
Q. And to your knowledge, were gender-affirming care -- surgeries, rather, covered for the treatment of gender dysphoria prior to the issuance of the June 2022 GAPMS report?
A. Yes.
Q. So since the three subject matters that are covered in the June 2022 GAPMS report -- puberty-suppressing medications, gender-affirming surgeries, and cross-sex hormones -- were already being covered by the agency, would a GAPMS report have been issued?
A. No. I would have completed the checklist, would have determined that it was already on the fee schedule, would have gone and spoken to my supervisor. And traditionally, because this has happened before, we would have got requests for things we already covered; we would just reach out to them, give them the billing code, the price that Florida Medicaid pays for it, and then we would move on to the next project.
Q. Now, sir, we were talking about the GAPMS report that's behind Tab 1, if you want to look at it.
If I understood your testimony, because all of these things

were covered, the report that's behind Tab 1 would not have been issued; correct?

A. Correct.

Q. And there would have been no need for it, correct, because all of these services were already being covered?

A. Correct.

Q. And was there actually a GAPMS report for puberty-suppressing medications already in existence before this report was issued?

A. I believe so, yes.

Q. And that's true for gender dysphoria; correct? There was a GAPMS report already issued for puberty-suppressing medications in 2016 --

A. Yes.

Q. -- for gender dysphoria?

A. Prior to my approval with AHCA; correct.

Q. Why would AHCA have issued another one then?

A. It's highly unusual. We don't typically re-review things.

Let me fix that. It is -- I've never seen an example where it was something that we had decided to cover through GAPMS and then later did another GAPMS to not cover it. That doesn't exist.

What does happen quite often is that a request comes in; we write the report; the report is denial of coverage for a whole host of different reasons, and then the requester accepts that

and then just turns around and reapplies for coverage again.
Q. Do you know why that was done here?
A. I do not.
Q. Now, the June 2, 2022 GAPMS report covers multiple treatments or procedures; correct?
A. Correct.
Q. Puberty-suppressing medications, cross-sex hormones, and gender-affirming surgeries; correct?
A. Correct.
Q. Is that typical to have a GAPMS report that covers multiple areas, multiple treatments, or multiple services?
A. Not at all.
I was told very, very specifically, one treatment, one GAPMS.
Q. While you were the GAPMS guy, was there anytime where you wrote a GAPMS report that covered multiple treatments, surgeries, or procedures?
A. No.
Q. And if I understood you earlier, the request for this GAPMS report did not come through traditional -- traditional channels; correct?
A. Correct.
Q. It came from the Governor; is that correct?
A. Yes.
Q. Do you know why you were not asked to prepare this report?

A. I only know what I was told by my supervisor.
Q. What were you told?
MR. PERKO: Objection, hearsay.
THE COURT: Overruled.
THE WITNESS: Jessie Bottcher explained to me that he was in a meeting with the bureau chief, and Jason Weida came in and inquired with Jessie if I would be willing to write the report. Jessie said I would not be willing to write the report. And Jessie and Ann recommended that Matt write the report, because Jessie said that he told Jason that Matt would complete any assignment that he was given.
BY MS. ALTMAN:
Q. You said Jason Weida came in; is that correct?
A. To the meeting with Ann and Jessie.
Q. Who is Jason Weida?
A. He's now the secretary of the agency.
Q. Was he at the time?
A. No. He was Medicaid director of policy and quality or something along those lines, I believe, at the time.
Q. And the other two people in the meeting, one was Ann Dalton?
A. The bureau chief. And the other was my direct supervisor, Jessie Bottcher.
Q. Did you at some point learn that this report was being prepared?

A. I did.
Q. How did you learn about that?
A. A member of the Canadian import drug team, Nai Chen, informed me that the project was underway.
Q. Was Nai Chen also working on the project?
A. That's my understanding.
Q. With Matt Brackett?
A. Yes.
Q. And do you -- other than what you just testified, that Jessie Bottcher told you as to why Matt Brackett was chosen, do you have any other understanding as to why Matt Brackett was chosen to write this report since he wasn't in the GAPMS department?
A. Only what Jessie told me. And I know that prior to my arrival at AHCA Matt had been responsible for the GAPMS process for a period of time.
Q. What was your reaction when you learned that Matt Brackett was asked to and was preparing this GAPMS report?
A. The project was explained to me, and as I understood it, I was actually concerned for him.
Q. Why?
A. Well, you know, when you are given an assignment like that coming from someplace like that, there's a lot of pressure to perform and to comply with what the assignment is made to be.
Q. What do you mean by that, what the assignment -- you mean

to reach a specific conclusion?
A. That, and, you know, Matt has a background in academics, and if he had wanted to continue to write or publish or anything like that going forward, I was concerned that, you know, his involvement in this process might do damage to that down the road.
Q. Now, you mentioned earlier that typically it would take six to eight months to prepare the research, the report itself. This report, according to testimony -- and I'd like you to assume that this is what's been testified, that they started on April 20th of 2022, and it was issued by June 2nd of 2022. Is that typical?
A. No.
Q. Is it unusual?
A. Highly.
Q. Would you be able to write a thorough, comprehensive report in that period of time following the rule?
A. I was never blessed with the assistance of experts.
Q. Well, the -- I'm assuming you are referring to the assessments that were attached to the report; is that correct?
A. Uh-huh.
Q. Do any of those experts, for lack of a better word, actually treat individuals with gender dysphoria?
A. Not that I'm aware of.
Q. Would you have reached out to treaters in an area --

individuals who don't treat people in the specific area that you were analyzing?

A. I mean, really, I was a one-man gang, so I wouldn't have reached out to anybody. I would have just sat down and researched and written the report.

Q. Well, for example, if you are looking at a pharmaceutical, do you have resources within the agency?

A. I could go and speak to the pharmacy team about that. Or if it were a piece of durable medical equipment, I could go and speak to the durable medical folks at AHCA.

Q. And what else would you do in order to thoroughly research and analyze whatever subject you were looking at?

A. Extensive, extensive literature reviews. You know, you scour -- research is half the job. So it's just going out and knowing where to find high-quality research and what the best available resources are for the subject matter that you're considering.

Q. Are news articles research that you would have relied on?

A. No.

Q. Are news articles something that's included within the June 2022 GAPMS report as a source?

A. There's probably about a half a dozen of them, yes.

Q. Did anyone ask you whether or not you had the time to evaluate the three procedures or treatments outlined in the June 2022 GAPMS report?

A. No.
Q. Sir, can you look at what's behind Tab No. 5?
MS. ALTMAN: And for the Court and Counsel, it's plaintiffs' trial Exhibit 302.
BY MS. ALTMAN:
Q. We can start at the back if you want. And it starts with an email from Dr. Cogle.
Who is Dr. Cogle?
A. The chief medical officer of Florida Medicaid.
Q. And this was an email exchange between yourself and Dr. Cogle; correct?
A. Correct.
Q. And it looks like the initial email came from Dr. Cogle on June 25th, 2022; is that right?
A. Yes.
Q. And that's about two -- two to three weeks after the GAPMS report was issued that we're discussing about earlier?
A. It is.
Q. And it says: *Hello, Jeff. Good talking with you this past Friday. Are there standard operating procedures* --
MR. PERKO: Objection, Your Honor. She's reading hearsay into the record.
THE COURT: I overruled the earlier hearsay objection under 801(d)(2)(D). Why isn't the same thing true here? This is a statement by a party opponent, is it not?

MR. PERKO: It hasn't been established it was within the scope of his duties.

MS. ALTMAN: I'm happy to --

THE COURT: I can read it and tell it's within the scope of his duty, can't I?

MR. PERKO: Your Honor --

THE COURT: Can you stand up when you are speaking?

MR. PERKO: I'm sorry, your Honor.

It wasn't part of his responsibilities at the time.

THE COURT: Let me make two statements about it.

First, I overrule the objection. I think on the face of it it indicates that it is within the scope of his duties.

Second, when you have to run away from the statements that your own medical director made, you -- when we get to closing argument, you need to explain why it is that I should ignore what your medical director said. That's a heads-up for closing.

Just when you have to run away from what your own people say, you ought to be concerned about how you are going to explain it.

I think it's admissible.

MR. PERKO: Yes, Your Honor.

And I apologize for not standing up. I meant no offense.

THE COURT: Well, I certainly take no offense.

As you've all figured out, I'm a dinosaur. I pretty much lost this battle in the judiciary. I still make people stand up. So -- but there aren't many of us left, and I take no offense.

BY MS. ALTMAN:

Q. Mr. English, at the time of this email exchange, you were still the GAPMS guy; right?

A. I was.

Q. Okay. So Dr. Cogle is asking you whether or not there are standard operating procedures for GAPMS; correct?

A. Correct.

Q. And if you turn back to the first page and then the next two pages, you give him a very lengthy explanation as to what the standards are; is that right?

A. I do.

Q. And that's what you've testified here today to the Court contemporaneously to Dr. Cogle back in June of 2022?

A. Correct.

Q. And in June of 2022, you went through a lengthy process -- and feel free to look at the email to see if you left anything out. But would you agree with me that the process you described to the Court today is akin to one you described to Dr. Cogle in your email on June 27th, 2022, at 2:30 p.m.?

A. It is.

Q. And I note just in the very first sentence, after you say,

"Good afternoon, Dr. Cogle," there is an SOP for GAPMS.

Did I read that right?

A. Yes.

Q. And SOP is short for standard operating procedure?

A. Correct.

Q. And you go on to say: *Typically the requests for consideration of coverage come in through a health service research email or from leadership (less often)*; correct?

A. Correct.

Q. That's consistent with what we discussed earlier, that these are determinations of coverage, not to try and exclude coverage?

A. They're seeking coverage.

Q. Okay. And you go on in the next paragraph -- and I'm certainly not going to make you read this entire document single spaced. But you go on to talk about the checklist.

A. Yes.

Q. And you say it's attached. It says: *The request gets run through the attached checklist, and once it is determined to be an actual GAPMS (rather than a decision point or 'simple' determination) I reach out to the requester and schedule a time to gently walk through the process.*

Did I read that right?

A. Correct.

Q. And I just want to confirm, is the checklist that you are

referring to in this email the one that we spoke about earlier?
A. The one I'm required to use.
Q. Okay.
You then go through a lengthy expression of the process --
A. I apologize.
Q. -- that you discussed with the Court earlier today.
And then you go down -- and I'm going to read from the paragraph that starts with "All of that..." And it says: *All of that is the ideal. The reality is that the reviews get done, the reports get written, and then they all bottleneck with leadership because GAPMS are fairly low on the totem pole of priorities, particularly since the pandemic began.*
Did I read that correctly?
A. Yes.
Q. And what were you trying to explain to Dr. Cogle when you said that?
A. There were at that point somewhere between five and ten completed reports, all of which had been completed for approximately two years. Something I was having to do with each of those reports -- it had been written, but, you know, it's -- a GAPMS report is kind of a snapshot in time, and coverage considerations can change, and the evidence can change.
So while I was awaiting those reports that had been written to be reviewed, I was having to periodically go through and update the coverage considerations and things; maybe another

major insurance company had added coverage or some additional states had added coverage. Everything had to be current for when it was presented to leadership.

Prior to the pandemic and when I was hired for the job, it was explained to me that the GAPMS aren't always a priority, and so you really have to try and stay on top of people to get them to route. When the pandemic started, not just GAPMS, a whole lot of things became less priority, and understandably so in some cases. So I kept a grease board in my office with a list of the completed reports as kind of an effort to shame people into taking a look at them so that we could reach out to the requesters and move forward.

Q. And I'm just going to flip down one paragraph, and it says -- because you mentioned five or six. I think you were short one. It says: *I believe there are currently about seven completed that are still awaiting review and approval from leadership. Some of them have been written for over two years. I have re-reviewed them and made any necessary updates concerning coverage, research, etc. I typically do that twice a year.*

A. Yes.

Q. And is that what you were just explaining to the Court?

A. Precisely.

Q. And so if there was approximately seven -- when you say they were two years, meaning they had been drafted and ready to

be signed for two years?
A. Yes.
Q. So would it be unusual if a GAPMS report was --
A. Well, I mean, something else -- to be fair, something else to consider was that there was a great amount of turnover at the agency, and so -- you know, I had multiple supervisors. We had multiple bureau chiefs. We had multiple secretaries. We had multiple Medicaid directors. And the bureau chief -- my supervisor, the bureau chief, and the Medicaid director are the three spots on my routing form that I need to get the report to.
And there's a big learning curve whenever anyone moves into a new position, and I don't think GAPMS was, quote/unquote, sexy enough for that to be an immediate priority when someone is trying to, you know, acquire the skills and the experience in their new positions.
Q. But in June of 2022 when the gender dysphoria GAPMS report was completed, there were seven in queue that needed to be finalized; correct?
A. Correct.
Q. And was the typical practice to go in the order in which they were received?
A. Ideally.
Q. Well, would it be unusual that a GAPMS report was completed and then signed and executed the next day, as was the case with the -- Plaintiffs' Exhibit 18, the gender dysphoria GAPMS

report?
A. Yes.
Q. Is that unusual?
A. Yes. I mean, there's not a lot of, quote/unquote, queue jumping, so to speak, with the reports. It might be a situation where hypothetically, you know, one topic is No. 4 in the queue and another topic is No. 6, but maybe we're waiting on the results of a clinical trial to finish on No. 4. So I can't go further with that report, so I'll go down to the next one. So there is some out of order, but not typically.
Q. The gender dysphoria GAPMS report, that was written in just over a month and signed the very next day.
A. That entire project was conceived, completed in an extremely accelerated time frame.
Q. Did it follow the GAPMS process, the standard operating procedures that you outlined to Dr. Cogle?
A. No.
Q. And I want to go to the last paragraph on the second page.
THE COURT: Tell me where we stand. We do need to get to a break here at some point. Are you --
MS. ALTMAN: We can break. That's fine. I only have a --
THE COURT: Now is as good as any?
MS. ALTMAN: Yeah.
THE COURT: Let's take 15 minutes, and we'll start

back at ten till 4:00.

(Recess taken at 3:34 PM.)

(Resumed at 3:50 PM.)

THE COURT: Please be seated.

Mr. English, you are still oath.

And, Ms. Altman, you may proceed.

MS. ALTMAN: Thank you, Your Honor.

BY MS. ALTMAN:

Q. Just a few more question, Mr. English.

Earlier you mentioned a conversation with Jesse Bottcher where he told you -- he discussed with you the meeting that he attended with Jason Weida, Ms. Dalton, and himself where he indicated that you would not write the GAPMS report that was being requested.

Do you recall that testimony?

A. I do.

Q. Did he say why he told them you would not write the report?

A. Yes. He did not think that I would be willing to write it. His perception of it was that it was either predetermined or political, and he said that he did not want to supervise the person who did write the report either.

Q. So I have one final question on your email to Dr. Cogle, and if you could turn to the second page at the bottom, and I'm just going to read something and ask you what you meant by that.

A. Okay.

Q. Starting at the last -- at the bottom of the page, it says: *If you will excuse me, I feel obligated to include this information: I was not informed or consulted, did not in any way participate, and did not write the GAPMS concerning gender dysphoria treatment. That particular GAPMS did not come through the traditional channels and was not handled through the traditional GAPMS process. Every report I have written represents my best effort at determining the most timely and accurate information available on the subject under consideration. I do not cherry-pick data or studies and would never agree to if I were so asked. All I can say about that report, as I have read it, is that it does not present an honest and accurate assessment of the status of the current evidence and practice guidelines as I understand them to be in the existing literature. I sincerely apologize if I come across as a bit agitated about it, but as the 'GAPMS guy' around here, lots of assumptions have been made by those who do not know me well. I'm a different sort of person than the author of that report. I can't speak for them. I conduct myself and my work with integrity, and I do not play favorites, yay or nay. Full stop, period.*

What did you mean by that?

A. Dr. Cogle is someone that I have a lot of respect for. He is -- he has very extensive knowledge of research and the type of work that I was doing. My interpretation of his initial

inquiry to me regarding a standard operating procedure for GAPMS was that he had looked at the June 2nd report and did not believe that it -- and this is me. My impression was that he was asking sort of, you know, like, Jeff, do we have an actual SOP for GAPMS? Because that one was a radical departure from the normal process.

And at the same time, shortly before I responded to this email, I had multiple employees that very day ask me about the report and whether or not I had written or participated, and that had been starting to wear on me a little bit.

And so it was important to me that Dr. Cogle understand that I have integrity.

MS. ALTMAN: I have no further questions.

THE COURT: Cross-examine?

MS. ALTMAN: Thank you, sir.

MR. PERKO: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. PERKO:

Q. Good morning, Mr. English.

A. Good morning.

Q. Or afternoon.

A. Or afternoon, yeah.

Q. You said that the request for the June 2022 GAPMS report came from the Governor?

A. Uh-huh.

Q. Did you talk with the Governor?
A. I did not.
Q. Did you talk with anybody in the executive -- in the Executive Office of the Governor?
A. I did not.
Q. Did you talk to the Secretary about the June 2022 report?
A. I did not.
Q. And in your three years working at the -- as the GAPMS guy at AHCA, how many times did you meet with the AHCA Secretary?
A. Maybe a couple of times.
Q. How many times have you met with the Governor's office?
A. I have not.
Q. Were you involved in any rulemaking while you were at the agency?
A. I was.
Q. Which one was that?
A. You know, it was shortly after I started as the state planning coordinator. Some of them had to do with, I think, reimbursements and some other things that were rules that had to be done in conjunction with some of the state plan movements, but the particulars -- I think one had to do with the iBudget program or something like that, but that wasn't really my area of expertise.
MR. PERKO: Can we pull up Plaintiffs' 23, please. It's a copy of the GAPMS rule.

We can -- there we go.

BY MR. PERKO:

Q. In paragraph 3, it says: *Health services that are covered under Florida Medicaid program are described in the respective coverage and limitations handbooks, policies, and fee schedules, which are incorporated by reference in the F.A.C.*

Then it goes on to say: *The public may request a health service be considered for coverage under the Florida Medicaid program by submitting a written request via email to* -- and it gives the email address.

Now, I see that it says that the public may request, but is there anything that prohibits GAPMS from being initiated by some other means?

A. No. I mean, technically, John Doe could send in an email requesting coverage for something. It's typically, like, a manufacturer or provider.

Q. You're familiar with the expedited GAPMS process, right?

A. I am.

Q. And those can get turned around in a matter of days, right?

A. They're required to be.

Q. I'd like to talk a little about your experience.

You worked for AHCA from September 2019 until -- did you say --

A. February of this year?

Q. -- February of 2023?

And from September 2019 to September '22, you were the GAPMS -- you wrote the GAPMS reports?

A. I did.

Q. Did you have other responsibilities during that time period?

A. I did.

Q. For most of those three years, you worked from home because of COVID; is that right?

A. You know, it all kind of runs together. It's probably -- it might be on the side of more months I was home than I was in the office. I'm not, honestly, sure. But there was a stretch where we were all working from home.

Q. In those three years, you had one GAPMS report make it all the way to the final approval; is that correct?

A. That's correct, one traditional GAPMS.

Q. Okay.

A. There were multiple expediteds.

Q. And in those three years, you never supervised anyone, did you?

A. I did not. When I was hired, I was told I would be supervising two people, but those hires were never made.

MR. PERKO: If we could pull the GAPMS rule up again, Plaintiffs' 23.

BY MR. PERKO:

Q. I wanted to talk a little bit about your interactions with

Dr. Cogle.

A. Okay.

MR. PERKO: If we could blow that up a little bit.

BY MR. PERKO:

Q. Is there anything in this GAPMS rule that provides a role for the chief medical officer of the agency?

A. Specifically the chief medical officer? No.

Q. Yes, sir.

A. But I -- in the process, I would have considered him a technical expert or a clinical expert on some of the subjects that were under consideration, and he's a well-established expert on research, publication, and study types, and that sort of thing.

Q. Had you ever consulted him before on a GAPMS report?

A. I had.

Q. How long has Dr. Cogle had his job?

A. I couldn't say. You mean at AHCA?

Q. Yes, sir.

A. I couldn't say exactly. Maybe -- by now maybe a couple years. He started after me, I know that.

Q. Are you familiar with Dr. Cogle's responsibilities at the agency?

A. I am.

Q. And do those include review of GAPMS reports?

A. It does not, but he is always available for discussion, and

he has participated in some of the meetings regarding GAPMS.
Q. You don't know whether every GAPMS report has a checklist, do you? Right?
A. I know that every one that I was responsible for was, and I know that every one from the creation of the checklist going forward does.
Q. Is the checklist a rule?
A. It's required in my annual performance review. It's stated in there that the checklist has to be performed within five days of receipt of the request.
Q. It hasn't been adopted as a rule by the agency, has it?
A. It's adopted insofar as my annual reviews are concerned, and I'm graded on that, literally.
Q. But my question is: It has not been adopted as an agency rule, correct?
A. I'm not sure what that means.
Q. You've been involved in the rulemaking process before?
A. Well, the rulemaking process and what pertains to employee behavior are two different things.
Q. Right. So has the checklist been adopted as a rule?
A. No. It's just internally part of the process that I was required to perform.
Q. Do you recall a draft GAPMS report that you prepared regarding total knee arthroplasty?
A. I sure do.

Q. And isn't it true that you took -- you cut and paste from a Blue Cross Blue Shield publication for an entire section of this report?

A. I did, and then I cited it.

MR. PERKO: Thank you, Your Honor. I have nothing further.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MS. ALTMAN:

Q. I'll be brief, Mr. English.

Very quickly, counsel mentioned an expedited GAPMS.

A. Uh-huh.

Q. Is an expedited GAPMS a public-facing document?

A. No, it's an internal document. It's like an internal memo between the health plan and the agency, or Medicaid policy really.

Q. So it's not like the GAPMS report that was issued in June of 2022 that was a public-facing document; correct?

A. Correct.

Q. And so when you're talking about an expedited GAPMS that could be prepared in one or two days or a week, that's not what the June 2022 GAPMS report is; right?

A. No. An expedited GAPMS comes in -- it's when a health plan is denying coverage for something as, quote/unquote, experimental and investigational, and we're required -- we have

three days to turn around a response to that, to either confirm or deny their claim for that.

And regarding the one that he was specifically speaking to, it wasn't three days; it was approximately seven hours.

Q. And just very quickly, have you ever -- because I'm not sure of the implication of counsel. Have you ever plagiarized anything?

A. No. And, I mean, plagiarism is, I guess, utilizing someone else's words or ideas and trying to pass them off as your own.

But the final copy of that expedited GAPMS report that was sent for routing -- it was emailed to Ann Dalton for Tom's signature -- included citations. There was no plagiarism.

Q. And I know you mentioned that the checklist was part of your performance reviews. Do you recall that?

A. Yes.

Q. Did you get good performance reviews while you at AHCA?

A. I believe so. I was the only -- I'm the only employee in Medicaid policy for whom GAPMS was a portion of my annual performance review. I routinely scored very highly. I believe on the last one I got a 5 of 5, and they don't typically like to give out 5s. It's normal you'll get a 4 or a 4.5. And I believe the comment actually referenced both my performance on the traditional GAPMS and praised for my performance on the expedited GAPMS.

MS. ALTMAN: I have no further questions.

Thank you for your time, Mr. English.

THE COURT: Mr. English, you've told us about your work at AHCA. Give me some background before that. What did -- give me the 30-second version of your career up until the time you came to work for AHCA.

THE WITNESS: History major. I love research and writing. I did about ten years in child welfare. I wrote reports and performance reports and things like that. In my spare time, I research and write about baseball history, and I accepted the job at AHCA because I love the research and writing. It's my hobby and what I prefer to do for a living.

THE COURT: If I understood what you told Mr. Perko, there was one GAPMS report that made it all the way to the end --

THE WITNESS: Yes.

THE COURT: -- during your tenure?

THE WITNESS: Correct.

THE COURT: Were there other full reports that you prepared that you got into the queue for approval?

THE WITNESS: There were approximately seven that were ready to go, and we had -- we had a handful of meetings with the bureau chief. I was in this unique situation where between the pandemic and then turnover among the leadership at the agency, I was -- you know, those reports stretched across multiple bureau chiefs, multiple Medicaid directors, and multiple supervisors.

So when someone new came in, they had to catch up.

THE COURT: But there were seven reports that you were responsible for preparing and then got sent up?

THE WITNESS: (Nods head up and down.)

THE COURT: Okay. There was some reference to Let kids be kids. Do you know where that came from?

THE WITNESS: That was a motto that was -- came along with the gender dysphoria GAPMS. It was something that was -- we had never had a GAPMS report that came with its own motto, but that was --

THE COURT: You don't know where it came from?

THE WITNESS: I do not.

THE COURT: Questions just to follow up on my questions?

MR. PERKO: No, Your Honor.

MS. ALTMAN: Nothing from me, Your Honor.

THE COURT: Thank you, Mr. English. You may step down.

(Mr. English exited the courtroom.)

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Thank you, Your Honor. Ms. Dunn is going to call our next witness.

MS. DUNN: Your Honor, I call Dr. Kellan Baker to the stand.

(Dr. Baker entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

DR KELLAN BAKER, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record, including your first name.

THE WITNESS: Kellan Baker, K-e-l-l-a-n B-a-k-e-r.

DIRECT EXAMINATION

BY MS. DUNN:

Q. Good morning -- or good afternoon, Dr. Baker.

What is your current profession?

A. I am a health services researcher and health policy professional.

Q. And when you submitted your expert report in this case, you submitted a copy of your CV?

A. I did.

Q. Does that CV accurately reflect your professional qualifications?

A. It does.

MS. DUNN: Your Honor, that curriculum vitae is Plaintiffs' Exhibit 363 and was included on the parties' stipulated exhibit list.

THE COURT: Plaintiffs' 363 is admitted.

BY MS. DUNN:

Q. Dr. Baker, have you ever testified as an expert before?

A. Not in court.
Q. What are you being compensated for your time spent on this case?
A. I'm being compensated at a rate of $200 per hour.
Q. Does this compensation affect your opinions or testimony in any way?
A. It does not.
MS. DUNN: Your Honor, I ask that Dr. Baker be qualified as an expert on health services research and policy.
THE COURT: Questions at this time?
MR. BEATO: No, Your Honor.
THE COURT: You may proceed.
BY MS. DUNN:
Q. Dr. Baker, what health policy topics does your research focus on?
A. My research focuses on health insurance coverage, cost utilization, with a particular focus on sexual and gender minority populations, with a focus on transgender populations.
Q. And do you conduct any research on insurance coverage policies for certain populations?
A. I do.
Q. What populations are those?
A. I do a variety of research related to health equity and health disparities, but with a particular focus on sexual and gender minority populations, and especially transgender

populations.
Q. What is your current position of employment?
A. I'm currently the executive director and chief learning officer of Whitman-Walker Institute. The Institute is the research policy and education arm of Whitman-Walker, which is a community health system in Washington, D.C. that is affiliated with a federally qualified health center. That health center turned 50 this year and has a history of serving LGBTQ populations and people living with HIV.
Q. What is a federally qualified health center?
A. A federally qualified health center is a recipient of federal funds through the Health Resources and Services Administration that is intended to make it possible for the clinic, the health center, to serve all patients who need assistance, regardless of their ability to pay.
Q. What did you do before becoming executive director and chief learning officer of Whitman-Walker Institute?
A. I was previously at the Johns Hopkins Bloomberg School of Health where I worked in research. And before that I was a senior fellow at a think tank, the Center for American Progress, in Washington, D.C., where my work focused on health reform with a particular focus on the Affordable Care Act and coverage reforms that were associated with the law.
Q. What is a chief learning officer?
A. A chief learning officer is a person who is responsible for

coordinating educational and training opportunities across the entire organization. We provide, for example, clinical training to health professionals. We also do a variety of training and education activities with local community-based organizations with the D.C. Department of Health, with other community-based nonprofit and government entities across the country.

Q. How does your role at the Whitman-Walker Institute touch on health policy issues?

A. I am the executive director of the Institute which is specifically charged with three portfolios; research, policy, and education.

So policy is probably my primary role at this point. We have a very large research department that has a variety of research studies funded by the National Institutes of Health. And within our policy department we do a great deal of work at the local, regional, and federal levels related to access to care and issues of understanding barriers to good health for populations experiencing health disparities.

Q. And do you have any oversight over the clinicians or clinical management for quality assessment and practice assessment?

A. I do not.

Q. Do you work with clinicians on these issues?

A. Very closely.

Q. Can you explain that?

A. Whitman-Walker is a community health system, so it has several components, if you will. The federally qualified health --

(Reporter requested clarification.)

A. Federally qualified health center, and that is where the clinicians reside. It's also where our population health and quality department is responsible for conducting quality assurance and quality improvement initiatives per HRSA guidelines.

The Institute as an affiliation of Whitman-Walker Health is responsible for leveraging research policy, education, and that clinical experience and expertise to improve care for our patients and to contribute to the knowledge base for serving patients, both at FQHCs and across the entire health system.

Q. And have you been called upon to contribute to or consult on reports regarding LGBTQ populations and health disparities?

A. Yes, many times.

Q. Are you familiar with the National Academies of Sciences, Engineering and Medicine?

A. I am.

Q. What is the National Academies of Sciences, Engineering and Medicine?

A. The National Academies of Science, Engineering and Medicine are private, independent nongovernmental institutions that exist to bring scientific authority to questions of national

importance. They often take requests, for example, from the National Institutes of Health or other government entities to apply an independent expert, unbiased and authoritative assessment of a particular question.

Q. And have you worked with the National Academies of Sciences, Engineering and Medicine on issues related to sexual and gender minority populations?

A. Yes.

Q. Can you describe those interactions?

A. I have a substantial history with the National Academies. I worked with them beginning in 2016 on the development of an NIH-sponsored study -- that has a number of other sponsors as well, but NIH was one of the primary sponsors -- wanting to learn more about the health and well-being of sexual and gender-diverse populations, that is, LGBTQI populations. And I was responsible for all aspects of developing that study, convening the committee. I participated in every aspect of the creation of the report.

And I was then the lead on dissemination of that report, so I was responsible for presenting on its findings to a variety of stakeholders, government entities, for example, back to the sponsors, NIH, other government entities, the Department of Justice, for example, and as well as other private and public stakeholders who had an interest in what the report had found.

MS. DUNN: Your Honor, I would like to pull up what

has been marked as Plaintiffs' Exhibit 142.

BY MS. DUNN:

Q. Dr. Baker, do you recognize this report?

A. I do.

Q. What is it?

A. It is the 2020 report from the National Academies on understanding the well-being of LGBTQI+ populations.

Q. Is this the report that we were just discussing?

A. It is.

Q. And can you explain your contributions to this report?

A. I was a consultant on this report, so I supported the consensus study committee in the elements of the deliberation, the drafting, and finalizing of this report. And then, as I mentioned earlier, was responsible for leading dissemination efforts to ensure that the findings of this report were communicated back to the sponsors and to other interested parties.

MS. DUNN: Your Honor, I would like to introduce this exhibit as a learned treaties. And I'll have Dr. Baker read certain portions into the record.

THE COURT: A learned treaties is just hearsay.

Is there --

MR. BEATO: Yes, sir.

THE COURT: You object?

MR. BEATO: Yes, sir.

THE COURT: Isn't that right? Isn't it just hearsay?
BY MS. DUNN:
Q. Dr. Baker, would you rely on this report in the -- in your professional activities?
A. Yes, I do.
MS. DUNN: Your Honor, Rule 803, the exception for a learned treatise, where it can be read into the record. May I have Dr. Baker read --
THE COURT: You can cross-examine a witness with a learned treatise and read it into the record, but not introduce it. In a bench trial it doesn't make a lot of difference whether you just read it.
But I take it you are not cross-examining him saying he's going to testify inconsistently with this. You are trying to introduce this as affirmative evidence.
Am I missing something?
MS. DUNN: I do not have the text of Rule 803 in front of me. I understood that it allowed it to be read on direct as well.
THE COURT: Well, you can impeach your own witness on direct, so it's not a direct cross.
MS. DUNN: Understood.
THE COURT: But it's to impeach the witness.
MS. DUNN: I'll ask a different question.
Your Honor, the way the rule reads, that a statement

is called to the attention of an expert witness -- I'm sorry -- is relied on by the expert on direct examination.

THE COURT: Yeah. What is it you are trying to put in?

MS. DUNN: I can just ask Dr. Baker to explain the opinion from this report that he helped to -- or that he contributed to.

THE COURT: Let me tell you what will help me more, is if you ask him what he knows and he can tell me what he knows. That's why he is here. And if it's something he relies on in accordance with the rule, yeah.

But, look, this rule is really not a way to put in a treatise in lieu of a witness.

MS. DUNN: Thank you, Your Honor.

BY MS. DUNN:

Q. Dr. Baker, did this report draw any conclusions that are relevant to the case that you're -- to our case that you are testifying on?

A. Yes.

Q. And what were those conclusions?

A. The report examined a large body of evidence and concluded that gender-affirming care is safe, effective, and medically necessary for the treatment of gender dysphoria.

Q. Did the report make any conclusions with regard to whether gender-affirming care improves mental health outcomes for

transgender people?
A. Yes.
Q. What were those conclusions?
A. The report concluded that gender-affirming care supports the health, physical and mental health, of transgender people.
Q. Did the report make any conclusions about the evidence-based guidelines that clinicians use in providing gender-affirming care?
A. Yes.
We reviewed those guidelines and we found them to be authoritative. We are very strictly bound within the Academy's process to rely on existing evidence, which means that we looked at the existing evidence, which includes expert standards of care.
Q. Are you been involved in efforts to connect low and middle income LGBTQ+ people with health insurance coverage?
A. Yes.
Q. And what are those efforts that you have been involved in?
A. In 2013, I founded a initiative that we called Out2Enroll, and the purpose of that initiative was to connect low and middle income LGBT people with affordable health insurance coverage through the health insurance marketplaces. We had done research that showed that LGBT people, including transgender people -- actually, especially transgender people were less likely than the general population to have health insurance coverage. So we

treated the Affordable Care Act with its expansion of coverage, and particularly covered subsidies for low and middle income people, as an opportunity to reach those people who were uninsured.

Q. Have you held any other positions relevant to health insurance coverage?

A. I am currently an appointed consumer representative to the National Association of Insurance Commissioners.

Q. Dr. Baker, I'd like to turn to your -- the opinions you've come to share today.

What did you review in coming to the opinions that you offer today?

A. I reviewed the rule. I reviewed the GAPMS report and the materials cited, discussed therein. I reviewed the scientific literature in my field, which is health insurance coverage, health services research. I reviewed relevant policies related to health insurance coverage. And I reviewed documents such as the National Academies' report.

Q. Are these materials the same type of materials that experts in health and public policy regularly rely upon when forming opinions?

A. Yes.

Q. Dr. Baker, what does it mean to be transgender?

A. According to the National Academies, being transgender is when your gender does not align with the sex that you were

assigned at birth.
Q. And have you done research into the demographics of the transgender population in the United States?
A. Yes.
Q. How many transgender people are there in the United States?
A. There are an estimated 1.6 million transgender people in the United States. That's approximately .6 percent of the population.
Q. How have estimates of the number of transgender people in the United States changed over time?
A. The estimates have remained stable since -- for example, the 2023 numbers that I'm referring to, .6 percent, when those estimates were done in 2016, the estimate was the same, .6 percent of the population.
Q. Since 2016 the number of transgender people in the U.S. has not changed demonstrably, according to the data you reviewed?
A. Not according to the data that I reviewed, no.
Q. Where do those numbers that you cited to us come from?
A. The numbers come from a variety of sources. For example, the 2016 number came from an analysis of the Behavioral Risk Factor Surveillance System, which is a nationwide survey, system of surveys, really, that's done by state departments of health in partnership with the Federal Centers for Disease Control and Prevention. There's also, for example, the Gallup poll, which is a nationwide nationally representative poll that has

collected information about LGBT demographics since approximately 2012.

So those are the two most reliable numbers.

Q. What has your research in transgender health focused on?

A. It has focused both on overall health and well-being, as well as on experiences of access to care. My research is really focused on health disparities, which are avoidable gaps in, for example, outcomes, quality, access, that affect specific populations.

The National Institutes of Health has designated the transgender population as a health disparity population in recognition of gaps related to the overall health and well-being of that population.

Q. Specifically what disparities affect the transgender population?

A. There are a variety of disparities that have been documented in the transgender population. For example, transgender people are less likely to report good or excellent health compared to the cisgender population. Transgender people are less likely to have access to health insurance coverage. They are less likely to have access to health care. They are more likely to encounter barriers to care, such as financial barriers, that make it difficult to access health care services.

Q. Dr. Baker, I'd like to turn your attention specifically to health care coverage.

How long has the medical community been providing treatment for gender dysphoria?
A. Internationally speaking, treatment for gender dysphoria has been provided for 100 years -- more than 100 years. In the United States the initial provision of gender-affirming care in relation to gender dysphoria for transgender people was in the 1960s.
Q. And we've been using the term "gender-affirming care" or "gender-affirming medical care." What do you understand these terms to mean?
A. I understand gender-affirming care to encompass services and supports that affirm the gender of a person.
Q. And are there specific health services that are being referenced when the term "gender-affirming medical care" is used?
A. I generally understand that term to refer to puberty-delaying medications, hormone therapy, and gender-affirming surgeries.
Q. In your research regarding insurance coverage of gender-affirming medical care, what types of insurance carriers have you studied?
A. I've studied a variety of public and private health insurance carriers.
Q. With regard to private insurance, what are the major ways that private health care coverage is regulated in the U.S.?

A. In the United States we have both state regulation of insurance coverage as well as federal regulation.

Q. And describe to me what types of insurance policies or plans are state regulated.

A. The states are the traditional regulators of insurance coverage, so every state has an insurance commissioner, and they are responsible for regulating individual, small-group, and large-group coverage.

Q. And what plans are federally regulated?

A. Plans that are federally regulated fall under ERISA, and those are large self-insured employers that, rather than purchasing coverage for their employees, actually act as the insurance carrier themselves. So they pay the claims of their employee when they need health care, and those are the federally regulated plans.

Q. With regard to state-regulated plans, what trends have you observed regarding the coverage of gender-affirming medical care?

A. In state-regulated plans, there has been a substantial increase, particularly over the last ten years, in states that have required plans under their jurisdiction to remove exclusions for gender-affirming care and, in many cases, to offer affirmative coverage.

For example, in 2012, there was only one state where the insurance regulators had required plans to be inclusive of the

medical needs of transgender people, and as of 2023, I believe we're at 24 states, plus D.C., that have such a requirement in place.

Q. What position have state regulators collectively taken regarding transgender people's access to gender-affirming healthcare coverage?

A. Many state regulators have spoken individually, and a number of them have signed on to group statements. For example, most recently in fall 2022, 21 insurance regulators, so regulators from 21 different states, signed on to a letter to the U.S. Department of Health and Human Services affirming their interest in ensuring that transgender consumers in the markets that they regulate are able to access the health care that they need without facing discriminatory barriers and that that health care should include gender-affirming care that is provided in accordance with expert medical standards.

Q. Turning to ERISA-regulated plans, what trends in coverage policies for gender-affirming care has your research identified?

A. The trend in ERISA-regulated plans has been the same. If anything, it's been even faster, what I would call an exponential increase over the last decade in the number of self-insured employers that cover gender-affirming care for their employees. As of the most recent analysis, I believe approximately 86 percent of the more than 1,200 major employers that were assessed by the Corporate Equality Index offered

inclusive coverage to their transgender employees.

Q. Can you identify any major employers in the U.S. that offer fully inclusive plans to employees?

A. I mean, there are -- pretty much anybody that you can think of. I believe at the top of the list include companies such as Walmart, Amazon, and CVS, among many others.

Q. What position have insurance carriers collectively taken regarding ensuring transgender enrollees can access treatment for gender dysphoria?

A. We have really seen a sea change in the last decade with regard to the types of coverage protocols that private carriers are coming out with that affirm the availability of coverage, refer to expert medical standards, and looking at -- they've spoken -- individually a number of carriers, for example, put in comments on nondiscrimination rules through the U.S. Department of Health and Human Services.

Most recently, America's Health Insurance Plans, AHIP, which is the major professional trade association -- it includes about 1,300 different carriers that cover somewhere around 200 million people across the U.S. -- they put in a letter to the U.S. Department of Health and Human Services affirming their interest in ensuring that transgender enrollees can access gender-affirming care and reiterating their support for nondiscriminatory -- as they put it, nondiscriminatory benefit design and coverage designs that are based on expert medical

standards.

Q. We've been discussing private employer healthcare coverage. What types of plans does the government offer as an employer -- do government entities offer as employers?

A. The government acts as an employer in a number of circumstances. For state governments, for example, the State acts as the employer and offers insurance coverage to its employees. The federal government also offers coverage to approximately 8 to 9 million federal employees and their dependents through the Federal Employees Health Benefits program, or FEHB.

Q. What trends in coverage for gender-affirming medical care in state employee benefit plans has your research identified?

A. The trend in state employee benefit plans has been the same as among self-insured employers, as well as among state-regulated plans. Over the last decades in particular we have seen a large number of states either removing explicit exclusions -- categorical exclusions of coverage for gender-affirming care and/or instituting affirmative coverage policies.

Q. How many states offer affirmative coverage policies for treatments for gender dysphoria?

A. I believe the number is approximately the same as the number of states that have regulation or guidance from their insurance commissioners, so 24 plus the District of Columbia.

Q. And how many jurisdictions offer employee benefit plans that do not categorically exclude treatments for gender dysphoria?
A. Over 40 different jurisdictions. So that includes states and territories. Over 40 jurisdictions offer plans that do not have categorical exclusions of gender-affirming care.
Q. With regard to the federal government -- and you mentioned the Federal Employees Health Benefits plan. How does the Federal Employees Health Benefits plan handle coverage for gender-affirming health services?
A. FEHB does not permit categorical exclusions of gender-affirming care. There is a requirement for this plan year that coverage be provided in a manner that is consistent with expert standards in the field.
Q. And what expert standards in the field are referenced in that affirmative requirement?
A. The WPATH standards and the Endocrine Society guidelines.
Q. What are the other major sources of insurance coverage in the United States?
A. The other major sources are what I tend to refer to as the three M's: Medicare, Medicaid, and the health insurance marketplaces.
Q. Let's turn first to the health insurance marketplace.
What is the health insurance marketplace?
A. The health insurance marketplaces were established under

the Affordable Care Act as the primary means by which people would access subsidies to purchase insurance coverage at a lower cost to make it more affordable.

There are two kinds of health insurance marketplaces at this point -- about 30, 33 states rely on -- as of this most recent year rely on healthcare.gov which is the federal platform, and the remainder of the states operate their own marketplaces.

Q. And have you researched the trends related to gender-affirming medical care coverage by the plans sold through healthcare.gov?

A. Yes.

Q. What has your research shown?

A. Out2Enroll has conducted research on the availability of coverage without exclusions through healthcare.gov. We have consistently seen a trend of a declining number of plans that have any exclusion at all, let alone a categorical exclusion of all care related to gender affirmation.

Q. And do you know approximately what percentage of those plans have no exclusions for treatments for gender dysphoria?

A. In the most recent analysis, over 90 percent of the plans for which we were able to access the plan documents and dig into the coverage -- over 90 percent do not have exclusions of care related to gender dysphoria.

Q. And how many of those plans that you were able to research

have affirmative coverage policies that cover treatments for gender dysphoria?

A. Roughly half, about 47 percent.

Q. How does Florida operate its marketplace?

A. Florida uses healthcare.gov.

Q. And what did your research show with regard to how the insurance carriers selling coverage through healthcare.gov in Florida handle coverage of gender-affirming medical care?

A. None of the plans that we reviewed in healthcare.gov in Florida had exclusions of gender-affirming care.

Q. And did any of those plans have affirmative coverage policies that explicitly provided for coverage of gender-affirming care?

A. Yes, the vast majority. I believe there was one that had unclear language, and one or two that didn't mention at all. But the vast majority had affirmative coverage.

Q. Turning now to Medicare, does Medicare currently cover gender-affirming medical care?

A. Yes, it does.

Q. Does that include gender-affirming surgeries?

A. Yes.

Q. And does that include hormone therapy?

A. Yes.

Q. Has Medicare always covered these treatments?

A. No. In 1981, HCFA, H-C-F-A, which is the precursor to the

Centers for Medicare & Medicaid Services, adopted an informal policy of no coverage, and that policy of no coverage was codified as a national coverage determination in 1989. That NCD, national coverage determination, was overturned in 2014.

Q. Dr. Baker, we're going to pull up on the screen what has been marked as Plaintiffs' Exhibit 71.

Do you recognize this document?

A. I do.

Q. What is it?

A. It is the Departmental Appeals Board decision in 2014 overturning the Medicare exclusion.

Q. Does this document reflect the Departmental Appeals Board's determination regarding whether gender-affirming surgeries are experimental?

A. Yes.

MS. DUNN: Your Honor, I ask that this be admitted as Plaintiffs' Exhibit 71.

THE COURT: Plaintiffs' 71 is admitted.

(PLAINTIFFS EXHIBIT 71: Received in evidence.)

BY MS. DUNN:

Q. Dr. Baker, can you explain the basis of the Departmental Appeals Board ruling?

A. The basis for the national coverage determination and the earlier informal policy from 1981 were that, quote/unquote, transsexual surgery was experimental and cosmetic.

The Departmental Appeals Board looked at the evidence in the 30 years since then and concluded that the characterization of coverage for gender-affirming care or the characterization of gender-affirming care itself as cosmetic and experimental was no longer reasonable.

Medicare uses a reasonableness test to determine whether or not something should be covered, and the Departmental Appeals Board found that the national coverage determination and that earlier informal policy did not meet the reasonableness standard and that the national coverage determination was thus no longer valid.

Q. What guidelines did this determination -- this appeals board ruling look to in determining whether gender-affirming medical interventions are reasonable and necessary pursuant to Medicare regulations?

A. The decision looks at the WPATH guidelines.

Q. Dr. Baker, has Medicare issued a national coverage determination with regard to any of the health services at issue to treat gender dysphoria?

A. No.

Q. Is this unusual?

A. No.

Q. Why not?

A. Most services and interventions covered by Medicare do not have a national coverage determination. They are provided under

the reasonableness standard.

Q. And in the absence of a national coverage determination, how does Medicare treat requests for coverage for treatments of -- of treatments for gender dysphoria?

A. It considers them on a case-by-case basis according to standards of medical necessity and expert medical guidelines in the relevant field.

Q. Turning now to Medicaid, how common are exclusions like Florida's for Medicaid coverage of gender-affirming medical care?

A. Extremely uncommon.

Q. Can you estimate how many states have similar categorical exclusions?

A. Roughly eight states at this point have some degree of exclusion of gender-affirming care, but the vast majority of those do not have the type of categorical exclusion that I understand to be under consideration here.

For example, some of them exclude some procedures and services but not others. Some have age limits, and some remain on the books, but according to Department of Health officials are not being enforced.

Q. How many jurisdictions do not explicitly exclude coverage for gender-affirming medical care?

A. Counting states and territories, since territories also have Medicaid programs, I believe 46 to 47. I don't remember

the exact number off the top of my head, but over 40, I guess I can say, do not have exclusions of gender-affirming care.

Q. And how many jurisdictions affirmatively provide coverage of gender-affirming health services?

A. 27 jurisdictions at most recent count did not have exclusions -- had, actually, affirmative coverage of gender-affirming care, which is where it's outlined in Medicaid regulations or a Medicaid handbook what procedures and services are covered.

Q. And just to clarify, we've been talking about affirmative coverage policies versus a lack of exclusions. Can you describe the difference?

A. A lack of exclusions means that -- well, so originally you would have the situation that you had in Medicare where you had an explicit, often categorical, exclusion that no coverage would be provided for gender-affirming care. Increasingly in response to medical consensus and the evolving scientific evidence in relation to gender-affirming care, those categorical exclusions began to go away.

In some cases, that simply means, as in the case of Medicare, that coverage decisions are made on a case-by-case basis according to a standard such as Medicare's reasonableness standard and with reference to the expert standards of care.

It is, however, possible to go one step further, if you will, which is a case for any medical condition to clarify

exactly what coverage is available, and so increasingly we have seen state Medicaid programs, private insurance carriers -- you know, this is the case with what a lot of the state regulators are doing is to say that it's important to spell out what coverage is available so that transgender enrollees and people who are administering coverage programs understand that coverage is available and are applying the correct rationale, criteria, and updated standards of care in making determinations of medical necessity for coverage.

Q. Have you reviewed the GAPMS report assessment of the status of Medicaid coverage in the U.S. for gender-affirming medical care?

A. Yes.

Q. Was there representation of the number of states that cover or don't cover this care accurate?

A. I did not agree with it on the basis of what I have already stated, that the type of categorical exclusion in Florida's Medicaid program is extremely rare, and for the states that do -- the relatively small handful of states that do explicitly exclude coverage, again, those types of exclusions are typically either for some procedures or services but not others, have some sort of age limit or are on the books but are not being enforced. So I did not agree with the way that the GAPMS memo characterized the status of Medicaid coverage for gender-affirming care.

Q. What does your research show with regard to the current trends among Medicaid programs with regard to coverage of gender-affirming medical care?
A. Those trends are following the same trend lines as every other type of public and private coverage. When you look at the state-regulated plans, you look at self-insured employers, you look at the state employee plans, you look at Medicare, you look at Medicaid, the trend, especially over the last decade, has been very strongly in the direction of coverage.
Q. What is the reason that every type of insurance carrier providing insurance coverage in the United States is moving towards coverage of gender-affirming medical care?
A. In response to the expert medical consensus acknowledging that gender dysphoria is a real and serious medical condition for which safe and effective treatments exist and that more than 20 major U.S. medical associations all affirm that gender-affirming care is important to the overall health and well-being of transgender people and is, thus, an important area of medicine and, thus, an important area of coverage for programs whose entire intent -- although we could argue about private insurance. But programs where coverage is being provided in order to make sure that people can access the health care services that they need.
Q. Dr. Baker, I'd like to ask you some questions about utilization trends of these health services for treating gender

dysphoria.

How has number of insurance claims for gender-affirming medical care changed in the past decade?

A. It has increased.

Q. What is this increase attributable to?

A. There are, I think, two main drivers of this increase.

One is the greater availability of coverage. This medical consensus that is causing more insurance carriers to provide coverage, so it's more accessible for transgender people.

And the other reason actually also relates to the medical consensus and the removal of these exclusions. Previously when a provider would code something with a code that was related to gender dysphoria, if there's an exclusion in place, then that plan -- that claim automatically gets denied. So there is now a trend in health care of providers who are providing gender-affirming care to transgender people to be more clear in actually using the codes that relate to gender dysphoria as a diagnosis, which allows us to see that information in, for example, a claims record much more easily.

One other thing that I would note is that there has been increasing data collected on transgender people, so there is an increasing understanding, I think, of -- back to one of your earlier questions -- the overall demographics, sort of who transgender people are and what kind of health care services they need.

Q. What does the increase in the number of insurance claims for treatments for gender dysphoria indicate?
A. It indicates both that coverage is more available and more providers can appropriately code for these services without feeling like they have to hide the care that they are providing in order to avoid triggering a coverage denial from a categorical exclusion.
Q. Turning now to the issue of cost effectiveness of these type of health services.
What is the overall impact of coverage on gender-affirming care on payor health insurance carrier budgets?
A. De minimis.
Q. Why is this?
A. There just aren't that many transgender people. So for an individual transgender person, the cost of care can be prohibitive. But when you are talking about health plan, whether that's a public plan, public program, or a private plan, it's simply -- when you are looking at sporadic claims from .6 percent of the population, you are just not talking about that much money.
Q. What evidence are the cost estimates that you've reviewed based on?
A. This are a number of estimates out there. Particularly in the last couple of years several states -- North Carolina, for example, looking at its state employee plan; Alaska Medicaid;

Oregon Medicaid; Wisconsin Medicaid. There is a number of states that have either performed or contracted out for an analysis of the cost, the actuarial cost of providing coverage for gender-affirming care.

Q. And generally what have these estimates shown?

A. That the costs of covering gender-affirming care are, again, de minimis; too small to matter, as I recall one state saying.

Q. And have any federal entities conducted analysis of the cost of covering gender-affirming care?

A. In the discussion about open service by transgender service members, the Department of Defense looked at the cost of providing coverage of gender-affirming care to trans service members.

Q. What was the result of that assessment?

A. He called it budget dust. Hardly even a rounding error.

Q. So we've been talking about the de minimis costs.

Have there been analyses looking at the costs in realization to the benefits of providing gender-affirming medical care coverage?

A. Yes.

Q. And what has the literature concluded about the costs and benefits of this type of care?

A. The literature demonstrates that the de minimis costs of providing this care are substantially outweighed by its

benefits.

Q. And how has that conclusion been quantified?

A. In a 2016 study, for example, which used standard cost utility analysis methodology, the incremental cost effectiveness ratio was calculated, which is where you quantify the amount of money in dollars that you are willing to -- that you are paying for some outcome, for example, quality of adjusted life years.

In this particular study the ICER, the incremental cost effectiveness ratio, for gender-affirming care was less than $10,000 per quality-adjusted life year, which, in comparison to in the United States and in many other countries, the standard willingness-to-pay threshold that we use, which is where you draw the cutoff of if I get a certain amount of benefit for a certain amount of money, I can consider it cost effective. If it costs me more money than this threshold -- willingness-to-pay threshold to get that benefit, I consider it not cost effective.

So the standard willingness-to-pay threshold in the United States is $150,000 per quality-adjusted life year.

Q. And, again, how much was the cost of coverage for gender-affirming health services?

A. Less than $10,000 for quality of adjusted life year.

Q. What procedures were assessed in making this conclusion regarding quality -- quality of adjusted life year?

A. The same definition of gender-affirming care that we have been --

Q. Including?
A. Hormone therapy and surgeries.
Q. Did that model also look at the cost of gender-affirming services on a per-member per-month basis?
A. Yes, it did. A per-member per-month basis is a standard measure in looking at costs of coverage. And that particular study found that the cost of providing coverage for gender-affirming care when spread across the U.S. population was .016 cents per-member per-month.
Q. Have you done any independent research regarding the cost effectiveness of gender-affirming care?
A. Yes.
Q. And can you describe your methodology in your research?
A. I accessed a proprietary commercial claims database that includes insurance claims from several hundred million people in the United States. I identified transgender people using codes that are associated with treatment for gender dysphoria. I identified the procedures that are related to gender-affirming care. And then I calculated how much -- added up over time, how much that care cost.
Q. And what did your own research indicate with regard to the cost effectiveness of gender-affirming medical treatments?
A. My research found that the cost of care for a transgender person on average in that database was less than $2,000 per year and considered on a per-member per-month basis, when spread

across that entire insured population. So a little bit more conservative than the other study that I was referencing. Rather than the U.S. population looking specifically at this insured population and this database, I found that the per-member per-month cost of coverage was 6 cents.

Q. How would you summarize the literature on cost and benefit for coverage for gender-affirming medical care?

A. The literature on the cost and benefits of gender-affirming care demonstrates that the de minimis costs of gender-affirming care are substantially outweighed by its benefits, financial and otherwise.

Q. Turning now to Florida's exclusion of coverage for gender-affirming medical services, the challenged exclusion. Have you reviewed that exclusion?

A. Yes.

Q. And what health services are excluded from coverage under the challenged exclusion?

A. I would call it a categorical exclusion that excludes coverage of puberty-delaying medications, hormone therapy, and surgeries.

Q. Is this coverage exclusion consistent with prevailing nationwide coverage trends?

A. No.

Q. Is this coverage exclusion consistent with expert medical standards used by health insurance programs?

A. No.
Q. And what expert medical standards are used by health insurance programs generally?
A. They refer to the WPATH standards, the Endocrine Society guidelines.
Q. Speaking of WPATH, Dr. Baker, are you a member of WPATH?
A. No. I have been in the past, but I'm not currently a member.
Q. Did you play any role in the formation of the WPATH Standards of Care 8?
A. Yes.
Q. What role did you play?
A. I was part of the research team at the Johns Hopkins Evidence-Based Practice Center, which is part of the Johns Hopkins medical institutions. It is an entity that is contracted to conduct evidence reviews. And it was contracted by WPATH while I was a staff member there to conduct reviews that would inform the development of the SOC 8.
Q. Are you still affiliated with the John Hopkins Evidence-Based Practice Center?
A. No.
Q. Were you the lead author on any published articles summarizing the results of those systematic reviews that you were a part of at the Johns Hopkins center for evidence-based medicine -- I'm sorry -- Evidence-Based Practice Center?

A. Yes.
Q. What systematic review -- what was the title of that systematic review that you published?
A. The one which I was the lead author was the Effects of Gender-Affirming Hormone Therapy on Mental Health and Quality of Life Among Transgender People.
Q. Dr. Baker, what is a systematic review? How would you define that?
A. A systematic review is a systematic review of a body of evidence that is intended to not cherry-pick, to ensure that the body of evidence is being fully scoped in order to answer a key question.
Q. And what was the purpose of the systematic review that you published with regard to hormone therapies?
A. It was to answer the key question, KQ11 -- I remember it very well -- the key question of what is the effect of gender-affirming hormone therapy on mental health --
(Reporter requested clarification.)
THE WITNESS: Gender-affirming hormone therapy on the mental health and quality of life of transgender people.
BY MS. DUNN:
Q. How did your systematic review do this?
A. We systematically searched the evidence. We searched PubMed, Embase -- you know, there is a whole range of scientific databases. So we developed a search strategy. We applied the

search strategy to these databases. We worked as a team. You don't really do anything alone in a systematic review; you are making sure that there's always someone else who is looking at the same studies and that you agree on your conclusions.

So we identified the studies that were relevant; we extracted data from those studies; we assessed the quality of evidence and risk of bias in those studies, and then we synthesized the findings, not quantitatively, but we synthesized the findings of what that body of evidence showed in relation to our key question.

Q. Was WPATH involved in the systematic review?

A. Yes.

Q. In what way?

A. They provided the key questions.

Q. Did they have any role in the study design?

A. No.

Q. Did they have any role -- or did WPATH have any role in the data collection?

A. No.

Q. Did WPATH have any role in the analysis or interpretation of the results?

A. No.

Q. And what were the results of that systematic review?

A. The systematic review found that gender-affirming hormone therapy supports the mental health and quality of life of

transgender people.
Q. What was the certainty of evidence supporting that conclusion?
A. The certainty of evidence, according to the specific rubric that we used, was low.
Q. And why was it considered low under your rubric?
A. Well, the GRADE methodology that we used automatically assigns a low certainty of evidence to any study that is not a randomized controlled trial. And the literature that we were looking at has very few randomized controlled trials. They are not very common in transgender health due to bioethical issues, as well as the difficulty of conducting a randomized controlled trial when you have a treatment that is well established to be effective.
Q. And what did your review of the entire body of the literature conclude?
A. We concluded that gender-affirming hormone therapy supports the mental health and quality of life of transgender people.
Q. You noted that your review accounted for potential flaws or bias. Is it unusual for a study to have potential flaws or bias?
A. No. All research has potential flaws and potential risks of bias.
Q. And how do you account for that when conducting a systematic review?

A. You look at the risk of bias. There are standard tools to do that. We used a standard tool that assesses different domains and looks at the overall degree to which the flaws of the studies outweigh their quality.

Q. What is the ultimate takeaway or conclusion of this article that you were the lead author on?

A. We concluded that gender-affirming hormone therapy is an important component of health care treatment for transgender people.

Q. And in the course of your review of the literature, did you identify any studies showing that hormone therapy harms the mental health or quality of life of transgender people?

A. No.

Q. As the author of this study, would you conclude that its findings support a categorical exclusion for gender-affirming care like Florida's?

A. Absolutely not.

MS. DUNN: I'm done. I have no further questions at this time.

THE COURT: Cross-examine?

MR. BEATO: Your Honor, considering it's after 5:00, would it be more appropriate to begin tomorrow morning?

THE COURT: If you wish. Up to you. You can do it in the morning or we can finish tonight, whichever you wish to do.

MR. BEATO: Let's do it in the morning. I can finesse

my answers -- or finesse my questions.

THE COURT: There you go. I knew you'd have it.

Very good. We'll start at 9:00 o'clock tomorrow morning.

How are we going on the overall schedule? Are you about where you thought?

MR. GONZALEZ-PAGAN: Yes, Your Honor.

Omar Gonzalez-Pagan, Your Honor.

We actually wanted to bring up -- I believe it is quite likely plaintiffs' case-in-chief would be done being presented morning or midday Friday. And so the question is how the Court would wish to proceed. I know there is some availability questions for some of the defendants' witnesses, and we were wondering --

THE COURT: Dr. Baker, thank you. You may step down.

And then if you'd be back on that witness stand, please, at 9:00 o'clock tomorrow morning.

THE WITNESS: Yes, sir.

THE COURT: And I'm not trying to run you off. You are welcome to stay or go.

THE WITNESS: I'm just sad I have to put it all back on again.

(Dr. Baker exited the courtroom.)

THE COURT: So you think you are going to finish midday Friday. What are you telling me about the schedule?

MR. JAZIL: Your Honor, my out-of-town experts won't be coming into town until Tuesday, which is when -- since we are not having court on Monday and Tuesday.

My two agency experts, one is testifying in a trial in the Southern District of Florida that's going on now. And the other's availability I'm just not sure of for the rest of the week.

So if we are going to finish midday Friday, perhaps we can pick back up Wednesday morning with our witnesses.

MR. GONZALEZ-PAGAN: Plaintiffs would have no objection to that if it is the amenable to the Court.

THE COURT: Not my first choice, but we can do that. If it works, we'll just plan on finishing the plaintiffs' case this week, and starting the defense case Wednesday.

MR. JAZIL: Yes, Your Honor.

And then I just have a conceptual question. I know we've been talking about the other cases being wrapped into this one.

Would the plaintiffs be closing their case or leaving it open so that if things are -- I just note the procedural hiccup.

THE COURT: Yeah, I didn't -- some of that was just kind of raising possibilities to discuss. And I haven't thought it all the way through. It does seem clear to me that the other case is the other case.

Anybody have any more information about when the Governor is likely to sign the law?

MR. JAZIL: I do not, Your Honor. However, I did go back and look to see when presentment happens, because there are two things that have to happen: The legislature has to present the bill to the Governor. Then there is a trigger for the Governor to either sign, veto, do nothing and it becomes law. Presentment goes on until June because laws usually don't become effective until July. So I don't have a good way to predict when it is the legislature will present the bill and the Governor will sign it. So we could be looking at possible presentment in June when this trial is done.

I'd just note that for the record.

I don't have perfect answers, Your Honor. I apologize.

THE COURT: All right. I'll give it some more thought.

Meanwhile, we'll have Dr. Baker back on the stand at 9:00 o'clock in the morning, cross-examine, and then call the rest of your people. We'll plan on the plaintiffs' case this week, the defense case starting Wednesday morning.

Is it Monday I'm getting your memo on the preliminary injunction?

MR. JAZIL: Yes, Your Honor. You'll get my memo on the preliminary injunction Monday. I'm done with the memo. I'm

just trying to get transcripts of the rulemaking hearings that the two boards had so I can make those available to the Court.

THE COURT: I guess it's the other case.

MR. GONZALEZ-PAGAN: That would be Ms. Levy and Ms. Chriss, Your Honor. And Ms. Dunn.

THE COURT: When are you going to be back in town? And if we -- Tuesday afternoon, can we do the preliminary injunction Tuesday afternoon? It makes more sense to put it back after we've had a couple of your experts. We can put it back on toward the end of the week.

MR. JAZIL: Your Honor, my understanding is we are not in trial Tuesday afternoon.

THE COURT: We're not.

MR. JAZIL: Okay.

THE COURT: But I can be available Tuesday afternoon. If I'm getting your memo Monday, depending on what time -- when you get it done; you get the attachments, go ahead and file it. Don't wait. So I can get to it. I'll need some time with it.

MR. JAZIL: Your Honor, I have a note saying that I have a hearing Monday at 6:00 p.m.

THE COURT: And I'm pleased to say that's not my case.

MR. JAZIL: No, it isn't, Your Honor.

MS. LEVI: We would just ask for some set time when the preliminary injunction would be heard.

THE COURT: Why don't we try to pick a time.

How long are your experts going to be in this trial?

MR. JAZIL: So we have four expert witnesses.

Your Honor, if we go half a day each with each expert, two days; plus Mr. Brackett will likely be on for half a day, Ms. Dalton; likely four days is what we are looking at.

No, I've got the math wrong.

THE COURT: That arithmetic doesn't work.

Would it help to have a set time to do the preliminary injunction, or do you want to do it first thing Friday morning?

MR. JAZIL: Next week?

THE COURT: Yeah.

MR. JAZIL: Fine with me, Your Honor, if it works for counsel.

MS. LEVI: We'll make it work.

MR. GONZALEZ-PAGAN: And, briefly, Your Honor, from this case's perspective, we have three rebuttal witnesses, two of which will be traveling, but we expect to present those.

THE COURT: I'm just curious, how do you know you have three rebuttal witnesses? You haven't even finished putting on your case. If it's somebody you already know is going to testify, how is that a rebuttal witness?

MR. GONZALEZ-PAGAN: Well, it's depending on who they call, Your Honor, and what the testimony is.

THE COURT: Well...

MR. GONZALEZ-PAGAN: We are happy to present them

earlier, if it pleases the Court.

THE COURT: Let me -- we probably all have different views about what rebuttal is. Let me tell you what I think rebuttal is.

I think rebuttal is something that you weren't planning on putting on unless there was something new and different than what you expected on the defense case.

This is not a case with a counterclaim or any of those complications. It's just your case. So what I would expect is your case and then their case and very limited rebuttal -- something new or unanticipated.

So just because you have, for example, an expert who is going to disagree with something they say, that doesn't make that a rebuttal witness. So you really ought to plan on putting on your whole case.

MR. GONZALEZ-PAGAN: Understood, Your Honor. We will reassess, and it may be then that we are not done by midday Friday, but we will then re-order our witnesses.

THE COURT: And that doesn't make a whole lot of difference in a bench trial. So if you've got somebody that you mistakenly thought I was more reasonable about rebuttal, and you just can't have them here until later, we can work with that, but try to put on your whole case the first time through.

MR. GONZALEZ-PAGAN: We will do that, Your Honor.

Thank you.

THE COURT: And, frankly, that's only fair to the defense. They want to meet your witnesses, too. So everybody gets -- if you hold back your real witness until rebuttal, they don't get a chance to put on their evidence.

MR. GONZALEZ-PAGAN: Sure, understood.

THE COURT: Put it all on. And they'll put it all on. And then if you have real rebuttal, you can put it on.

MR. GONZALEZ-PAGAN: Understood, Your Honor.

Thank you.

THE COURT: All right.

So Friday morning, maybe more like 8:30, and we'll do the preliminary injunction at 8:30 Friday morning and then finish up whatever we've got with the trial. And you should feel free to finish up on Thursday if you're done.

MS. LEVI: Just want to be clear, are we talking this Friday or next Friday?

THE COURT: Next Friday.

MS. LEVI: The 19th?

THE COURT: Yes, the 19th.

MS. LEVI: I just want to be clear.

Thank you.

THE COURT: That meets whatever emergencies you've got, right? I mean, the 19th is soon enough? Sooner is better, but the 19th can work?

MS. LEVI: We've made our case and the facts, and

we'll argue them in front of you of the serious urgency of the preliminary injunction.

THE COURT: All right.

I'll see you at 9:00 o'clock tomorrow morning.

(Proceedings recessed at 5:16 PM on Wednesday, May 10, 2023.)

* * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy is noted within the transcript.

/s/ Megan A. Hague 5/10/2023

Megan A. Hague, RPR, FCRR, CSR Date
Official U.S. Court Reporter

I N D E X

E X H I B I T S

DEFENDANT'S EXHIBITS	OFFERED	RECEIVED
DX6	419	419
PLAINTIFFS' EXHIBITS	**OFFERED**	**RECEIVED**
18	419	419
30	423	423
71	482	482

Doc. 225

Dekker v Weida: 4:22-cv-325

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
v.	)	Tallahassee, Florida
	)	May 11, 2023
JASON WEIDA, et al.,	)	
	)	9:00 AM
Defendants.	)	Volume III
_____	)	

TRANSCRIPT OF BENCH TRIAL PROCEEDINGS
BEFORE THE HONORABLE ROBERT L. HINKLE
UNITED STATES CHIEF DISTRICT JUDGE
(Pages 508 through 711)

Court Reporter: MEGAN A. HAGUE, RPR, FCRR, CSR
111 North Adams Street
Tallahassee, Florida 32301
megan.a.hague@gmail.com

Proceedings reported by stenotype reporter.
Transcript produced by Computer-Aided Transcription.

APPEARANCES:

For Plaintiffs:

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.com
120 Wall Street
19th Floor
New York, New York 10005

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JENNIFER ALTMAN
Attorney at Law
jennifer.altman@pillsburylaw.com
600 Brickell Avenue
Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall
Suite 1800
Sacramento, California 95814

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorney at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DEBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

APPEARANCES (continued):

For Plaintiffs (continued):

National Health Law Program
By: CATHERINE ANNE MCKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

For Defendants:

Holtzman Vogel Baren, et al.
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street
Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(Call to Order of the Court at 9:00 AM on Thursday, May 11, 2023.)

THE COURT: Good morning. Please be seated.

Dr. Baker, you are still under oath.

Mr. Beato, you may proceed.

MR. BEATO: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. BEATO:

Q. Good morning, Dr. Baker.

A. Good morning.

Q. Just a few questions and I'll be brief.

A. And enunciating clearly.

Q. Yes, absolutely.

During your testimony yesterday, you opined on the cost of gender-affirming care coverage; is that correct?

A. Yes.

MR. BEATO: I'd like to pull up PX23, which is a stipulated exhibit.

BY MR. BEATO:

Q. Dr. Baker, are you familiar with this document?

A. Yes.

Q. What is it?

A. The GAPMS rule.

Q. I'd like to focus your attention to 4(a) through (f).

What does this section talk about?
A. It talks about the factors that the agency shall consider when determining whether a health service is consistent with generally accepted medical standards.
Q. Based on your review of this section, is cost expressly mentioned here?
A. No, it is not.
Q. Dr. Baker, you also talked about health insurance marketplaces on direct; is that correct?
A. Yes.
Q. When discussing health insurance marketplaces, you relied on data collected from Out2Enroll; is that right?
A. Yes.
Q. And Out2Enroll collected data from 33 states?
A. Yes.
Q. And you're affiliated with Out2Enroll?
A. Yes.
Q. How so?
A. I am the cofounder.
Q. And, Dr. Baker, you also talked about Medicaid coverage for gender-affirming care on direct?
A. Yes.
Q. Did you mention a 2016 Centers for Medicare & Medicaid Services decision memo on gender dysphoria and gender reassignment surgery?

A. No.
Q. Are you aware of this document?
A. Yes.
MR. BEATO: I'd like to pull up DX4, which is also a stipulated exhibit.
BY MR. BEATO:
Q. Dr. Baker, does this document look familiar to you?
A. Yes.
Q. And what is it?
A. It is a decision summary -- or decision memo on gender dysphoria and gender reassignment surgery.
Q. Do you know what this document concluded?
A. Yes.
Q. What did it conclude?
A. It concluded that there was not sufficient evidence in the Medicare population to take the relatively unusual step of creating a national coverage determination for treatment of gender dysphoria, specifically gender reassignment surgery.
Q. And you didn't use it to form your expert opinion in this case?
A. I --
Q. You didn't rely on --
A. I did. I'm familiar with it, yes.
Q. And just to finish up, just to clarify, you're not a medical professional?

A. I'm a health services researcher.
Q. Are you an endocrinologist?
A. No.
Q. Psychiatrist?
A. No.
Q. Surgeon?
A. No.
Q. So you can't opine as a medical professional on the medical appropriateness of gender-affirming care?
A. I can summarize the medical evidence, which is my training as a health services researcher.
Q. You just an expert on insurance?
A. And other things, but in this case, yes.
Q. Last few questions.
Have you written any articles criticizing Florida's actions on gender-affirming care?
A. I have written opinion pieces criticizing trends similar to Florida's.
Q. And Florida specifically?
A. No.
Q. You haven't written an article called "Florida's Ban on gender-affirming care is dangerous for us all"?
A. Can you show it to me?
Q. Would it help if I refresh --
A. Yes, sure.

Q. -- your recollection?

MR. BEATO: May I approach, Your Honor?

THE COURT: Sure.

BY MR. BEATO:

Q. You wrote this article?

A. I did.

Q. And this article criticizes the Florida Board of Medicine's rule?

A. Yes. And I apologize. I had my head in Medicaid, which confused me.

Q. Okay. What did you say in this article?

A. I said that this trend is inconsistent with -- medical evidence is inconsistent with historical trends, and that it concerns me greatly that there are efforts that are not based in medical science and evidence that would restrict access to care that has been shown to be safe and effective for the treatment of gender dysphoria.

Q. Did you state: *Florida's ban itself is not based on research - rather, it's fueled solely by misinformation and political punditry*?

A. May I look for that quote?

Q. Of course.

A. Yes, I said that.

Q. Oh, I'm sorry.

A. No, I realized I'm not allowed to read out loud.

MR. BEATO: No further questions, Your Honor.

THE COURT: Redirect?

MS. DUNN: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. DUNN:

Q. Dr. Baker, Mr. Beato asked you about a 2016 national coverage determination by Medicare?

A. Yes.

Q. What -- what happened with that national coverage determination?

A. There was a request from a community member, a Medicare beneficiary, to the Centers for Medicare & Medicaid Services asking them to establish a national coverage determination for gender reassignment surgery, I believe Medicare called it, and when Medicare receives such a request, they go through a process called a national coverage analysis, which is intended to determine whether a national coverage determination is needed.

The process took about a year, and they looked at the evidence, looked at standards of practice in the field, and concluded that a national coverage determination was not needed at the time. And in 2016, they issued the decision memo that said that they had concluded that a national coverage determination was not needed.

Q. Is it unusual for a surgical procedure or other health service to not have a national coverage determination?

A. No. Most do not.
Q. And what does -- as a result of that 2016 national coverage determination decision, how does Medicare approach requests or claims for gender-affirming surgeries?
A. Medicare covers gender-affirming care on a case-by-case basis. So when a request comes in from a beneficiary or from a provider, the Medicare program assesses that request according to the reasonableness standard, which is in the Medicare statute, and determines whether or not in this -- in any particular case any particular treatment or intervention is appropriate.
Q. And that national coverage determination looked specifically at the Medicare population.
Why is that important?
A. The Medicare population is fairly unique. I mean, we're talking about people over age 65, and Medicare wants to ensure that the information that they're putting out is specific to the Medicare population. So they really look to put together guidelines or to make decisions that are specific to that older, over age 65, population. So that's what they focused on.
Q. So that 2016 national coverage determination looked only at the evidence base related to the population of Medicare beneficiaries who would be older than 65?
A. It looked broadly at the evidence base, but it weighed very heavily on the population over age 65.

Q. The article that you were shown by Mr. Beato, was that article with reference to the AHCA-challenged exclusion that we are here on today, or was it related to the State Board of Medicine ban on the provision of gender-affirming care?
A. It was really focused on the decision by the State Board of Medicine.
Q. So it wasn't specific as to the rule that we're challenging today?
A. It was not specific to that rule, no.
MS. DUNN: All right. No further questions.
THE COURT: Thank you, Dr. Baker. You may step down.
(Dr. Baker exited the courtroom.)
THE COURT: Please call your next witness.
MR. GONZALEZ-PAGAN: Good morning, Your Honor. I'm ready to call our next witness.
I did want to, if it was amenable to the Court, just revisit a little bit the conversation at the end of the day yesterday and inform the Court of some of the rearrangements that we have made.
I apologize to the Court for us thinking that we would be calling the rebuttal witnesses out of order and the like. We have now contacted all of those witnesses, and we arranged their travel. Unfortunately, that cannot happen for tomorrow, but we can present all of them on Wednesday. So there may be a slight gap tomorrow, and I apologize to the Court for that. But we

wanted to make sure that, in response to the Court, we were presenting all of our case together. If it works for the Court, that's how we would suggest to proceed.

THE COURT: The people that may not be here tomorrow are people you thought you could call in rebuttal?

MR. GONZALEZ-PAGAN: Yes. And we would be -- are now calling them as part of the case-in-chief on Wednesday, as per our conversation yesterday.

THE COURT: All right. I get it.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

THE COURT: Meanwhile, call the next one.

MR. GONZALEZ-PAGAN: Thank you.

The plaintiffs call Dr. Johanna Olson-Kennedy, Your Honor.

(Dr. Olson-Kennedy entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

DR. JOHANNA OLSON-KENNEDY, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: My name is Johanna Olson-Kennedy, O-l-s-o-n, hyphen, K-e-n-n-e-d-y.

DIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Good morning, Dr. Olson-Kennedy.

A. Good morning.

Q. What is your profession?

A. I am a medical doctor.

Q. What type of medical doctor are you?

A. I'm board certified in pediatrics and subspecialty board certified in adolescent medicine.

Q. Where are you currently employed?

A. I'm an employee of the University of Southern California, but I work at Children's Hospital Los Angeles.

Q. What is your role within Children's Hospital of Los Angeles and USC?

A. I am the medical director of The Center for Transyouth Health and Development, and I'm also an associate professor of clinical pediatrics.

Q. And as the director of the trans youth center and professor, what are your responsibilities? What do you do?

A. I split my time, roughly equally, between doing research and providing clinical services for transgender young people and young adults.

Q. How many transgender young people and young adults do you provide care for, Dr. Olson-Kennedy?

A. I currently have an active panel of around 650; over the 17

years I've been doing this work, probably about a thousand.
Q. What are the ages of these patients that you provide care for?
A. I see patients between the ages of 3 and 25 or 26.
Q. And what is the condition for which you are providing care for to these transgender young patients and young adults?
A. Gender dysphoria.
Q. What, if any, is the care that you provide to prepubertal patients?
A. So for prepubertal patients, they do not get any medical intervention or surgical intervention. There is no medical intervention that's indicated or appropriate for prepubertal children.
For families that have young children like that, I provide information about trajectories -- developmental trajectories. I provide information about how to keep those young people safe, how to navigate difficult things that come out, maybe disclosure, talking to family members. It's pretty much support of those parents who need other parents of gender-nonconforming or diverse children.
Q. And what is the care that you provide to adolescent patients?
A. So adolescent patients may come in for a variety of different reasons. They're coming in to address their gender dysphoria. The recommendations that I make have a large range,

and those things range from puberty blockers to gender-affirming hormones, referrals for surgery, and sometimes no medical interventions.

Q. What about adult patients?

A. So same thing for adult patients. They may want to go on to medications that block their endogenous hormones; they may want to take gender-affirming hormones; they may need referrals to surgery. Similar.

Q. Are there any clinical guidelines that you utilize in providing this care?

A. Yes, I look to the WPATH Standards of Care -- Version 7 was the majority of my career up until September of this past year when they shifted over to a Version 8 -- as well as the endocrine guidelines, and then I also utilize the UCSF, or University of California San Francisco, guidelines for care.

Q. You mentioned, I believe, the years, but just to make it a little bit clearer, how long have you been providing that care?

A. This will be my 17th year providing this care.

Q. And the trans youth center that you lead, is that a multidisciplinary center?

A. It is.

Q. Can you provide the Court with context about how care is provided within this center?

A. Sure. So within our center, we have five medical providers, including four medical doctors and one nurse

practitioner. We have one medical fellow who also is learning how to provide care. We have four social workers, two psychiatrists trained in adolescent and pediatric psychiatry. We have two Ph.D. psychologists.

And then on the other side -- they're not -- we're combined, but they're not technically housed in the same place -- we have a surgeon, a surgical social worker, and a nurse practitioner, as well as a physician's assistant that all work in the surgical section.

Q. And, Dr. Olson-Kennedy, you mentioned that your panel is about 750 patients?

A. 650 to 700, something like that.

Q. How many patients are being seen at the trans youth center at present?

A. I think we have about 2,400 active patients at the center right now.

Q. And are all the services that these patients need or utilize provided at the center, or do you work with other providers?

A. So we are highly networked, particularly with mental health providers that are in the area, A, because we have a large catchment area, but also because there are many professionals that are skilled in the care of transgender young people as far as mental health goes. So we work with outside psychiatrists and psychologists and social workers.

Q. And aside from the providers that you work with as part of this network, are you aware of how care is provided by other medical providers outside academic centers?
A. I think that people have a similar model in the sense that they have a multidisciplinary team, but it's not necessarily housed under one roof so -- such that maybe a medical provider that is operating in a solo practice or a group practice will be networked with professionals outside of their actual building.
Q. Can a provider who provides care to adolescents with gender dysphoria outside of an academic gender clinic do so in a careful and appropriate way, in a multidisciplinary way?
A. Yeah, such as I just described. I do think it's important for people to know the people that they're networked with and understand that they're skilled and trained, but that's absolutely necessary in this care because academic centers are not available to a large percentage of people in the country.
Q. Can you talk a bit -- a little bit about how care is provided for adults?
A. So I can't speak for the whole adult care provision world, but I can tell you, because my patients age out of my clinic into adult services, and sometimes it's because they are 18, I'm always sad to see them go, but I'm happy to see them go to college and other places. And so I help those young people find places where they can access care. Sometimes, if they're local, I will refer them to larger academic programs. Sometimes they

don't have access to those things because of where they're located or the type of insurance that they have, so they can disperse into a multitude of different places, and I try to help people with that process.

Q. Just to put a little bit of a finer point on this, is gender-affirming medical care only provided within academic gender clinics?

A. No, there are multiple types of ways that gender-affirming care is provided, particularly for adults. There are multiple centers where it's maybe a -- the way that medicine is, it's maybe a group practice where there's many -- multiple doctors, but one person is specializing in this work and, again, networked out with other people.

Q. And can this care be provided outside academic gender clinics in a manner that is consistent with Standards of Care and Clinical Practice Guidelines?

A. Yes, I believe so.

Q. You said that you spend your time sort of half and half between providing clinical care and doing research.

What are the areas of study that you research?

A. The primary area of study that I do research in is looking at the impact of medical interventions on both the physiologic and the psychosocial well-being of young people and young adults.

Q. Have you published any research or scholarly articles

related to the treatment of gender dysphoria?
A. I have, I think, around 30 manuscripts. Maybe four or five of those are not related to what we're talking about.
Q. Are these peer-reviewed publications?
A. They are.
Q. Have you ever served as a principal investigator?
A. I have, and I currently do right now. I'm the principal investigator for a large NIH-funded, multisite, longitudinal observational study that involves one cohort of young people who are new to puberty blockers and one cohort of young people who are starting gender-affirming hormones. That study started in 2015. It was extended for an additional five years, so we are in the process of actively still collecting follow-up data, as well as enrolling new participants.
Q. And just for clarity, these patients that you're following with regards to the provision of puberty blockers and hormones, are these transgender patients with gender dysphoria?
A. The ones in the study?
Q. Yes.
A. Yes.
Q. What has the research coming out of the NIH-funded study so far shown?
A. So we have published on a number of NIH aspects. A lot of what we have published has been regarding the protocol, the baseline data for our two cohorts. But the follow-up data that

we have published has demonstrated, particularly in the article we published earlier this year, an improvement in depression, an improvement in positive affect, and improvement in life satisfaction. We've also published a handful of manuscripts on the safety of gender-affirming hormones.

Q. Have you published any other articles pertaining to the treatment of gender dysphoria outside the context of this NIH-funded study?

A. I have.

Q. Can you tell us a little bit about those studies?

A. Sure. I published a manuscript looking at the efficacy comparing two different puberty blockers. That's a little strange because they're actually the same, but they're slightly different in the amount of medication they secrete on a daily basis. And I also have published a paper looking at the impact of chest surgery on chest dysphoria for young trans masculine individuals.

Q. Dr. Olson-Kennedy, did you submit a curriculum vitae as an attachment to your report in this case?

A. I did.

Q. And does that curriculum vitae accurately reflect your professional background and experience?

A. I think there's probably about five or six or seven or maybe ten additional lectures that I've given since that CV was submitted.

Q. But it otherwise accurately reflects your experience?
A. Yes.
MR. GONZALEZ-PAGAN: Your Honor, Dr. Olson-Kennedy's curriculum vitae has been admitted into evidence as Plaintiffs' Exhibit 361.
THE COURT: Plaintiff 361 is admitted.
(PLAINTIFFS EXHIBIT 361: Received in evidence.)
MR. GONZALEZ-PAGAN: Your Honor, at this time I will ask that Dr. Olson-Kennedy, as a physician and clinical researcher, be qualified as a -- to testify as an expert on the study, research, and treatment of gender dysphoria.
THE COURT: Questions at this time?
MR. JAZIL: No, Your Honor.
THE COURT: You may proceed.
MR. GONZALEZ-PAGAN: Thank you, Your Honor.
BY MR. GONZALEZ-PAGAN:
Q. Dr. Olson-Kennedy, I want to pivot a little bit and take a step back and talk a little bit about the history of gender-affirming medical care.
How long has the use of surgery to treat gender dysphoria been around?
A. I think the first surgeries were in around 1930.
Q. And can you tell us a little bit more about that history?
A. I think we heard a little bit of this yesterday from Dr. Schechter, who was talking about really the origins of

transgender experience being explored and written about primarily in Germany. This is not to suggest that there were not transgender people. There have been transgender people as long as people. There's anthropologic and archeologic evidence to suggest that.

But I think when it moves into the world of study, when it moves into the world of investigation and academia really starts around the late 1800s, and the person whose records we have the most understanding and knowledge of come from Magnus Hirschfeld, who is a scientist in Berlin, and he collected an enormous amount of data and wrote down an enormous amount of information about the community, published numerous books and manuscripts, and much of it was destroyed when his institute was burned down by the Nazis. So we lost a lot of that, which is very unfortunate because he did so much work in this area.

There was a physician named Harry Benjamin who studied with Magnus Hirschfeld and then came back to the United States and started doing academic work with transgender people, and he has also contributed greatly to the literature, and he really started doing his work in and around the 1940s, 1950s, and '60s.

Q. Dr. Olson-Kennedy, how long has the use of hormones to treat gender dysphoria been around?

A. Since shortly after we synthesized hormones. So that was in the late 1920s and early 1930s.

Q. Would it be accurate to say, then, that gender-affirming

hormone therapy and surgery have been around for a century or so?

A. That would be accurate.

Q. How long has the use of puberty-delaying medications to treat gender dysphoria been around?

A. So I think that puberty -- central blockers -- and I want to be clear, because we're talking about central blockers, gonadotropin-releasing hormone analogs were synthesized and introduced in the late 1970s, I think, but they were approved in 1990, I believe, early '90s.

And from what we know from the work that was going on in The Netherlands, puberty blockers or central blockers were being utilized right around that time for gender dysphoria based on a case study that was published by them entitled *A 22-Year Follow-Up*. I can't remember the exact date of that publication, but indicated that they had been using central blockers since the '90s.

Q. What about in the United States? How long has the use of puberty-delaying medications been around?

A. So there was a physician named Norman Spack who worked at Boston Children's Hospital, and Dr. Spack, who is a wonderful, amazing doctor, went over to The Netherlands to study with that team and then came back to the United States and started using central blockers in the early 2000s.

Q. Can you tell me a little bit about the history of providing

gender-affirming medical care to adolescents at your own institution?

A. So I was not there yet, but my boss, who is the head of the division -- his name is Marvin Belzer -- he was providing HIV services for young people, older adolescents and young adults. And in the early '90s, one of his patients who was receiving HIV care asked if he could do her hormone care, and he started providing hormone care at that time. And then that was followed by increasing numbers of patients.

Q. Dr. Olson-Kennedy, we've heard a little bit about the care that was being provided by the Dutch -- the Netherlands throughout this trial.

Are you familiar with the term "Dutch protocol"?

A. I am.

Q. Can you tell us a little bit about what that is?

A. Because the Dutch had been doing this care probably a little bit earlier than most people in the world, they published a manuscript that described their approach to care. So it included, you know, an assessment period and then a time period where people were on puberty blockers, followed by gender-affirming hormones, followed by surgical interventions.

MR. GONZALEZ-PAGAN: Your Honor, if I may, I'm going to show the plaintiff [sic] what's marked as Plaintiffs' Exhibit 141.

THE COURT: Is this something that should not be on

the public screen?

MR. GONZALEZ-PAGAN: It can be on the public screen, Your Honor.

THE COURT: All right.

THE WITNESS: Is it coming up here?

MR. GONZALEZ-PAGAN: It should.

THE WITNESS: Okay.

BY MR. GONZALEZ-PAGAN:

Q. Before I ask you about this, Dr. Olson-Kennedy, are there any research studies that document the care that was being provided at the Dutch clinic in Amsterdam?

A. Yes, they've published pretty extensively about the care that they've done, and this is one such article.

Q. And this article, Plaintiffs' Exhibit 141, is this -- can you tell us a little bit about this paper?

A. Yes. So this paper outlined the findings of 70 young people who were provided central puberty blockers, or what we see here -- as referred to as gonadotropin-releasing hormone analogs -- sorry. That's a mouthful -- and it talked about the psychological functioning of these 70 young people before and then after their course of puberty suppression as an only mechanism. So they were moving into the stage of gender-affirming hormones. So this was after their time on blockers as compared to before they started.

Q. Dr. Olson-Kennedy, I'm going to refer you to Table 1 of

this study on page 2278 of the paper, Bates stamp PLAINTIFFS006596.

Can you tell us a little bit about what this table tells about the demographics of the participants in this study?

A. Sure. So this table is a pretty common table that you see in research. It talks about the basic characteristics of the individuals that are participants, and it also gives some indication about the ranges of time between interventions. So what you can see here is that the people that were starting central blockers were -- ranged from the age of 11 to 18, and that by the time they were starting gender-affirming hormones, they were between the ages of late 13, so 13.9, and 19, and then kind of a time start between their time on central blockers and gender-affirming hormones.

And the Dutch, for some reason, feel compelled to always talk about IQ. I'm not sure why, but they do that. So it talks about that as well, in addition to some other demographic information.

Q. Thank you, Dr. Olson-Kennedy.

So would it be accurate to say, then, that there were no set ages at which any of the particular treatments that we've been discussing were provided at the Dutch clinic?

A. So while the Dutch protocol outlines basic ages of 12 for, you know, central blockers and 16 for gender-affirming hormones and 18 for surgery, they acknowledge that because the age of

consent in the Netherlands is 16, that that tends to be the age around which their participants generally average out.

However, as you can see from that article, the youngest person that was accessing gender-affirming hormones was just under 14.

Q. And what type of study was this study that we were just discussing?

A. This was a prospective longitudinal study.

Q. And was one of the authors of this study Annelou de Vries?

A. Yes.

Q. What did the study show with regards to the outcomes of these patients?

A. So this study that we were just looking at demonstrated that there was improvement in psychological functioning for those young people over the time that they were on puberty blockers.

What the study also demonstrated is that they -- this process of putting somebody on puberty blockers really pauses them, and so they're not -- they're kind of at a stopping point. They're not necessarily moving forward in a way that moves their body into alignment with their gender, but they are paused, so they are not moving in the other way either, which is what has been demonstrated repeatedly to be beneficial for young people.

Q. And when you say "moving in the other way," what do you mean by that?

A. So as somebody moves through their endogenous puberty, the puberty that the gonads that they have would bring them through, that is -- has been shown repeatedly to be very detrimental for people who identify as a gender other than the one that that puberty would bring them through. And so puberty blockers allow them to pause that process.

Q. I'm not a doctor, so I'm trying to get a little bit in layman's terms, if you will -- would that mean that there are no physical changes that would, therefore, cause distress to the person that -- further physical changes that would cause distress to the person?

A. Yes. So the process of going through puberty is the process where you develop secondary sex characteristics that would primarily make you perceived as male or female. And so if you are a girl and you go through puberty that makes you look like a boy, that's extremely difficult.

Q. Some of the defendants' experts have said that the Dutch research is not applicable to care provided in the United States because the protocols are purportedly different here.

What's your response to that?

A. A, I don't think that they're necessarily different. I think that most people that are going through this process have a similar basic trajectory through this time period in their life. I also think it's really important to understand that in the world of science and medicine, we adjust our -- the way that

we think about work as we get more and more data to help us refine that process.

But one of the things that's really important about that early study is demonstrating that while the Dutch protocol may be described as 12, 16, and 18, even from -- the studies that that Dutch protocol arose from demonstrate that there are people under those ages that are receiving these interventions.

Q. And we discussed a little bit one of the authors of that first Dutch study, Annelou de Vries.

Did Annelou de Vries have any involvement with the WPATH Standards of Care 8?

A. Absolutely.

Q. What was that involvement?

A. So Annelou De Vries has had -- played a big role in the development of -- she was a primary author on the WPATH SOC 8 as well as the endocrine guidelines.

Q. Defendants' experts also say that because the participants of the Dutch -- in the Dutch research had purportedly -- purportedly had gender dysphoria from early childhood and also have therapeutic support, that that research is not applicable to gender diverse and transgender youth that have not had those experiences.

What's your response to that?

A. It -- people that are coming into care for puberty blockers in early puberty have been experiencing gender dysphoria and

talking about it. I just want to be really clear about this, that in order for someone to get into services in the beginning of their puberty, they have experienced gender dysphoria in childhood.

And so the -- it is -- it's really important to understand that there are less than 5,000 people in the United States on puberty blockers. It is an incredibly small number, because most people do not engage in care when they are in that early prepubertal stage. It is incredibly rare.

Q. And just for the edification of those of us here today, can you tell us a little bit about how people begin to understand their gender identity or begin to experience gender dysphoria?

A. So remember that we have everything constructed in our world that anticipates that people are going to have a gender that aligns with their designated sex at birth. In other words, when babies are born, they have -- they are given a gender marker based on their external genitals or, perhaps, an ultrasound prior to birth. And so everything is organized around those two things being -- that someone's gender and their sex assigned at birth is going to align. It's unusual and it's a very rare occurrence when that does not happen, which is what we are talking about in this court case.

So you have to recognize that everything is organized around those things being aligned. So if they don't align, essentially people have to swim upstream to understand that

their gender is different than what they were assigned at birth.

So what that means is there's going to be a very small number of people who in childhood recognize that their gender is not the same as their sex assigned at birth. And so those very rare cases are really the cases of young people who, A, recognize it; B, talk about it; and, C, have parents or guardians who are going to listen to that information.

That is a lot of things that need to happen in order for someone to engage in the process of getting puberty blockers in early puberty.

Q. And given all of those obstacles, if you will, that somebody has to face, would you say that somebody that's presenting for care at that age, having already gone through all of that, is a strong predictor of persistence of their gender identity?

A. Absolutely. There is -- understand that because people who have a gender different from their designated sex at birth, they are swimming upstream. They have to overcome a lot of obstacles in order to understand, talk about, and then get care related to their gender. That's why it's so extremely rare that people go on blockers in early puberty, even in these time frames that we are talking about.

Q. Thank you, Dr. Olson-Kennedy.

You know, we've been talking a little bit about the provision of this care and some of the Dutch studies with regard

to adolescents.

Has gender-affirming care been studied throughout the decades that it has existed?

A. No. Because gender incongruence or the experience of having a gender that is different from what you were assigned at birth has been happening since people, and so there haven't been studies from -- you know, that go back thousands of years. The time that this particular occurrence starts being studied is really in the early 1900s when it moves into the world of medicine.

Q. And as a clinician and an investigator, are you familiar with the body of research that exists pertaining to the treatment of gender dysphoria?

A. I think so.

Q. Dr. Olson-Kennedy, I want to start off about -- talking about the existing research into the medical interventions to treat gender dysphoria.

Is there scientific research evaluating these medical interventions?

A. There is.

Q. And what are the type of studies that are out there assessing the efficacy of treatment for gender dysphoria in adolescents?

A. There are studies that address the use of blockers, puberty blockers, that we were talking about. There are studies that

address the impact of blockers -- blockers and gender-affirming hormones. There are studies that look at gender-affirming hormones. There are studies that look at surgical interventions, particularly chest surgery.

Q. And what about adults? Is there scientific research evaluating these medical interventions for the treatment of gender dysphoria in adults?

A. Yes.

Q. And what type of studies are out there assessing the efficacy of gender-affirming treatment for gender dysphoria in adults?

A. The studies range all the way from focus groups talking about experiences of adults all the way to assessing and evaluating the interventions that are available regarding medications, regarding surgical interventions. Those studies range from longitudinal studies to case studies to one-time-in-point studies. There's just -- there's gobs of research about transgender adults and the care.

Q. Dr. Olson-Kennedy, you've described a few of the types of studies that have been utilized to study treatment of gender dysphoria in adolescents and adults.

Dr. Olson-Kennedy, you heard the testimony of some of plaintiffs' experts stating that randomized controlled trials are neither feasible nor ethical in the context of gender-affirming medical care.

Do you agree with the opinions of Drs. Shumer, Schechter, and Antommaria in this regard?

A. I do.

Q. When looking at the body of research that exists about the efficacy of treatments for gender dysphoria, what is it that this body of research looks at?

A. So research can -- is variable in looking at the physiologic impacts of interventions. A lot of the research around gender dysphoria and interventions is concerned with the psychological impact of gender-affirming hormones, puberty blockers, surgical interventions.

There -- I think because the issue of safety has really been put to rest -- these are medications that have been used for decades -- their safety is not really something that is studied extensively anymore because those studies have been done.

Right now what people are primarily studying is the impact on people's life, quality of life, capacity to function. Those are the things that are studied.

I do want to say in my study we are looking at physiologic impact because it's always good to have additional data, but the safety of these medications has been studied extensively.

Q. And when looking at the impact on mental health and quality of life, what are the metrics of this study's use?

A. So there are multiple ways that we can look at the impact

of interventions on quality of life. We can -- there are multiple domains that go into that understanding. We can look at depression. We can look at anxiety. We can look at the things that I described in the previous study which have to do with, you know, general life satisfaction, capacity to function. There's -- there are so many things that we study. Even within my own study, we have 15 or 20 different measures of -- that really look at quality of life in one dimension or another.

Q. And just getting a little bit more granular into this, what are some of those scales that measure those outcomes?

A. So there are outlined measures that the NIH provides, such as emotional function that looks at anger, looks at sadness; it looks at loneliness. It looks at some of the things that we just saw in the study that you presented on the screen that looked at overall general life satisfaction and different domains of that.

Q. And what do these measures tell us about the efficacy of treatment for gender dysphoria?

A. If you look at the body of evidence, it -- the evidence is pointing to improvement across all domains of life. There are certain things that we look at that are inherent to the experience of transgender people, like anxiety, that are impacted by the world in which people live. But the psychological pieces about people's self esteem, their feelings about themselves and the way that they move around in the world

are -- all demonstrate improvement across the body of literature.

Q. And you've referenced when we look -- when we look at the research as a whole, or when we look at the entirety of the research.

Can you explain to us why it's important to look at the body of the research as a whole as opposed to any individual study?

A. An individual study can only really address a limited number of people and a limited number of findings. This is related to the fact that, for example, there are around maybe slightly less than 5,000 people in the United States who are utilizing puberty blockers for the purpose of addressing their gender dysphoria. But all 5,000 of those people are not in one place. And so maybe one place that has 40 people can do one piece of that work, and another place that has 100 can do that piece of that work.

And just like as a physician I don't evaluate somebody's pinky to tell me about their entire body, we to look at the entire collective of evidence.

Q. I want to ask you some specific questions about the research into the efficacy of puberty-delaying medications.

Is there specific research on the efficacy of puberty-delaying medications to treat adolescents with gender dysphoria?

A. Yes.
Q. What do the studies evaluating the efficacy of puberty-delaying medications to treat gender dysphoria show?
A. So the study that we just looked at in particular, which was published in 2011 from the Dutch team, demonstrated that there was improvement in global psychological functioning, that there was improvement in depression. And for those young people, because they were paused, they have no movement around their experience of gender dysphoria, but these other elements of their functioning are improving, which is very similar to what we see in the clinical population.
Q. Are there any other particular studies that you would point to that specifically assess the efficacy of puberty-delaying medications?
A. So just to back up, I do want to say, in the -- that same study, the follow-up of that study where they -- those young people go onto gender-affirming hormones, you do see improvements in gender dysphoria. That's a really important follow-up to understand that puberty blockers are just putting a pause on that development.

Yes, there are other studies that look at the efficacy of puberty blockers. Another study from The Netherlands that actually enrolled something like 250 -- I can't remember the exact numbers, but looked at -- tried to address this issue of what does an untreated population look like? And so they

compared -- so a lot of the studies that are done look at the psychosocial functioning of people before they start puberty blockers and then compare it to after, because of what we've talked about, that an untreated control group is not an ethical approach to this research. But they do have natural cohorts of people who have not yet started puberty blockers.

And so there was a study by van der Miesen, et at., so van der Miesen and colleagues, that looked at the psychosocial functioning of people that were new -- they had not yet started blockers -- compared to a larger cohort of people who had been on blockers, demonstrating similar findings, improvement in psychosocial functioning.

Q. You mentioned van der Miesen. What was the author of the other study you were discussing?

A. The one from 2011 was Annelou de Vries and her colleagues.

And then there have been -- there have been numerous other studies, but one that comes to find is a study by Costa, et al., that was done in the United States, and also demonstrated a similar -- a similar process, where half of the cohort they concluded was immediately available to go onto blockers, and the other half of the cohort was a delayed start on blockers and had psychological intervention only. Both groups improved for the first 6 months. But between 6 and 12 months after, the blocker group continued to demonstrate improvement in psychological functioning, but the psychological intervention arm did not.

Q. So it's safe to say that the psychological intervention did not at least treat as effectively the gender dysphoria in these adolescents?

A. That's correct, over the time of a 12-month period.

Q. Are there any limitations to these studies?

A. Of course. All studies have limitations.

Thinking about the cost of the study, for example, that had 50 people in it, it -- you know, this is -- when you are talking about a very rare intervention, such as puberty blockers, where we only have around 5,000 people in the country on puberty blockers, it is common that people are not going to have large sample sizes in those studies. That's one of those things -- one of the limitations.

One of the other limitations is time of follow-up, right. So puberty blockers used for gender dysphoria is a relatively -- when you look at the larger body of medicine, a relatively newer intervention.

And so the -- yes, we are continuing to collect longitudinal data, as are the Dutch and many other places around the world. So we are a little bit limited just by the fact that this particular intervention has only been available for, you know, 20 years or so.

Q. Has this intervention been limited also in terms of studying the long-term effect, even in older adults, with regards to central precocious puberty, for example?

A. Absolutely. So you have a medication that gets approved for use in 1993. You are not going to have somebody who is 70 to look at yet.

Q. When you look at the whole body of research pertaining to the efficacy of the use of puberty-delaying medications to treat gender dysphoria, what is the full picture that you get?

A. The data -- the body of evidence that exists right now demonstrates the positive impact of the use of puberty blockers in youth with gender dysphoria.

Q. Thank you.

Does this research that you've been discussing -- how does it compare to your clinical experience?

A. So I have been providing puberty blockers and gender-affirming hormones for -- this will be my 17th year. I desperately wish that I could have enrolled all of my patients into studies to demonstrate how they benefit from these interventions.

So these studies line up. But I think what studies sometimes don't capture is the euphoria that people experience when they do not have to progress through their endogenous puberty and develop secondary sex characteristics that are not in alignment with their gender. We don't capture euphoria, unfortunately, in our studies. We capture these metrics that we know are proxies for that experience.

Q. So you would say from your clinical experience, then, that

your patients have experienced a positive affect in accessing puberty-delaying medications?

A. Absolutely.

Q. Turning to hormone therapy specifically, is there specific research on the use of gender-affirming hormone therapy to treat gender dysphoria?

A. Yes, there is.

Q. Are there studies that focus on the treatment of adolescents with gender dysphoria you are seeing in hormone therapy?

A. Yes, there.

Q. What are some of those studies that assess the efficacy of hormone therapy as treatment for gender dysphoria in adolescents?

A. So there are several. I can focus on a few of them.

One is the follow-up study from de Vries and her team that was published in 2014, demonstrating continued improvement across psychological functioning and domains. That was an important study because it's probably one of the oldest studies that enrolled people between 2000 and 2008.

Of importance is that all of those 70 young people that went onto blockers continued onto gender-affirming hormones in an upward trajectory of their psychological functioning.

There is another larger cross-sectional study that looks -- only is measuring one point in time that -- from the

United States that was -- that looked at -- I think it was about just under 12,000 LGBTQ individuals, youth. Particularly, they isolated about -- I think just under 6,000 trans or nonbinary young people in that study.

And what the study assessed was for the people who had access to gender-affirming hormone therapy versus the people who did not but wanted it, there was a significant difference in the psychological functioning of those two groups. So in the -- I don't know -- 1300 or something like that people who had access to gender-affirming hormones, their psychological profile was better than the several thousand people who wanted access but did not have it.

Q. And who is the primary author of that study, do you remember?

A. Greene.

Q. And you've mentioned a study that was published as a result of your NIH funded study --

A. Yes.

Q. -- is that right?

Can you tell us a little bit about that study?

A. So I'm the senior author on that study, but the first author is Diane Chen, who is an investigator at Lurie Children's Hospital in Chicago.

That study looked at the psychological findings from people who had been on hormones for two years, demonstrated an

improvement in positive affect, in life satisfaction, improvement in depression symptoms.

And that study is important because it is pulling participants from four sites around the United States. True, they are urban centers, gender centers, where this work is the primary focus of the center, but those were also important findings from a cohort of 314.

Q. Dr. Olson-Kennedy, I'm going to apologize for this couple of questions, but some of the defendants' experts have brought up that there were two subjects who, during the course of this longitudinal study, died by suicide.

My first question is: What are you at liberty to tell us about these subjects? And, separately, how does this play into or have any effect on the validity of your study?

A. So we did, unfortunately, lose two participants. They -- you know, gender-affirming care does not address everybody's entire life circumstances.

But what I can tell you is that their gender dysphoria improved, that they had peace and felt comfortable in their body, but they were not existing in a world that was supportive of them.

I'm so sorry.

Just because people receive gender-affirming care does not mean they are in a gender-affirming world.

Q. Do you need a break, Dr. Olson-Kennedy?

A. Yeah.

MR. GONZALEZ-PAGAN: May the Court be amenable to a short two-minute, five-minute break?

THE COURT: We can take a break and -- if we need to. If we just need to be at ease here for a minute, we can probably do that.

MR. GONZALEZ-PAGAN: Dr. Olson-Kennedy, just take your time.

THE WITNESS: No, it's okay. We can go.

MR. GONZALEZ-PAGAN: Your Honor, may I approach with water?

THE COURT: Surely.

THE WITNESS: Thank you.

THE COURT: Doctor, we are in no hurry. Take your time.

BY MR. GONZALEZ-PAGAN:

Q. And, Dr. Olson-Kennedy, again, I apologize this had to be brought up.

I thank you for your candor in sharing those experiences and speaking to the circumstances of those people.

The study that we are talking about, was that study published in a peer-reviewed journal?

A. Yes.

Q. What was that journal?

A. That study was published in the *New England Journal of*

Medicine earlier this year.
Q. And was it peer reviewed?
A. Yes.
Q. And, again, what were the findings of the study with regards to the efficacy of hormone treatment for gender dysphoria?
A. So over two years of gender-affirming hormone treatment, we saw an increase in positive affect, in life satisfaction, and a decrease in depression.
Q. When you look at this whole body of research pertaining to the efficacy of gender-affirming hormone treatment for adolescents, what does the whole body of research tell us?
A. The body of research continually tells us that people's lives are improved when they have access to this care.
Q. Are there any studies that assess the efficacy of hormone therapy to treat adults with gender dysphoria?
A. There is a large body of evidence that looks at this question and has for many decades looked at various aspects of people's lives.
Q. And would you consider -- in your estimation as a clinical researcher, how you would characterize the quantity of research that exists out there with regards to adults?
A. In my research language, I would say significant. In my layperson's language, enormous.
Q. How do the results that you just discussed with regards to

adolescents, with regards to the whole body of research being treated with hormone therapy, compare to that of the general body of research that exists in adults?

A. This is a growing body of research. I think it's really critical to think about, when interventions become available -- you know, trans adults start as trans kids. They start as trans kids; they become trans adolescents, and they grow into trans adults. And so as interventions have become available for adolescents, they are going to be utilized at an increasing rate. And so when people have access to that care, as that increases over time, we're going to have a growing body of literature. It is still a very significant body of literature at this time.

Q. And does the body of literature with regards to adults similarly show that the treatment is efficacious?

A. Yes.

Q. How does this research that you just have discussed with regards to the efficacy of hormone therapy to treat gender dysphoria compare with your clinical experience?

A. The clinical experience that I have working with young people -- I've probably taken care of a thousand young people over the course of my career, and what I see over and over again is that people improve -- their whole life improves. There are people who feel like their life has not started until they have their gender addressed and they're able to move around in the

world in a way that feels authentic to them.
Q. Can you tell us a little bit about what you've seen with your patients who have been -- how have they been impacted or what you've seen them do following their access to gender-affirming medical treatment?
A. I was thinking about this last night, and I was thinking that when I first started doing this work, I was really happy when my patients graduated high school. And now 17 years later having patients become doctors and lawyers and get Ph.D.s and move forward in their lives in a way that I would want for my own child, but also for any child and young person and young adult moving through the world, it's been incredible. I think it's just really changed the trajectory of people's lives.
Q. You've mentioned that they've become lawyers and doctors.
I apologize to even ask it in this way, but would you say that somebody being transgender doesn't affect their ability to contribute to society?
A. No, absolutely not. If somebody has access to early interventions, I anticipate them to have the same chance at a robust and thriving life as anybody.
Q. And would you say that that is the case when somebody's gender dysphoria is treated and managed?
A. Yes, absolutely.
Q. I'm going to pivot a little bit and talk about surgery.
Is there research specifically evaluating the efficacy of

surgical treatments for gender dysphoria?
A. Yes.
Q. Overall, what do the studies on the efficacy of chest surgery in adolescents tell us?
A. Chest surgery is a critical intervention for transmasculine people. It is absolutely imperative, and all of the research to date has demonstrated that chest surgery is one of the most efficacious interventions for people.

And just speaking about this from a regular person's perspective, the process of having to bind your chest is incredibly uncomfortable, even painful. It is something that young people have to do for hours in a day, and being able to do that means that people can go through their life freely without being, literally, bound up. It is incredibly uncomfortable to wear a chest binder. Some people utilize tape -- duct tape; some people utilize Ace bandages to flatten their chest.

So when people have chest surgery, they are free of that, and that's a whole different way of living. That's why chest surgery is such a profound intervention and is demonstrated to be in the existing research.
Q. You spoke earlier about a study of yours that specifically pertained to chest surgery in adolescents and young persons.

Can you tell us a little bit about what that study specifically showed?
A. So over the years of my practice, I had repeatedly heard

similar things from my patients. Things like, I avoid taking showers because of my chest; things like, I avoid going to public places to swim or to the beach; things like, I feel like my life hasn't started because of my chest.

I collected these things into a measure so that I could see what the impact of chest surgery was for young people, and my study, like some of the follow-up studies after that, has demonstrated that those elements are significantly -- like, profoundly improved after people have chest surgery. It is one of the most profound interventions that's available for transmasculine people.

Q. And you said that you developed a measure -- or would it be safe to call it a scale?

A. Yes.

Q. You said that you developed a scale to measure the dysphoria that arises out of somebody -- out of their chest -- having a chest incongruent with their identity.

Has this scale been used in studies conducted by others?

A. Yes. So the chest dysphoria scale was utilized in a handful of follow-up studies that had remarkably similar results to the ones that I had in my study and correlated chest dysphoria to anxiety and depression.

Q. And can you tell us what a couple of those studies may be?

A. So there's -- I think one that really sheds light into the nuances of this experience was -- let me try and think of --

remember the name of the author. But it was a qualitative study where they had 20 young people in a focus group and really asked them about the impact of their -- female chest contour on their lives as nonbinary or transmasculine individuals, and demonstrated -- out of that study came very similar things to what is in the chest dysphoria scale.

There have also been two studies that looked at young people prior to chest surgery utilizing that scale, correlating it to anxiety and depression, and then that same group of researchers, after those young people had chest surgery, demonstrating similar findings to what I had in my study.

Q. And, again, the findings were findings of improvement?

A. Yeah, so a reduction in chest dysphoria after surgery.

Q. Given that some studies used this scale and that -- had similar findings, would you then agree that your study is reproducible?

A. I think that the study is reproducible. It has been reproduced in the studies that I just mentioned. And I also think that scales have what's called face validity, which means that the items on the scale are tested informally in processes where you take care of patients.

And what I can tell you is I had 67 young people in that study who had chest surgery and 67 people who didn't, but the findings and the -- of that scale -- the results on that scale mirror what I see in clinical practice. They demonstrate the

relief that people experience after chest surgery.

And I now have hundreds of patients in my practice who have undergone chest surgery who have similar positive responses.

Q. We've been talking about the existence of research and studies regarding the efficacy of gender-affirming medical treatments and the relation to mental health.

Is there longitudinal data that shows the benefits of gender-affirming medical treatments for patients with gender dysphoria?

A. Yes.

Q. What is that data?

A. When did you say, or what?

Q. What is that data?

A. So are you talking about as a whole -- the body as a whole?

Q. What are the types of longitudinal data that exist showing the efficacy of treatment?

A. There's a lot of longitudinal data, especially in the adult population. So there are so many elements of the experience of gender dysphoria and the experience of the alleviation of gender dysphoria. There are so many studios I couldn't even review all of them right now.

But in youth, obviously, it's a more limited dataset because we've only been doing youth care for 20 or 30 years, as opposed to a hundred. So that body of evidence is growing and expect it to have similar findings to what we've seen so far.

Q. We've been speaking a lot about research and in some instances about how it accords with your own clinical experience.

Can you tell us what role clinical experience plays in helping -- determining the efficacy of treatment?

A. Yes. I think it's really important to talk about the elements that go into understanding evidence-based care, but it is not only research studies that help guide us in this care. It's clinical experience as well, and it's also patient experience. Those three things together are what inform decision-making in this work.

It is profoundly difficult to do scientific studies. It takes time; it takes money; it takes willingness of participants, as opposed to clinical care. Our clinical care outpaces our research. I've taken care of a thousand young people over the course of my career, and they have not all been involved in research.

And so we absolutely, in all areas of medicine, lean on our clinical experience to help us -- to help guide us in making decisions that are the best for people's outcomes.

Q. And does that clinical experience also inform what research is -- should be done?

A. It does. I think that people approach research from a variety of perspectives. Sometimes that research is to support what they're doing or to get those findings down on paper, and

sometimes it's exploratory.

Q. Shifting gears a little bit, I'm going to ask you a few questions of what is sometimes referred to as desistance in the literature.

Are you familiar with the term "desistance"?

A. I am.

Q. What does this term refer to?

A. Desistance commonly refers to people whose gender or experience of their gender pivots.

Q. Some of the defendants' experts suggest that as many as 98 percent of minors with gender dysphoria come to identify with their sex assigned at birth, and those don't need treatment.

I guess my question is, is it true that the overwhelming majority of adolescents with gender dysphoria come to identify with their sex assigned at birth?

A. No.

Q. How so?

A. It's really that these different cohorts of people are distinguished is really critical in understanding the existing literature.

So the research that that particular assertion relies on is, A, old. It's very old research. That's the first thing. It's research that happened even before the criteria for a diagnosis of gender dysphoria were in their current iteration. And so it is true that there are a lot of prepubertal children

whose gender expression is variable. So, for example, there are a lot of cisgender or nontransgender boys who like to wear dresses when they're children or whatever, do things like that.

The experience of gender dysphoria as it's defined today that leads to medical interventions, extraordinarily rare for desistance to occur.

Q. Do you think that these studies that you just discussed support the claims that defendants' experts are making about them?

A. Absolutely not about adolescents at all. In fact, the data has demonstrated that if people reach adolescence and they still have gender dysphoria, that it is not going to desist.

Q. Dr. Olson-Kennedy, are you familiar with the term "detransition"?

A. I am.

Q. What do you understand this term to mean?

A. That means somebody that stops being in a gender role and goes back to living in a gender role that they were designated at birth.

Q. Within the medical literature, what are some of the things that may lead someone to detransition?

A. The predominant reasons that people detransition have to do with their experience of trying to get along in a hostile world, in a world that is hostile to trans experience.

So, in other words, there are -- it just reminds me of a

patient I had that came in and said, You know, I'm going to stop taking hormones.

And I said, Why are you going to stop taking hormones?

It's just too hard.

This was a person that started their transition after they had gone through their endogenous puberty; they had acquired all of their male secondary sex characteristics. That is an extremely difficult scenario, and what she told me was, It's just too hard. Like, I can't walk in the world and not have to answer questions all the time about my selfhood, and so I'm going to stop.

Q. Are there some people who detransition because they come to actually identify with their sex assigned at birth?

A. A very, very small number.

Q. What is the percentage of people who detransition that do so because they come to identify as their sex assigned at birth?

A. About 1 to 2 percent.

Q. And what do you rely on for this assertion?

A. There's a limited number of data that demonstrate this, my clinical practice as well, and --

Q. Does the fact that some people detransition mean that gender-affirming medical care is ineffective or experimental?

A. No.

Q. Does the fact that someone detransitions mean that they regret receiving gender-affirming medical care?

A. No. The regret rates are actually even lower than the detransition rates.
Q. What is the percentage of people who receive gender-affirming medical treatment who experience regret?
A. 1 percent.
Q. And if someone regrets their medical treatment for whatever reason, does that mean that they no longer identify as transgender?
A. No.
Q. The defendants' experts argue that in some studies evaluating medical treatments for adolescents with gender dysphoria there were no findings of mental health improvements for some of the interventions.

Is that accurate?

A. That's just not true. The resounding body of data demonstrates improvement across multiple domains of function.
Q. Would a lack -- does the fact that a study didn't -- a particular study may not have found statistical significance with regards to the improvement -- does that mean that there was no improvement?
A. No. Statistical improvement is a number. It's a number. So if -- just because somebody doesn't meet a threshold that is a mathematical consideration does not mean they didn't experience improvement in their symptoms.
Q. And when looking at the body of research about the efficacy

of gender-affirming medical interventions to treat adolescents with gender dysphoria, what does that research show?

A. I'm sorry. Could you repeat the question?

Q. Sorry. When we look at the body of research about the efficacy of gender-affirming medical treatments to treat adolescents with gender dysphoria, what does that research show?

A. Improvement across multiple domains of psychological functioning.

Q. Are you familiar with the term "rapid-onset gender dysphoria"?

A. I am.

Q. What do you understand the concept of rapid-onset gender dysphoria to mean?

A. Rapid-onset gender dysphoria was introduced by Lisa Littman as a way to characterize how parents of some transgender young people talked about the experience with their young person; in other words, that this assertion of a different gender came out of the blue or came on very quickly.

Q. To your knowledge, does Lisa Littman provide gender-affirming medical care?

A. No, sir.

Q. To your knowledge, had Lisa Littman prior to this one study published any literature pertaining to gender-affirming medical care?

A. No.

Q. Is it unusual -- is it unusual that there are parents who would express surprise at learning that their adolescent is transgender?

A. No.

Q. Why not?

A. Young people are, in general, very -- have very strong feelings about potentially being rejected for who their authentic self is. So it is often the case that young people will keep this part of themselves from their parents as a safety measure, but also -- so let me give you an example.

If you don't tell anyone that your gender is different from what they think it is and they continue to use your birth name and the pronouns associated with that, it is way less painful than if you tell someone, and they continue to use your birth name and your pronouns.

And so that perspective is really important for both adolescents and adults, that there's an assessment of what's going to happen if people disclose this information to, particularly, their parents or caregivers.

Q. And the fact that they -- that adolescent doesn't feel free to come out to their parents, guardians, or family, does that mean they're not experiencing gender dysphoria?

A. Absolutely not.

Q. Is rapid-onset gender dysphoria recognized as a mental health diagnosis?

A. It is not.
Q. In conducting research about the experiences of trans adolescents, is it important to take into account their own narrative when conducting that research?
A. Yes.
Q. Did Lisa Littman's study look at all into the experience of the adolescence question?
A. No.
Q. When you're evaluating patients for assessment in making a diagnosis of gender dysphoria, do you consider social influence in your assessment?
A. Could you clarify what you mean by "social influence"?
Q. Sure. What do you take into account when making an assessment of an adolescent and whether they have gender dysphoria?
A. So even though we only talk about, I feel like in the lay community, about this one event of somebody coming out, there is the more critical piece of what I affectionately call coming in. So it's that process whereby somebody is undergoing some kind of research, some kind of quest to understand what they're experiencing. And so maybe it starts with a question like, Oh, I don't really feel like a girl. What does that mean?
And then it's going into the worlds that they're surrounded with, right. So for a lot of young people, that's online communities, seeking information -- What if I'm not a girl?

What if I'm not a boy -- and gathering a lot of information. People do a lot of information gathering before they ever invite anyone else into that question. And so maybe that's books; maybe it's online content; maybe the next step is finding other people with a similar situation.

And so we all do that as humans. We find people who have similar experiences, and we ask questions, and we -- sometimes maybe young people will create an avatar in the gender that they identify with and do online gaming in that avatar and see how that feels. There is a process of exploration before anyone comes out. And, generally, young people will talk about this with their peers before they talk about it with their parents or caregivers or teachers or anybody like that. It's a process whereby people are understanding what's going on for them around their gender.

Remember that our world is organized for cisgender people. Before you are even born, you have a nursery with according colors. Then you come into that nursery, and then the world is funneling you down a cisgender pathway. So if you are a trans person, you have to swim upstream in that world, which is also why some people don't come out until later, because what you have access to and what's in your world is going to determine some of how you understand this to be your truth.

Q. Thank you, Dr. Olson-Kennedy.

Can adolescents experience gender dysphoria because of peer

pressure to identify as transgender?
A. No. That doesn't make any sense. The majority of people are not transgender. The majority of people are cisgender.
Q. Some of the defendants' experts actually argue that adolescents identify as transgender because of a desire to fit in or be popular.
What's your response to that?
A. Well, if someone can explain to me the reward for being transgender, undergoing medical interventions and potentially surgery, then I might have a better understanding of that. But there is no reward for being trans. There is no peer reward, and there is no reward in the world. It's very hard to be a transgender person in the world as it is constructed right now.
Q. Some of the State's experts have pointed to reports from government entities in other countries, specifically the UK, Finland, and Sweden, as demonstrating a lack of evidence of the effectiveness of gender-affirming medical interventions for adolescents.
Are you familiar with those arguments?
A. I am.
Q. Do any of the reports referenced by the defense experts recommend banning treatment or coverage of gender-affirming medical interventions?
A. They do not.
Q. And, to your knowledge, are any of these reports peer

reviewed?
A. They are not.
Q. What is the purpose of peer review?
A. The purpose of peer review is to try to minimize bias in the reporting of findings.
Q. Is it common in medicine to have -- strike that.
Do you or people in your field typically rely on nonpeer-reviewed governmental reports in assessing the efficacy of medical treatment?
A. No.
Q. We've been talking a lot about the research regarding the efficacy of gender-affirming medical treatments to treat gender dysphoria.
Is there any research demonstrating the effectiveness of other treatments to treat gender dysphoria?
A. No, not that I'm aware of.
Q. I think this is answered, but to be a little bit more specific, is there any research demonstrating the efficacy of the use of psychotherapy alone to treat gender dysphoria?
A. No.
Q. We've heard a little bit throughout this trial about the rising number of people who have been presenting to gender clinics for treatment.
What are your thoughts on that?
A. I think that as interventions become available for

adolescents, it is -- absolutely makes sense that people -- more people are going to show up for care. Again, trans adults start as trans kids that become trans adolescents and then trans adults. And so it stands to reason that when interventions become available for people at a younger age and the national discourse changes on this experience, that more people are going to seek care related to this.

Our bodies have more hormone receptors when we are younger. If you can establish care and get care at a younger age, you are going to have more changes, those physiologic changes that are going to align with your gender that create a sense of peace for people. And so if people can access care in adolescence, they are going to have vastly different results than if they access this care later on.

Q. Can the rising numbers be attributable or -- be attributable -- let me restart that.

Can the rising numbers be attributable to the rising number of people experiencing gender dysphoria?

A. I don't think so. I think that just access to services and a more profound national discourse about this experience is very similar to other situations where people now see themselves reflected in the world and opportunities and pathways for addressing this distress.

Q. You mentioned other situations.

Are there any particular analogies that you consider

helpful in this regard?

A. One that I've thought of before is related to handedness, right, so left-handedness. For a long time the approach to this, if somebody was left-handed, was to tie their left hand behind their back so that they were forced to use their right hand, and even, like, people would get hit on their left hand so they didn't use it.

And so from an external lens looking in at that, it's like, oh, there are so few people that are left-handed. Well, yeah, because it wasn't -- these were the punitive measures, because people who were left-handed were considered to be less than or somehow, you know, problematic.

As that changed over time, it wasn't that more people became left-handed, it's that we no longer created punitive environments for left-handed people.

It feels very similar -- it feels very -- like a very similar situation.

Q. So any rise in the number of people that identified as left-handed was just people feeling freer to be left-handed. And did that plateau in any way?

A. Yeah. We haven't reached a point where everybody is left-handed, no.

Q. What is the effect of delaying medical treatment for gender dysphoria when it is medically indicated?

A. So I think we can -- when I think about this, I think about

the physiologic and the mental health piece of this.

So from a physiologic perspective, I've already made mention of the fact that the younger you are, the more hormone receptors you have, so that interventions when you're younger are going to have more physiologic impact in your body.

But the probably more devastating piece is untreated gender dysphoria. And the literature is very clear on this, that people with untreated gender dysphoria struggle in multiple domains of their life. So the longer that that goes untreated, the worse people are going to be.

Q. Just a few concluding questions, Dr. Olson-Kennedy.

As a clinician and researcher, do you consider the use of puberty-delaying medications to treat gender dysphoria to be experimental?

A. No.

Q. Do you consider it to be safe?

A. Yes.

Q. Do you consider it to be effective?

A. Yes.

Q. As a clinician and researcher, do you consider the use of hormone therapy to treat gender dysphoria to be experimental?

A. No.

Q. Do you consider it to be safe?

A. Yes.

Q. Do you consider it to be effective?

A. Yes.
Q. As a clinician and researcher, do you consider surgical treatment for gender dysphoria to be experimental?
A. In general, yes -- no, it is not experimental.
Q. Sorry. Just to clarify, do you consider surgical treatment for gender dysphoria to be experimental?
A. No.
Q. Is it safe?
A. Yes.
Q. Is it effective?
A. Yes.
Q. Just one concluding question, Dr. Olson-Kennedy.

We have talked a lot about research and statistics surrounding treatment -- medical treatment for gender dysphoria during your testimony and this trial.

As a healthcare provider, as a clinician, can you tell us a bit about why this care is so important for the patients that you care for?
A. So for the past 17 years, I have been doing gender care, and what I can tell you is that it is life changing for people. It is life changing for people to be able to live authentically, not just internally, but externally. Walk in the world and be perceived as their gender accurately is a lifesaving intervention. It is absolutely, without a doubt, one of the most profound interventions. This is one of the reasons that I

have devoted my career to it.

Q. Thank you, Dr. Olson-Kennedy.

MR. GONZALEZ-PAGAN: No more questions, Your Honor.

THE COURT: That makes this the time for the morning break.

Let's take 15 minutes. We'll start back at 10:55 by that clock.

Doctor, if you'd be back on that stand in 15 minutes.

Thank you.

(Recess taken at 10:41 AM.)

(Resumed at 10:55 AM.)

THE COURT: Please be seated.

Dr. Olson-Kennedy, you are still under oath.

Mr. Jazil, you may proceed.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good morning, Doctor.

As I understood your testimony, you devote your practice to working with transgender individuals; right?

A. That's correct.

Q. You work with patients who have gender dysphoria as well?

A. The majority of people that I see in adolescence and young adulthood have gender dysphoria.

Q. And you testified that you write about treatments for gender dysphoria as well?

A. Yes.
Q. You are a member of WPATH, right?
A. I am.
Q. And you've been a member since 2020?
A. That's correct.
Q. So, Doctor, to your knowledge what is the age of the youngest person that you know who has received puberty blockers?
A. 8.
Q. Okay. And, Doctor, to your knowledge, what is the age of the youngest person who received cross-sex hormones?
A. Can I just clarify? Because puberty blockers are used for another indication in children who are younger than that.
Q. I'll ask you another question.
A. Okay.
Q. Maybe a more specific one.
To your knowledge, what is the age of the youngest person diagnosed with gender dysphoria who received puberty blockers?
A. 8.
Q. What is the age of the youngest person diagnosed with gender dysphoria who received cross-sex hormones?
A. That I know, 12.
Q. And what is the age of the youngest person who has been diagnosed with gender dysphoria who received some kind of surgical intervention for that diagnosis?
A. I think there have been one or two people that had chest

surgery at 13.

Q. Now, Doctor, you talked about psychotherapy alone not being enough to treat gender dysphoria.

Do you recall that testimony?

A. Yes.

Q. You also testified that prepubertal children do not get medical interventions, which I understood to mean cross-sex hormones, puberty blockers, or surgeries?

A. That's correct.

Q. Do you recall that?

So is it your testimony that psychotherapy alone for prepubertal children does not help with their gender dysphoria?

A. I think that therapy is helpful for people in a lot of ways. Does it change their gender dysphoria? Does it change their gender? No.

Q. Can we agree that for prepubertal children psychotherapy alone can be helpful to help with their gender dysphoria?

A. Sure.

Q. Doctor, you also talked about the 1 to 2 percent detransition rate for adolescents.

Do you recall that testimony?

A. Not specific to adolescents.

Q. So who was it related to, the 1 to 2 percent?

A. It depends on what study we are talking about.

So in the studies that have been done of transgender people

or people with gender dysphoria as a whole.
Q. Okay. And these studies look at someone from their initial diagnosis, regardless of whether or not they were prepubertal to adulthood?
A. It depends on which study you are talking about. There are not, that I know of, lifetime studies of people over the entire course of their life.
Q. Okay. So the 1 to 2 percent number that you discussed with my friend, that was related to the entire transgender population as a whole?
A. No. That comes from studies. There is no study that studies every single trans person or person that's undergone interventions.
Q. Okay. Then as a follow-up question to my friend when you threw out the 1 to 2 percent number, I think you said -- and correct me if I'm wrong -- that there is limited data to support that 1 to 2 percent detransition rate that you discussed?
A. In the context of -- you can't do a study that looks at every single person. But I also think it's relevant to say that those studies are at one point in time. So there are people who move in and out of transition, and that's not characterized either.
So clinically the people who may stop interventions and then go back on them I've had a handful of people like that in my practice, who stopped interventions. I'll give you one

example. So I had a young person who went on blockers his parent died, and he got put into foster care with somebody who held very specific ideas about gender and had to stop his process. And then when he was able to get into care, taken with somebody who did not share those views, came back for care. And so that person moved in and out of gender-affirming medical care.

And so it's -- when we characterize people in one way, we don't take account of the movement that they might experience throughout their lifetime.

Q. Understood.

Doctor, I'd like to switch gears for a moment and talk about cross-sex hormones.

You testified that you are familiar with the literature concerning cross-sex hormones?

A. That's correct.

Q. And based on the literature, the percentage of adolescents put on puberty blockers that then go on to receive cross-sex hormones is as high as 98 percent; right?

A. Yes.

Q. And you also prescribe cross-sex hormones to adolescents in your practice for gender dysphoria; right?

A. I do.

Q. Before prescribing those cross-sex hormones, you discuss with your patients the risks associated with the medication;

right?
A. Yes.
Q. As you're discussing the risks, it's my understanding of your testimony -- and tell me if I'm wrong -- that you follow the WPATH Standards of Care as part of that discussion; right?
A. Yes.
Q. Doctor, I'd like to point you to the chapter in the WPATH Standards of Care that deal with hormone therapy.
MR. JAZIL: Your Honor, may I approach?
THE COURT: You may.
MR. JAZIL: This is Defendants' Exhibit 16.
BY MR. JAZIL:
Q. Doctor, I'd like to point you to Chapter XII, which begins on page 112 on the Bates numbering on the bottom right.
This is the chapter on hormone therapy in WPATH Version 8; right, Doctor?
A. Yes.
Q. Doctor, I'd like to move us to page 114, bottom right.
If we look at the first paragraph on the left, there is a sentence there that says: *TGD individuals treated with testosterone may also have increased adverse cardiovascular risks and events, such as increased myocardial infarction, blood pressure, decreased HDL-cholesterol, and excess weight.*
Do you see that, Doctor?
A. I don't see it exactly, but I know what you are talking

about.

Thank you. That's super helpful.

Thank you.

Q. Doctor, you discuss these risks with your patients before you prescribe the cross-sex hormones?

A. I do.

Q. Doctor, let's go to page 120 of this document.

The first sentence under Statement 12.12, if we go down some. It says: *Pubertal suppression and hormone treatment with sex steroid hormones may have potential adverse effects on a person's future fertility.*

You discuss fertility issues with your patients, Doctor?

A. I do.

Q. If we go to the column on the right, there is a sentence that begins: *Nonetheless, there are major gaps in knowledge, and findings regarding the fertility of trans feminine people who take estrogen and antiandrogens are inconsistent.*

Do you see that, Doctor?

A. I do.

Q. Do you tell your patients about these major gaps when you discuss cross-sex hormones with them?

A. Yes.

Q. Doctor, if we look down to the next paragraph, second sentence: *There are also major gaps in knowledge regarding the potential effects of testosterone on oocytes and subsequent*

fertility of TGD patients.

Am I correct that you also discuss these issues your patients?

A. Yes.

Q. And just so the record is clear, oocytes are cells in the ovary?

A. That's correct.

MR. JAZIL: Can we go onto the next page?

BY MR. JAZIL:

Q. The first full paragraph, it says: *Treating a TGD adolescent with functioning testes in the early stages of puberty with a GnRHa not only pauses maturation of germ cells but will also maintain the penis in a prepubertal size. This will likely impact surgical considerations if that person eventually undergoes a penile-inversion vaginoplasty as there will be less penile tissue to work with. In these cases, there is an increased likelihood a vaginoplasty will require a more complex surgical procedure, e.g., intestinal vaginoplasty.*

Doctor, do you discuss these issues with your transgender patients who you think might progress to surgical intervention as well?

A. Absolutely.

Q. Doctor, I'd like to discuss some of the studies that my friend talked to you about.

First was Littman article. Do you recall that?

A. Yes, basically. I don't have intimate knowledge of all of it.

Q. Understood, Doctor.

Doctor, in your expert report, you criticize Littman article by saying that parental reports are not necessarily a reliable basis for understanding a particular youth's experience with their gender, let alone whether Littman youth has gender dysphoria.

Do you recall writing that?

A. That sounds like something I would write.

Q. I just want to understand what you are saying there. Are you saying that parental reports would not serve as a basis to exclude a diagnosis of gender dysphoria under Littman *DSM-5*?

A. Yes.

Q. Doctor, you also discussed with my friend your paper on chest dysphoria. You talked to him about how you developed a scale for measuring chest dysphoria.

Do you recall that?

A. Yes.

Q. And Littman participants for Littman study where you used to develop Littman scale were from your practice? Did I understand that right?

A. Yes.

Q. Do you recall the sample size of the study that you undertook?

A. I think that I had 67 young people who had undergone surgery and 67 people who had not.
Q. Okay. And then the participants in the study, they were asked to help generate the questions used to come up with the scale; right?
A. Not per se in that way. I developed the scale from things that I had heard all of my patients talking about over the time I'd been doing the work.
Q. So the participants had input in the questions that were used to develop a scale.
Is that a more accurate way to put it?
A. Indirectly through my time providing services for them.
Q. And the scale, at its core, measures happiness with surgical treatment that they've undergone; right?
A. The scale in and of itself measures the experiences of having a female chest contour while identifying as something other than female.
Q. So satisfaction with the surgery, is that --
A. No. So the items on the scale include things like, I often avoid taking baths or showers because of my chest. I feel like my life hasn't started because of my chest. I feel like -- it's items like that that are related to having a female chest contour that are impairing people's capacity to do everyday, average things.
Q. Got it.

Doctor, I'd like to move on to the deVries study.

MR. JAZIL: Plaintiffs' Exhibit 141, please.

BY MR. JAZIL:

Q. This is one of the studies that you talked to my friend about.

Isn't that right, Doctor?

A. Yes.

MR. JAZIL: I'd like to go to Table 1 in the study, which is on Bates page 6596.

BY MR. JAZIL:

Q. Doctor, am I correct that there were 70 participants in the study?

A. That's correct.

MR. JAZIL: If we could go to Bates page 6600, the last paragraph before "Conclusions" on the left side.

Q. It says that: *Finally, this study was a longitudinal observational descriptive cohort study.*

Do you see that, Doctor?

A. I do.

MR. JAZIL: We can take that down.

BY MR. JAZIL:

Q. Doctor, I'd like to compare the longitudinal observational cohort study to the van der Miesen study that you discussed with my friend.

As I understood your testimony about the van der Miesen

study, there were 250 participants in that study; right?
A. I can't remember the exact numbers. If we could look at it, that would be helpful, and I could describe the cohorts more completely.
Q. Can you approximate for me? Was it more than 70?
A. Yes.
Q. And when you were discussing that study with my friend, you talked about how there was a natural cohort built into the study; right?
A. To the best of their ability, they had a cohort that was -- that was coming in for intervention, so baseline.
Q. So the study was comparing, as I understood it -- and you tell me if I'm wrong -- people who had not started on puberty blockers yet with people who had started on puberty blockers; right?
A. That's correct.
Q. So the natural cohort was analogous to a control group in that instance; right?
A. It's not analogous to a control group in the sense that there had been a process of intervention that happened for the group that we're defining as being on blockers.
So what they're trying to do is, as close as possible, create an untreated control group. It's not identical because in an untreated control group in a randomized controlled trial, you have people starting at the same point, and some of them are

treated and some of them are not. They're randomized into those interventions.

But for reasons that we've talked about previously in this court hearing, that -- it is not ethical to assign people to an untreated control group when we know that treatments exist that are beneficial to people. So, in this case, they're trying to present as close as possible to an untreated control group.

Q. And so, Doctor, am I correct that the authors' attempt, as close as possible, to come up with an untreated control group improves the quality of the study if we were using the GRADE methodology to grade it. Right?

A. Maybe.

Q. Doctor, can we go to Plaintiffs' Exhibit 164, please? It will pop up on your screen.

And, Doctor, is this the January 2023 *New England Journal of Medicine* article that you were discussing with my friend?

A. Yes.

Q. And, Doctor, in the "Background" section of this article, it says that: *Limited prospective outcome data exist regarding transgender and nonbinary youth receiving gender-affirming hormones.*

Is that correct?

A. That is correct.

Q. If we go on to the next page, the second paragraph, last sentence, it says that: *Evidence has been lacking from*

longitudinal studies that explore potential mechanisms by which gender-affirming medical care affects gender dysphoria and subsequent well-being.

And that's right, Doctor?

A. Yes.

MR. JAZIL: If we can go to page 247 of this study -- it's Bates stamp label 6567 -- last paragraph on the right.

BY MR. JAZIL:

Q. Doctor, here the paper discusses certain limitations and it says that: *Because participants were recruited from four urban pediatric gender centers, the findings may not be generalizable to youth without access to comprehensive interdisciplinary services or to transgender and nonbinary youth who are self-medicating with GAH.*

You'd agree that that was a limitation to the study?

A. Yes.

Q. And, Doctor, I'd like to piggyback on that point.

Is -- I understand from your resume you've worked at clinical centers at universities for most of your career; right?

A. That's correct.

Q. And you yourself have never worked in a rural setting providing medical care to transgender youth; right?

A. That's correct.

Q. If we can go back to the paper, the next sentence says: *In addition, despite improvement across psychosocial outcomes on*

average, there was substantial variability around the mean trajectory of change. Some participants continued to report high levels of depression and anxiety and low positive affect and life satisfaction, despite the use of GAH.

And that was one of the conclusions from the study, Doctor?

A. That's correct.

Q. Doctor, you were a co-author of this study?

A. I'm the senior author on this study.

Q. You're the senior author on this study. Thank you.

Doctor, I'd like to go to Plaintiffs' Exhibit 176.

Doctor, is this the Dr. Green article that you mentioned in your discussions with my friend earlier?

A. Yes.

Q. Now, Doctor, I'd like to point you to the first sentence under "Purpose" right there. It says that*: There are no large-scale studies examining mental health among transgender and nonbinary youth who receive gender-affirming hormone therapy.*

Is that your understanding as well?

A. In this case, what this -- I believe what this author is talking about is the fact that because gender-affirming hormone care is relatively rare in the United States, that large-scale studies such as the one that this author performed -- she's talking about having a broader catchment area because -- we talked about people on blockers, there only being about 5,000

people. Youth on gender-affirming hormones is limited to just under 15,000 people in the United States. So doing large-scale studies is very difficult, if not impossible, except through mechanisms such as Amy Green is talking about in this study.

Q. Okay. Let's look at some of those mechanisms.

MR. JAZIL: If we can go to page 6677.

BY MR. JAZIL:

Q. Under "Methods," "Procedure," the second sentence there says: *Youth were recruited via targeted ads on Facebook, Instagram, and Snapchat.*

It goes on to say near the bottom of the paragraph: *Youth were able to select 'decline to answer' for any questions in the survey* and they -- *that they did not want to answer. Respondents were eligible to be entered into a drawing for one of 100 gift cards worth $50 each by providing their email addresses after being routed to a separate survey.*

That was the method by which the authors of this study recruited participants. Is that understanding correct, Doctor?

A. Yes, this was part of their recruitment strategy.

Q. Understood.

MR. JAZIL: If we could go to page 6681 of this document.

BY MR. JAZIL:

Q. Under "Limitations," second sentence, it says that: *First, causation cannot be inferred due to the study's crossectional*

design.

Do you see that, Doctor?

A. I do.

Q. Do you agree with the authors of the study that causation --

A. I think that's often a limitation in research.

Q. Understood.

Doctor, I have in my notes a quote from you from your direct. You said that: *We should change our approach based on further research.*

Do you recall saying something to that effect?

A. Yes.

Q. If further research urges caution in the use of puberty blockers or cross-sex hormones or gender-affirming surgery, do you think that we should follow that approach?

A. If research demonstrated, you mean, that it was not effective in the care of gender dysphoria? If there were compelling research, we should, yes.

Q. Understood.

MR. JAZIL: Thank you, Your Honor. No further questions.

THE COURT: Redirect.

MR. GONZALEZ-PAGAN: Just a couple of questions, Your Honor.

REDIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Olson-Kennedy, you were just asked a little bit about some of the risks associated with hormone therapy for the treatment of gender dysphoria that were outlined in the WPATH Standards of Care 8.

Do you recall that?

A. Yes.

Q. Are those risks specific -- specifically associated because hormones are being used to treat gender dysphoria, or are those risks just general risks associated with the use of hormone therapy regardless of the --

A. Those are general risks related to the use of those medications even outside of the world of gender-affirming care.

Q. And those are risks that are -- that you discuss with your patients?

A. Of course.

Q. Dr. Olson-Kennedy, you were asked about a statement contained within your report regarding the -- how informative or indicative the parent reports may be with regards to transgender adolescents' experiences.

Do you recall that testimony?

A. I do.

Q. Do you consider what a parent reports when you're diagnosing or assessing a patient?

A. Yes, of course.

I just want to -- I want to provide some clarity about this because I think it can be confusing. So parents, just like young people, go through a process of understanding what's happening with their kid. They don't start out knowing all of it.

Their young person goes through a process that I call coming in, figuring out what's going on with their gender. They tell their parents, and their parents start back here because they haven't had all the data. So the young person has engaged in a process that then comes to the point of disclosure, because you can't get any interventions if you're a minor unless you disclose to your parent or caregiver.

And then the parent starts at Step 1. And so there are stages where parents are, like, What do you mean? What are you talking about? This is new information. All the way up to, Oh, I completely understand what's going on with your gender. Let's move forward with you getting care.

There is a very long process that is often disregarded when we're talking about this care.

Q. And providing the care -- it is the parents or guardians who provide the consent; is that correct?

A. In the case of people who are under 18, yes.

Q. Dr. Olson-Kennedy, you were asked a couple of questions about the recruitment strategy utilized by the Green study.

Does the fact that participants were recruited to participate in the study invalidate its results?

A. Not at all. When you recruit for a large-scale study like that, you have to go where the youth are, and the youth are online. So that's where you get large-scale studies such as the one described by Green.

Q. And is online recruitment actually something that is used not just in this field, but throughout medicine?

A. Absolutely, yes.

Q. And is -- the use of rewards to participate in a study, is that something that is common in research?

A. Yes.

MR. GONZALEZ-PAGAN: Thank you.

THE COURT: Doctor, I want to make sure I understood some details about one of the things you said.

You had a number, I think, just under 5,000 of people on puberty blockers in the United States and just under 15,000 for people in hormone therapy in the United States.

Are those people on those treatments for gender dysphoria?

THE WITNESS: Yes.

THE COURT: And on -- for the puberty blockers, at one point in the discussion you said something about early adolescence or outset of adolescence, something like that.

THE WITNESS: Uh-huh.

THE COURT: But the number for puberty blockers, that's everybody on puberty blockers for gender dysphoria regardless of what age they started?

THE WITNESS: Yes.

THE COURT: Now, I want to understand a little better the progression.

I think I understand that, ideally, if the patient comes to you early enough, puberty blockers start right at the outset of puberty.

THE WITNESS: Yes.

THE COURT: How does it go from there to hormone therapy? What age or what part of the puberty cycle does that happen?

I guess the puberty blockers stop when the hormone therapy starts. I want to make sure I understand that correctly and then what the age of the stage of puberty is when those things happen.

THE WITNESS: So people start puberty blockers anywhere from Tanner Stage 2, which is the first stage -- Tanner Stage 1 is no puberty; Tanner Stage 2 is the beginning of puberty; and Tanner Stage 5 is considered adult development.

So there are people who are started on puberty blockers across 2 through 5 at any point in that process, because the use of puberty blockers is -- has multiple purposes. The first one is if somebody is 9, and they started puberty and

they have gender dysphoria, we're not going to put them on gender-affirming hormones, A, because they're 9 and because the cognitive capacity for people to understand an intervention that has permanent impact really isn't intact until about 12 -- 11 or 12.

So we have this intervention that allows people to push the pause button. They're not going through their puberty and developing secondary sex characteristics that they, then, are going to have to reverse, have surgery for, et cetera. So it gives people this pause until they are two things: Peer concordant in their puberty -- really, we don't want anyone going through puberty at 9. It's a really hard age to start your puberty process, but for kids with gender dysphoria, it gives them time to be more peer concordant and have cognitive development so that they can make better and informed decisions about permanent interventions. That's one thing.

The majority of people going on puberty blockers, though, are not 8, 9, and 10. The majority of people going on puberty blockers in Tanner Stage 2 is 11 -- about 11 on average, at least in my practice.

But there are also people who are 12, 14, 15, 16, who are going on puberty blockers as well. And for those people who have already gone through puberty, what puberty blockers allowed them to do is, for example, stop having a period, like that would be a good reason for somebody to go on a puberty blocker.

There is other mechanisms to do that, but this is one of the strategies.

And so among those 5,000 people, it's not 5,000 9-year-olds, right. They are ranging from -- the earliest cases -- because the early end of puberty for people with ovaries is 8. If they start puberty before that, they are going on puberty blockers for a different reason, for precocious puberty. But if they're starting at 8 and they're going on puberty blockers for gender dysphoria, they are not going to go on to hormones at 8.

THE COURT: And so in just an average case, if somebody's 11 and they go on puberty blockers at that age, when are they likely, then, to move to hormone therapy?

THE WITNESS: So there is a whole host of factors that play a role in that decision-making. So it's certainly not one way for every person.

So if somebody goes on puberty blockers at 11, it's highly likely that they've experienced gender dysphoria in early childhood and continue to experience it. Put them on puberty blockers to halt their endogenous puberty and then try to match their peers with puberty, because there's pretty compelling data that demonstrates when you are late to puberty compared to your peers, it's -- causes psychosocial issues.

So maybe somebody goes on puberty blockers at 11, let's say, and then two years later, we will add hormones. That

was another thing. We generally add hormones to puberty blockers because we don't want someone to go from no puberty to a lot of puberty. We want to mimic what their body would go through like their peers. And so they need to have puberty blockers on board, because we're not going to give somebody a whole bunch of hormones right away, right. We want to escalate them in a way that their peers would be.

THE COURT: So somebody starts puberty blockers at 11. Then maybe 13 you start -- that they're still on puberty blockers, but you start hormones -- cross-sex hormones?

THE WITNESS: Yes.

THE COURT: And then gradually stop the puberty blockers and increase the hormones until they are all the way through puberty?

THE WITNESS: Yes.

THE COURT: You've had people -- a couple of instances of chest surgery for trans boys at 13.

THE WITNESS: Uh-huh.

THE COURT: What's the average age -- assuming that you've got a patient who wishes to get the aggressive treatment, who has signed onto this, getting parental support, everything is going in favor of the treatment, what would be the average age for a person like that to get chest surgery?

THE WITNESS: Probably 16 or 17. It's very rare that people get surgery under that age.

THE COURT: All right. Questions just to follow up on mine?

MR. GONZALEZ-PAGAN: Just one brief question, Your Honor, if I may.

FURTHER EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Olson-Kennedy, you spoke a little bit about having a puberty that matched your peers.

And within the gender-affirming care model, is the plan or the process to begin the provision of hormones to stop the use of puberty blockers, if necessary, so that it occurs within the normal window of puberty for an adolescent?

A. It's probably important to clarify that the window for puberty in people with ovaries is between 8 and 14, and for people with testes it's between 9 and 14ish. You know, it's slightly later.

Q. So on average it would be mean that most folks would be starting hormones sometime at least before 14 so that they -- folks that have been on puberty blockers sometime before 14 so that they start puberty with exogenous hormones within the normal time window?

A. Yes. But I really want to draw attention to the fact that it is extraordinarily rare that somebody is presenting for gender care in early puberty that's then going to go on to hormones. That's going to be a person who has a long-standing

history of gender dysphoria.

But that is not the majority -- the majority of patients in my clinic that are accessing services are 16. So most people don't have the incredible opportunity to have their endogenous puberty blocked. That's why I feel very strongly about this intervention, because it is critical for people to, if they can, avoid those secondary sex characteristics that are incongruent with their gender. It's a total game changer in the clinical world.

Q. And, Dr. Olson-Kennedy, you were asked a little bit about the instances in which somebody has presented and necessitated chest surgery, a trans male adolescent, as early as -- on rare instances as early as 13.

Those are instances in which the individual has gone through their endogenous puberty and, therefore, has a good amount of dysphoria because of advanced chest development; is that correct?

A. That's correct. People don't get chest surgery if they don't have chest development. That's the incredible benefit of not ever getting that particular change.

But the -- just for clarity, the two 13-year-olds that were in my study were actually not my personal patients. I've actually never had any of my patients have chest surgery, I think, maybe even younger than 15, possibly 14. But the -- there are many people with ovaries that are done with their

puberty at 12 years old.

So we talk about these as chronologic ages, but when we think about the developmental stages of puberty, it's not uncommon that people will have a lot of chest tissue by 12 or 13 years old.

MR. GONZALEZ-PAGAN: Thank you.

THE COURT: Mr. Jazil?

MR. JAZIL: No further questions, Your Honor.

THE COURT: Thank you, Doctor. You may step down.

(Dr. Olson-Kennedy exited the courtroom.)

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Yes, Your Honor. Ms. Coursolle will be calling the next witness, and it will be one of the plaintiffs.

It would be Ms. Jane Doe.

MS. COURSOLLE: Your Honor, we are calling -- the plaintiffs call Ms. Jane Doe to the stand, please.

(Ms. Doe entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing raise your right hand.

JANE DOE, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state the name that you will be using during this proceeding.

THE WITNESS: Jane Doe.

THE COURT: And for the public and for the record, there will be a filed reference sheet within the record that will be sealed that will match up the name Jane Doe to her actual name.

DIRECT EXAMINATION

BY MS. COURSOLLE:

Q. So, Ms. Doe, I think maybe we've made this clear, but you're participating in this lawsuit under a pseudonym; is that right?

A. Yes.

Q. Ms. Doe, where do you live?

A. Brevard County.

Q. And who lives with you?

A. My husband and two children.

Q. How old are your children?

A. My son is 16 and my daughter is 13.

Q. And your 13-year-old daughter, is she a plaintiff in this lawsuit?

A. She is.

Q. Is she also participating in this case under a pseudonym?

A. She is.

Q. And is that pseudonym Susan Doe?

A. Yes, Susan Doe.

Q. How did Susan come into your life?

A. I adopted Susan through foster care through the State of

Florida.
Q. How old was she when you adopted Susan?
A. 2.
Q. And what is a medical adoption, exactly?
A. She was under medical foster care. It's specialized. She had some health issues, and so she went to a foster care parent, so it's a little different.
Q. Is it -- in your experience is it difficult for Florida to find placements for children for medical foster care?
A. It is. It requires a little bit more care or -- I'm sorry.
Q. Take your time.
A. Just it takes a little bit more effort and can support -- these children need more support.
Q. Is Susan enrolled in Medicaid?
A. She is.
Q. Do you know why she's eligible for Medicaid?
A. All children adopted through foster care in Florida are eligible for Medicaid.
Q. Did your son also come into your life through adoption?
A. Yes, he did.
Q. And is he also eligible for Medicaid?
A. He is, yes.
Q. Tell me about Susan. How would you describe her?
A. She's funny and energetic and very friendly and outgoing.
Q. What does she like to do?

A. She likes to -- she loves to swim. She loves to hang out with her friends. She's learning to surf. And she likes -- you know, she loves being a Florida girl.

Q. What was Susan's birth-assigned sex?

A. She was male. She was assigned male at birth.

Q. Is Susan transgender?

A. She is. She's a transgender girl.

Q. What is her gender identity?

A. A girl. She's female.

Q. When did Susan first tell you that she identified as a girl?

A. The first time she told me, she was 3 years old. I was sitting on the couch. She was just playing with her toys beside me. And she just said -- she's like, Mommy, when I was born, I was born a girl. And I was a little taken aback because that's kind of surprising to hear from a 3-year-old. And I tried my best to stay neutral and just, you know, not say anything negative or positive, just to stay neutral and, Thank you, you know. Like, Okay, I hear you, and just left it at that at that time.

Q. What was she like when she was 3?

A. Well, she was -- she was a very cheerful child. She liked to play with typical -- what you would call typically girl toys. She liked dolls. She liked her princess dresses. She loved her -- she actually had, like, two or three dollhouses. That

was the things that she liked to play with.
Q. Did Susan tell anyone else that she was a girl?
A. At that time, no. It was just me.
Q. What kind of clothes did Susan like to wear when she was 3?
A. She preferred her princess dresses.
Q. At some point did Susan start to show signs of distress because her gender identity did not match her sex assigned at birth?
A. At 6 years old when she was in first grade is when she started having distress because the other children were -- she always played with stereotypically girl toys and girl behaviors and the other children noticing, and they were making fun of her.
Q. How did you -- what did you observe about her distress at that time?
A. She would just be upset when she got home. I mean, as soon as she would get home, she would change out of her school clothes and put on her girl clothes when she was home, and she would be much happier.
Q. It must have been hard to see that distress?
A. It was. I talked to her teachers. I tried to kind of restart -- when we realized this was not going away, we tried to get as much information as we could and tried to get the support from her educators also.
Q. Is there anything else that you did in response at this

time?
A. At that time we bought her clothes -- like, she would wear clothes to school that -- they would be from the girl's section, but they weren't necessarily overtly girl clothes. She would just know that they were girl clothes, and it would help her feel more confident or more secure in herself.
Q. Did you seek out a therapist at any point?
A. Yes, we did. I initially sought off -- sought out therapy for me to educate myself and then brought Susan into therapy.
Q. How old was Susan when she first saw a therapist?
A. I think she was 6.
Q. Did the therapist provide you with any materials to review?
A. Yes, she gave us information, tried to explain as much as she could of what is possible -- what is happening, how we should proceed as the parents to a transgender child.
Q. Did you do any of your own research about what Susan was experiencing?
A. I did. I initially did that before seeking therapy, but that -- it's hard to find, you know. Most things on the Internet are going to be biased. It's going to have a bias one way or another. I would rather seek guidance from a professional.
Q. Is there anything else you did to support Susan at this time?
A. Just -- let's see. When she was that age? Just let her

have clothes that she felt comfortable with, started -- she picked out her own name, and then she -- we -- I started calling her "she" and "her," using the pronouns that she preferred and using her preferred name at home, and it brought her a lot of joy.

Q. Had Susan told other family members that she identified as a girl at this time?

A. Slowly, yes, yeah. The close-knit family understood.

Q. Did you eventually take Susan to see another therapist?

A. Yes, yes.

Q. And when did that happen?

A. If we're talking, like, Rebecca or --

Q. Did you take Susan to see Dr. Linda Ouellette?

A. Yes, first it was Linda Ouellette, and then eventually -- she has another therapist at this point.

Q. Let's go back to Dr. Ouellette.

When did Susan first start seeing Dr. Ouellette?

A. When she was 6.

THE COURT: Ms. Doe, it will help us if you keep your voice up. If you will talk loudly enough that the people in the very back of the room can hear you, that will help.

THE WITNESS: Okay. Thank you. I'm sorry.

BY MS. COURSOLLE:

Q. You mentioned that Susan started using her preferred name.

About when did that happen?

A. She was around 6 years old when she started using her preferred name, and she was actually -- we realized she was telling people -- like, if she would meet them at the park, she was telling them on her own her preferred name. We didn't know that she was doing that. But it just was another sign of how important it was for her -- for people to perceive her as who she was.

Q. Was there a time when she started presenting herself as a girl outside of the home consistently?

A. Yes. Two weeks before second grade, she let me and her father know that she wanted to go to school and live her life as a girl, and she didn't want to hide it anymore. And we had to take back her school clothes and exchange them. And at that time we sent out letters -- you know, like a message -- emails to her educators to let them know that when she returned to school, she was -- this was her name, and this was -- she was going by she/her pronouns.

Q. That's a pretty big change. How did you feel about it?

A. I was scared. I mean, it was scary, but at the same time she had been very sad that whole summer thinking about and worrying about going back to school. And so I -- you know, she was happy, and she was very excited. So whatever my fear was, I knew I was doing the right thing, seeing the joy in her eyes and her being so excited about going back and being herself.

Q. Once Susan went back to school, did you notice any

differences in how she felt or behaved at home?
A. She was looking forward to going to school every day. She was very joyful going to school, putting on her clothes. She was very excited.
Q. Have you ever taken Susan to see a pediatric endocrinologist?
A. Yes.
Q. And when did you first take Susan to see an endocrinologist?
A. I believe she was around 8 or 9 years old.
Q. Why did you decide to do that?
A. It was under the suggestion of her therapist that we -- as she was getting closer -- she wasn't -- she was not in puberty yet, but to go and establish and meet with an endocrinologist and get a baseline -- medical baseline of her maturity and progression.
Q. And what happened during that first visit with the endocrinologist?
A. She just -- she just gave us education and gave us -- showed us, like -- explained more about the standards of care if we were to proceed and how we started -- how right now it was just monitoring and, you know, watching -- you know, watching and waiting and seeing how things were going to go, how she was going to grow up and proceed.
Q. Did the endocrinologist eventually prescribe medication for

Susan?
A. Eventually, yes.
Q. When did that happen?
A. It was around July in 2020. She -- my daughter was finally at a point in puberty where we were going to put a pause with the -- it was just for Lupron and putting a pause on her puberty at that time.
Q. You'll have to forgive me. My math isn't that great.
How old was Susan in July 2020?
A. I guess she was 10.
Q. And you said the medication that the endocrinologist put her on was called Lupron.
Do I have that right?
A. Yes. It was.
Q. Were there any criteria that Susan had to meet before the endocrinologist would prescribe her the Lupron?
A. Well, we received a letter. She had an evaluation from her therapist first. And then after that it had to be -- the doctor had been watching and monitoring her progression of puberty, so she had to reach a certain point in puberty and then we would pause it.
Q. What's your understanding of what the Lupron was described to treat?
A. It was just pausing her puberty, just keeping her hormones -- just blocking the hormones so that she would not go

into male puberty.
Q. Before prescribing Lupron, did the endocrinologist discuss the potential risks and benefits of the medication with you?
A. She did, yes.
Q. Do you and your husband make medical decisions for your children?
A. Yes, along with the help or support -- just the guidance of therapists and the actual medical doctors.
Q. Did you and your husband ultimately decide that Susan should begin taking the Lupron?
A. Yes. We believed it was very important to pause her puberty at 10.
Q. How did you reach that conclusion?
A. Well, she was -- she told us herself that she would be devastated if she went through boy puberty. She presents as a girl. It's been consistent since she was 3. It has not changed. That's a pretty long time. And for us it was a pause to, like, let's see if she proceeds to mature and go this path, and she has.
So for us, we -- it wasn't a question. It was just, we have to do what's best for her.
Q. Did the endocrinologist talk to you -- tell you about any potential side effects that the medication might have?
A. Lupron, it was -- the bone density is one of the things that we need to watch out for. And so we -- you know, we were

prescribed vitamin D and omega 3, and just watched her, her bone density levels. It was very important to watch that.

Q. How has Susan been doing since she's started taking Lupron?

A. She's been fine. She's been fine. She doesn't really care for shots, but she's fine with this. She looks forward to getting her Lupron shots, because she knows how important it is.

Q. You said she started in 2020. So she's been on Lupron for about three years now; is that right?

A. Yes, almost three years.

Q. If Medicaid were to stop covering Lupron, what would you do?

A. I don't know. But I would have to -- there's -- it's not a question for us; we are going to continue her care. Like I said, she said she would be devastated if she went through male puberty. And I don't want her -- that to happen for her.

Q. If Susan could no longer receive Lupron, how do you think that would affect her?

A. Well, she said that she would rather die than go through boy puberty, so I don't want that to happen.

Q. I'm sorry. That must be really hard to hear.

Has Susan's endocrinologist talked with you about starting Susan on hormone therapy?

A. Yes. At this point, with her bone growth, monitoring her bone growth and her maturity -- like her physical maturity, she is ready for gender-affirming hormones. It's what her

endocrinologist says. And she's met with her therapist, and her therapist says that she's ready, that she's informed her, and she feels that she's ready. And so we are just kind of in a holding pattern right now. We are just waiting to proceed.

Q. What is your understanding of what hormones will do for Susan?

A. It will -- it will help her have female puberty.

Right now it's on pause. And she would proceed with, like, breast growth and less hair and not develop male characteristics.

Q. Has Susan's endocrinologist discussed the risks and benefits of starting hormone therapy with you?

A. Yes.

Q. Have you and your husband decided that hormones would be the right course of action for Susan?

A. Yes.

Q. How did you reach that conclusion?

A. Well, she's been consistent. This whole time she hasn't wavered. And we know that she's living her life as a little girl, and she's seeing her friends progress. And she wants to live her life as -- you know, just go through puberty like her peers. And so for her it's just -- we believe it's the right time.

Q. How does Susan feel about potentially starting hormones?

A. She's excited, actually. She's really excited. In fact,

that's what keeps her going, is that she sees -- for her it's like this hope, this light at the end of the tunnel. And she's, like, Once I get there, it's like -- then she'll start being with her peers, like, breast growth, and I guess the other things.

Q. Does Susan know why you are here today, Ms. Doe?

A. She does.

Q. And how have you observed -- well, what does she know about why you are here today?

A. She knows that the -- well, she knows that the State was putting -- like, wanting to stop her treatment. And she knows that we are coming here to try and preserve her right to have that treatment. Two years ago this wasn't a question. We had a path we were set on, and this just came out of nowhere for us, just -- you know, we knew that the science was there, the -- you know, the data was there. We -- you know. And we just thought they are the standards of care; we were following the standards of care and everything would be fine. This has just kind of put a wrench and a lot of added stress on our life that is unnecessary, actually.

Q. I just want to clarify something that I think has been implicit in your conversations. But has Susan been officially diagnosed with gender dysphoria?

A. Yes.

Q. So the Lupron that she receives and the hormone therapy

that she would potentially receive in the future are both being prescribed to treat her gender dysphoria; is that right?

A. Yes, exactly. Yes.

Q. So based on what she just said, that Susan knows about why you are here today and this lawsuit, how does she feel about all that?

A. She's -- she's stressed because of the fact of even having to go through this. And she worries -- she worries, you know, that -- it's just she worries about not being able to access that help, that medical care. And I just -- for me, I just try to shield her from that as much as possible, the stress, so that she keeps being a happy, thriving young child, as long as I can.

Q. Where is Susan today?

A. She's at home. She's back at home with my husband.

She was too afraid to come. She saw a lot of things on the Internet, and things that were happening in the state capital, and so she did not want to come here.

Q. Is Susan entitled to Medicaid coverage?

A. She is.

Q. And I know you mentioned earlier that her brother was also adopted out of medical foster care. Is he also enrolled in Medicaid?

A. Yes. Both of my children are medical adoptions, and they are both eligible for Medicaid.

Q. And putting aside the question of the care that Susan needs

for her gender dysphoria, have both of your children been able to get their health care coverage -- the health care they need covered through Medicaid?

A. Yes. It's been continuous care this whole time.

My son is autistic, and he hasn't had any hiccups with any of his therapies. And he's had extensive therapists with ADA therapy, and it hasn't been an issue.

Q. How do you feel that Medicaid is refusing coverage for Susan's care just because she's transgender?

A. It hurts. It feels a bit discriminated against my child, because there's other -- I believe the doctor had talked about it, it's like all the therapies that she's getting, those same therapies are going to other children, it's just the diagnosis is different. Those same medicines are safe for other children. It's just because she's transgender, it's that diagnosis, for some reason she's not allowed to access the same medications.

Q. Ms. Doe, what do you want to get out of this lawsuit?

A. Just to continue her care, to get the care that she needs and she has a right to.

Q. Thank you.

MS. COURSOLLE: I have no further questions, Your Honor.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good morning.

A. Good morning.

Q. I have a few questions about Susan, and I want to get to know her medical records a little bit better.

Ms. Doe, it's my understanding -- and please correct me if I'm wrong -- that Linda Ouellette diagnosed Susan with gender dysphoria when Susan was 6.

Does that sound right?

A. I believe so, yes.

Q. And it's also my understanding that Linda Ouellette isn't a psychiatrist?

A. She's not. It was very hard to find -- during those years back then it was very hard to find a child psychologist of any kind, of any therapist that had any experience with transgender children, in my area anyway.

Q. Understood.

And you adopted Susan from foster care; right?

A. Yes.

Q. And Susan's birth mother had a history of drug abuse during her pregnancy with Susan; right?

A. Yes.

Q. There is also a history of neglect with Susan before you adopted her?

A. Yes.
Q. Ma'am, when you saw your therapist for the first time, she also said Susan had anxiety; right?
A. When she was 6, I'm not sure. But I do know that she was stressed because of the friends. Like I said, she -- like, you know, with the friends, like she was being herself and she was getting negative feedback from peers.
Q. Was she at some point diagnosed with anxiety?
A. I'm sorry?
Q. Was she at some point diagnosed with anxiety?
A. Yes. But that actually -- more the anxiety came when she was in fourth grade.
Q. Okay. So this is after the gender dysphoria diagnosis?
A. Years after.
Q. And do you know when she was diagnosed with ADHD?
A. She was 6 or 7.
Q. And I see a depression diagnosis in her medical records. Do you recall when that diagnosis was made?
A. It was -- it was about two years ago. She was sad. That that was around the time when she started -- her friends were progressing and -- physically progressing and going through puberty. And she felt like she was being left behind. She wanted to go through the female puberty like her friends.
Q. I understand.
Ma'am, you mentioned discussing with your endocrinologist

bone density issues. Do you recall that testimony?
A. Yes.
Q. Did you also discuss fertility issues with your endocrinologist?
A. Yes.
Q. And did the endocrinologist walk you through the possible permanent effects of cross-sex hormones on Susan's fertility?
A. Yes.
MR. JAZIL: No further questions, Your Honor.
THE COURT: Redirect?
MS. COURSOLLE: No, Your Honor.
THE COURT: Susan is 13; your son is 16?
THE WITNESS: Yes.
THE COURT: How old was he when you adopted him?
THE WITNESS: He was around 2 -- they were about -- he was around 2 also. He was around the same age.
THE COURT: When you adopted him did you know he was on the spectrum?
THE WITNESS: No. He didn't get diagnosed until he was 7.
THE COURT: But he had some kind of medical issue?
THE WITNESS: He had a lot of medical, yes.
THE COURT: You don't have other children?
THE WITNESS: These are the two.
THE COURT: Questions just to follow up on that?

MR. JAZIL: No, Your Honor.

MS. COURSOLLE: No, Your Honor.

THE COURT: Thank you, Ms. Doe. You may step down and return to counsel table.

It's noon. We can break, but probably put on another witness or two -- if the other witnesses are not going to take longer than this, we can break later -- if we can get another 45 minutes in, it would be great.

MR. GONZALEZ-PAGAN: Your Honor, we do have the three other plaintiffs that are ready to testify.

THE COURT: Yep.

MR. GONZALEZ-PAGAN: But I think if we can do that break, that may be best now, and we'll put them on in the afternoon.

THE COURT: You don't want to put one on first?

MR. GONZALEZ-PAGAN: We would prefer to take the lunch break, if it's alright with the Court.

THE COURT: All right. Let's do that. It's a couple of minutes after noon. Let's start back at 1:05 by that clock.

Some change? Did you decide you have somebody you want to put on?

MR. GONZALEZ-PAGAN: Your Honor, if it's alright with the Court, actually my counsel has indicated we would prefer to proceed with the second witness now.

THE COURT: Good.

MR. GONZALEZ-PAGAN: I apologize.

THE COURT: Let's go ahead.

Who is the next witness?

MS. CHRISS: Your Honor, Brit Rothstein --

(Brit Rothstein entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

BRIT ROTHSTEIN, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: Brit Rothstein. Last name is spelled R-o-t-h-s-t-i-e-n.

DIRECT EXAMINATION

BY MS. CHRISS:

Q. All right. Hello, Mr. Rothstein.

How old are you?

A. I am 20.

Q. Where do you live?

A. I mostly live in Orlando when I'm in school, and then I come down to South Florida during breaks.

Q. And who do you live with?

A. I am living with my boyfriend and his family right now. He's actually here with me. Then I'm starting a lease soon with him as well in Orlando.

Q. Where do you go to school?
A. In Orlando. I go to University of Central Florida.
Q. What are you studying?
A. I'm studying digital media and I'm minoring in information technology.
Q. Very nice.
What do you want to do with your degree?
A. I'm still kind of trying to figure that out. But I'm interested in, like, IT work.
Q. Okay. Did you get any financial assistance to attend college?
A. Yes. I'm on a variety of, like, scholarships and grants.
Q. So, Mr. Rothstein, tell us a little bit about yourself, your interests, et cetera.
A. I'd say I'm a pretty creative person. I like a lot of, like, artsy crafts and stuff. I like painting and drawing. I have my own Etsy shop where I, like, make handmade, like, earrings and key chains and I sell them.
Q. Where did you grow up?
A. Kind of all over South Florida, but mostly just like in Broward County.
Q. Are you employed?
A. Yes. I'm in the federal work study program. I work at the IT department at my school.
Q. Okay.

Are you enrolled in Florida's Medicaid program?
A. Yes.
Q. Prior to the rule at issue that we are here about today, did Florida Medicaid cover all of your medically necessary health care?
A. Yes.
Q. What is your gender identity?
A. Male.
Q. And what was the sex assigned to you at birth?
A. Female.
Q. When did you come to understand that you were male?
A. It's kind of hard to, like, pinpoint it exactly. But, like, ever since, like, I was about 8, I had, like, kind of -- I don't know how to, like -- the word for it. Identity issues, kind of. Not a great word, but I'm trying.
But I was able to sort it out more and put words to feelings in about sixth grade or when I was about 12.
Q. How did you come to understand that you were male?
A. I -- well, I was experiencing a lot of -- what I've learned was gender dysphoria, but I didn't know the word for it at the time, of uncomfortableness or, like -- I'm sorry. I don't know the right word for it. About gender roles that were imposed on me.
And I -- in sixth grade I was starting a female puberty, so I was starting to get chest growth and I was starting my period,

and I had a lot of discomfort and anguish surrounding it.

And so I was starting to do, like, research on my own, like online. And I came across, like, medical journals and, like, blogs of, like, transgender people or about -- like, the medical journals were about transgender issues or just being transgender. And it helped me put words to what I was feeling. And it was a long process. Like, it took me months to even, like, accept that I was trans. And then, yeah.

Q. About how old would you say you were or about when was it that you sort of were able to put words to it and understand, you know, sort of what transgender meant?

A. I think I, like, really, like, was able to, like, come to terms with it and kind of, like, call it what it was. I was a male, like, definitively, about, like, seventh grade, or when I was 13.

Q. So when you -- you mentioned the distress of having to experience puberty.

Can you explain a little bit more about how it felt to go through the changes to your body that accompanied puberty?

A. It was a lot of anxiety and depression, and my social anxiety was very bad because I felt wrong, and I felt like my peers could see -- could tell that or, like, the other people around me could tell that something was wrong with me.

I also would be -- it also -- like, the anxiety would be so bad that I would get physically ill. Like, in sixth grade, I

was in -- I went to PE class in that part, and I was in the -- I was assigned to the girls locker room, and I would get physically ill just being in there because it was just such an overwhelming feeling of: I do not belong here. I am not supposed to be here.

Q. Thank you for sharing that.

When did you officially sort of come out as transgender in that you shared with other people that you identified as male?

A. Also in seventh grade, around 13. I came out to friends first, and then I eventually came out to family.

Q. How did folks respond and react when you told them?

A. My friends were very supportive of me. They were -- like, they were happy that I was happier, kind of like figuring myself out, and my dad and sister both supported me. My mom was not supportive.

Q. Okay. I'm sorry to hear that.

Did you take any step at that point, when you initially came out, any steps related to your gender identity to try to live in congruence with it in any way?

A. Yes. After I came out to my dad, he took me to get my hair cut shorter into a more masculine haircut with shaved sides and all that, and I started wearing a chest binder, which is just a -- like compression top that, like, gives the appearance of a flat chest, and I was also wearing baggier clothes, kind of more masculine clothes.

Q. Why did you wear what you referred to as a binder?
A. Because I was going through female puberty and some of it came with chest development, and I felt a lot of distress with it because it wasn't how I felt on the inside. It didn't feel like I was supposed to be having it.
Q. At this time did you use a different name or pronouns?
A. Yes, I started going by Brit and using "he" in pronouns, and it felt a lot better being referred to in masculine terms. Like, it -- I don't know how to describe it. It just -- being referred to as a girl and then starting to be referred to as a guy, sort of all that, it felt good.
Q. Did you at any point legally change your name and gender marker to align with your gender identity?
A. Yes, I did so a couple years ago. I can't remember, like, the exact thing. But, yeah, I updated my gender marker and name.
Q. So those steps that you took that you were describing for the Court about, you know, cutting your hair, wearing baggier clothes, things of that nature, would you describe that as social transition?
A. Yes.
Q. And so after socially transitioning and beginning to live in accordance with your male gender identity, were you still experiencing the dysphoria that you discussed earlier?
A. Yes, very much so. And I would even say it was, like, a

bit worse or it was different than the dysphoria I was feeling before, because while I was taking, like, steps to try to improve it and try to live more as how I felt. I was still dealing with things like bullying from my peers because I wasn't fully passing, and also dealing with -- I still had -- I was still going through female puberty. I was still getting my period. My chest was still growing. So nothing was physically changing, and I still felt physically wrong.

Q. So we're going to talk a little bit about the medical treatment that you've received.

Have you ever sought mental health treatment for your gender dysphoria?

A. Yes. In sixth and seventh grade when I was starting to, like, put words to feelings, I was already seeing a therapist. It was Dr. Lappin. She was a family counselor for the school board, and I was seeing her for family-related issues. But I was seeing her, like, one-on-one, and then I brought it up with her.

Q. You were seeing Dr. Lappin for issues unrelated to gender identity, and then you began discussing how you were feeling with her?

A. Yes.

Q. Was she able to help you address your gender dysphoria in any way?

A. She was. She helped me kind of figure out some, like,

coping mechanisms, which I think fall under, like, social transition, because it was things of just, like, dressing more, like, aligned with my gender, so more masculine clothes, being referred to as male pronouns, things like that. But she also recommended that I try to look for a therapist who was more specialized with, like, transgender issues, because she's just a family counselor.

Q. Did you find someone who had more of that specialization in issues related to gender?

A. Yes. My dad went looking for one, and so he was able to find Dr. Grayson, and I think I started seeing her in, like, 2016, I believe --

Q. Okay.

A. -- before high school started.

Q. How long did you see Dr. Grayson just in total?

A. Throughout high school up until I left for college, so 2020.

Q. And do you know, by chance, what Dr. Grayson's qualifications are?

A. I don't remember the, like, exact, like, name of her, like, title or, like, degrees, but she has a lot of experience with transgender issues and, like, sex and gender-related things.

Q. Did Dr. Grayson diagnose you officially with gender dysphoria?

A. Yes.

Q. Did you have any other mental health diagnoses at that time when you were diagnosed with gender dysphoria?
A. Yes, I was previously diagnosed with anxiety and depression.
Q. And were you receiving treatment for those diagnoses?
A. Yes.
Q. Did either of those diagnoses impact your ability to understand your gender dysphoria?
A. No.
Q. Did they impact your ability to consent to treatment for gender dysphoria?
A. No.
Q. Did Dr. Grayson recommend that you see any other type of medical provider?
A. I spoke with her a lot about my dysphoria and my dysphoria related to my physical attributes and having to go through female puberty. So she recommended I speak to an endocrinologist about this and possible, like, further treatments about that.
Q. Do you recall approximately how old you were at that point?
A. I believe I was 15 -- or 14 or 15 --
Q. Okay.
A. -- I believe.
Q. Did you end up seeing a pediatric endocrinologist?
A. Yes. She gave me a recommendation for Dr. Hart-Unger, who

is an endocrinologist at Joe DiMaggio Children's Hospital, and so I went to see her, like, at -- by, I think, like, around the end of 2016. And I spoke to her, and I brought a letter written by Dr. Grayson that recommended -- that recommended I talk to her and that my issues -- like, yeah.

And we discussed HRT, hormone replace therapy, and, like, the options with it and talked about, like, my dysphoria and how it can help alleviate it and risks of it and, like, how we would -- like, how, like, the process of it would go, because she wanted me to do puberty blockers first and then, like, ease onto testosterone.

Q. Okay. We'll come back to the reason for that in a moment.

But were you able to be treated and receive a prescription for any treatment when you were, I believe, 14 when you saw Dr. Hart-Unger?

A. No, I wasn't able to because I -- I'm sorry. To give a little background, I was living full-time with my dad, but my mom still had custody over me. She just wasn't really in the picture because custody battles are a lot.

But to go forward with any sort of HRT or hormone blockers, I needed both parents' consent, and my mom didn't give her consent. So my parents had to go through a custody battle for two years, and the judge -- the final ruling, the judge decided -- granted my dad full custody over -- or, like, decision-making over medical transition-related things. I don't

remember the exact wording, but -- yeah, because it was in the best interest for me.

Q. Okay. So the Court granted your dad medical decision-making so that you could begin treatment --

A. Yes.

Q. -- because he thought that was in your best interest?

A. (Nods head up and down.)

Q. You said that took about two years?

A. Yes.

Q. So when were you finally able to actually get prescribed treatment from Dr. Hart-Unger?

A. I believe I was 16, like, about to turn 17, and she prescribed puberty blockers first.

Q. Okay. We'll come back to that in a moment.

But can you just, for the Court's benefit, explain what that process was like between, you know, about 14, being recommended and having the letter that you were ready to start treatment and talking to Dr. Hart-Unger about the treatment, and then having to wait those years before actually being prescribed any treatment for your gender dysphoria? What was that like?

A. It was very hard and frustrating to have to just wait on, like, everyone else deciding things. And I still was going through puberty; I still was getting my period; my chest was still growing; I was still dealing with bullying at school; I was still in therapy. I was still seeing Dr. Grayson during

this time, but it still didn't alleviate my dysphoria.
Q. So you were still socially transitioned, living in accordance with your male gender identity, and receiving therapy from Dr. Grayson throughout that time?
A. Yes.
Q. Were you still receiving treatment for your anxiety and depression during that time?
A. Yes, I was still doing counseling, but it wasn't very effective because I was still -- like, even though I socially transitioned, I was still physically in the wrong body.
Q. And so you still were experiencing gender dysphoria?
A. Yes.
Q. So you mentioned that you were first prescribed puberty blockers.
Can you explain why that was the course of treatment?
A. Yes. I have a solitary kidney. I was born with renal atrophy, which just means that my other kidney didn't develop when I was born, and because of this I developed hypertension in my, like, early childhood. I don't remember exactly when.
And due to the hypertension and solitary kidney issues, she wanted to make my transition gradual and not, like, shock my body by just introducing testosterone. But she wanted to, like, balance out my hormones and then slowly start introducing testosterone gradually until it got to a level that was, like, average for other teenage males, yeah, because one of the

effects of testosterone is higher blood pressure, and so she didn't want to, like -- yeah.

Q. So she took a cautious approach?

A. Yes.

Q. Have you always been followed for these other conditions, the renal -- I'm sorry, not renal atrophy -- solitary kidney and the high blood pressure, hypertension?

A. Yes. Like, I don't remember exactly when I was diagnosed with the hypertension, but I have been seeing a nephrologist at least since I was young. Like, I don't remember exactly what age, but, like, I'm still seeing one today. And she just makes sure -- she makes sure that my kidney function is good, that my blood pressure is being maintained. She does -- I get annual scans -- I get annual ultrasounds of my heart and kidneys, and I also get an annual, like, 24-hour blood pressure monitor on me to, like, check my blood pressure throughout a day. So it -- yeah, it's been monitored.

Q. So for the benefit of those of us who might not know that word, can you explain what a nephrologist is?

A. Yes, a nephrologist is a doctor that specializes in, like, the kidney and urinary system and also blood pressure too, because it's affected by kidneys.

Q. So has your nephrologist and your endocrinologist coordinated regarding your care because of these other conditions?

A. Yes, they have. They actually work in the same office at Joe DiMaggio, the same building. They -- yeah, they work together and in -- like, when I go to an appointment of either of them, they're asking if I'm still, like, checking in with the other one. Like, whenever I see my endocrinologist, she's like, Are you, like, checking your blood pressure? Are you still seeing the other one? And I'm like, Yeah.

Also, my -- because I get blood tests about every couple months to, like, every six months or so, they will sometimes, like, piggyback off of each other's blood tests so they don't, like, have to order more tests if -- so they'll look at, like, the results from, like, the other one's blood tests to, like, check things. But they work together.

Q. Great. So before you were prescribed puberty blockers -- that was the first thing you were prescribed; right?

A. Yes.

Q. Before that did Dr. Hart-Unger do a comprehensive assessment?

A. Yes. She -- when I went back to her after we got the court case ruling, I got an updated letter from Dr. Grayson, because I was still seeing her, but we updated the letter, and it was still the same, though. It was medically necessary for me to start hormone blockers. And we had the, like, same conversation again multiple times of risks, benefits, what to be aware of, stuff like that.

Q. What were some of the risks and benefits that she made you aware of?
A. Some of the effects of which specifically?
Q. Let's start with blockers.
A. All right. Blockers -- the effects of it that we discussed were things like stopping my period and stopping chest growth from continuing, and there were also risks associated with it like hot flashes due to stopping your period, and bone density was a thing that was, like, being checked out.
Q. So at this time you were still under 18, right?
A. Yes, I was 16, 17, yeah.
Q. So did your dad go through the informed consent process with you?
A. Yes. I don't remember which one of us -- or if it was one of us or both of us signed the, like, papers, but -- I don't remember if there was one for puberty blockers, but for testosterone I know there was, like, multiple sheets of paper, and it was, like -- each symptom had its own line, and there was, like, an -- I had to, like, initial next to each one to, like, verify that I read it and understood it, yeah.
Q. And so just to be clear, Dr. Hart-Unger required the letter from Dr. Grayson prior to prescribing any treatment?
A. Yes. And she also -- like, she doesn't want just a letter and then that's it. She wants -- she wants me to continue counseling and therapy, which I still am.

Q. So you're still receiving therapy for your gender dysphoria today?
A. Yes.
Q. So you mentioned the potential risks of blockers, and then I think you mentioned the informed consent process for testosterone.
But can you explain to the Court some of the risks and benefits that were explained to you with regard to testosterone?
A. Yes. With testosterone, it has effects like a deeper voice, body fat redistribution, facial hair growth. It also has effects like stopping the puberty -- stopping the period and chest growth, but I was already having that from the blockers. And it also has other risks like increased blood pressure, increased, like, blood cholesterol, and other stuff like that. But I get regular blood tests, and everything is, like, closely monitored.
Q. Did you talk about fertility preservation at all or the potential future desire to have children?
A. Yes, we did talk about that because -- oh, I forgot to mention it. Testosterone does, like -- it can have an impact on fertility. Like, it won't make you -- it's not guaranteed to make you infertile, but it does, like, present a risk for having issues with fertility. So we did talk about that risk.
She -- Dr. Hart-Unger brought up the possibility of, like, egg freezing or egg donation -- or egg preservation in case I

wanted kids down the line, but I spoke with Dr. Grayson; I spoke with family friends, I also spoke with Dr. Hart-Unger that I had no desire to freeze my eggs, and I have no desire to have kids.

Q. And do you still feel that way today?

A. Yeah. I mean, if further down the line I want kids, I can adopt. It's -- they -- it's a great option, yeah.

Q. Did Medicaid cover your blockers?

A. Yes.

Q. And did Medicaid also cover your testosterone prescriptions?

A. Yes.

Q. How has it felt to be on testosterone? Like, what changes have you noticed?

A. I've had changes, like, facial hair growth and my voice lowering, and it has helped so much with my gender dysphoria. It's also helped my, like, confidence because it's made me feel more comfortable in my body. But it's not the, like, end-all-be-all because I still have other -- I am -- I still have gender dysphoria.

Q. Did you experience any issues or complications when you were taking -- when you began taking testosterone?

A. I believe the only, like, slight issue that showed up was an increase in my blood pressure, but I worked with my nephrologist to adjust the medications I'm on to -- because I'm on blood pressure medication to lower my blood pressure, so just

adjusting those to, like, even out, I guess, the changes from the testosterone.

Q. And so have your nephrologist and endocrinologist worked together to make sure that you're healthy and everything is as it should be?

A. Yes.

Q. Did testosterone -- having access to testosterone alleviate your chest dysphoria?

A. No. Because, like, the blockers and testosterone did alleviate it a bit as in it didn't keep growing, but it didn't help it because it was still there. I still had to go through a female puberty. So what physically happened, happened. So it did not alleviate my chest dysphoria.

Q. Did you do anything to address your chest dysphoria?

A. I was binding at the time to alleviate it.

Q. Can you just explain a little bit more about what binding is and what impacts it had on you?

A. Binding is just kind of compressing the chest to make it have a more flat appearance. And I was wearing my binder, which is just a compression top that makes it flat -- I was wearing it for -- probably almost every day for about, like, 10, 12 hours when the recommended time is up to 8 hours a day. But I was wearing it further than that because my chest dysphoria was so bad.

Q. Was it painful?

A. Yes. It -- because it's a compression top and it's around your chest, it constricts your lungs and ribs, and it can sometimes make it hard to breathe.

I also had an incident of where I had to go to the ER for rib cage bruising because I was wearing my binder for too long.

Q. I'm sorry to hear that.

Did you receive any other medical intervention to treat your gender dysphoria?

A. At what point?

Q. After -- other than the puberty blockers and therapy and testosterone, have you received any other interventions?

A. Yes. I got top surgery.

Q. And can you explain to the Court what top surgery is?

A. Top surgery, also called mastectomy or double mastectomy, is just the removal of breast tissue.

Q. Was your top surgery recommended by a medical provider?

A. Yes. Dr. Hart-Unger recommended it based off the -- me talking about my issues with my dysphoria and how my chest dysphoria was still continuing even while I was on testosterone. And she provided me a list of resources of, like, top surgeons in Florida.

Q. And did Dr. Grayson, your mental health provider, also deem that you were ready to undergo top surgery?

A. Yes, she did, and she also wrote a letter, like, recommending it, and yeah.

Q. And am I correct that you were about 19 at that point?
A. Yes.
Q. So you had been seeing Dr. Grayson for gender dysphoria specifically for about five years?
A. Yes.
Q. And had been on testosterone for about two years?
A. (Nods head up and down.)
Q. Who did you find to perform your top surgery?
A. Dr. Sara Danker in -- at UM Health in South Florida.
Q. Is UM University of Miami?
A. Yeah, University of Miami Health.
Q. What was the process that led to you obtaining top surgery?
A. Could you -- I'm sorry. It was kind of vague.
Q. No. That's okay.

What does -- just sort of walk us through the process of how you got to Dr. Danker and what led you there.

A. I was going down the list of surgeons that Dr. Hart-Unger provided me with, and it was, like, three pages. And none of the top surgeons on any of those pages took Medicaid at all, like even partially.

And my dad found Dr. Danker because at, like, some point around then she had just come back to Florida, because she was practicing in another state. And UM Health takes my insurance. So that's how we found her.

Q. When you say your insurance, you mean Medicaid?

A. Yeah, Medicaid.
Q. What was your consultation with Dr. Danker like? What happened during that?
A. It consisted of a physical evaluation, discussion about my dysphoria and my chest dysphoria. I didn't physically have the letter from Dr. Grayson at that moment, but she was -- but Dr. Danker was requiring it to, like, continue the process. But it was just, like, relaying the information that was on it, and, like, what I was feeling. And it consisted of a physical examination and a discussion of the surgery process, the pre-op, post-opt process, and yeah.
Q. Did Dr. Danker discuss with you the risks and potential complications associated with the procedure?
A. Yes. They were, I think, pretty standard risks of any surgery, like issues with, like, reactions to anesthesia, infections, or issues with the surgical site, things like that.
Q. Do you recall if you went through the informed consent process again and signed the informed consent form?
A. Yes, I did, and I signed it myself because I was 19 -- no, I think I was 20. I believe I was 20 when I actually signed it.
Q. Okay. Mr. Rothstein, did you receive prior authorization from Medicaid for this procedure?
A. Yes.
Q. How did it feel when you got that notification?
A. I was so excited, because I was emailing -- I was told over

email through -- with, like, one of the people from the surgeon's office, and I was running up and down the stairs to, like, tell my dad. And I was, like, Okay, this date -- you got to clear your calendar for this date. And I was running back up and down the stairs, and I was like a kid on Christmas. And I was excited because it felt like a lot of my transition has just been waiting, especially because I had to wait, like, so long to even get blockers or testosterone. And it was, like, the weight is, like, kind of almost over.

Q. Were you able to schedule your surgery at that point?

A. Yes. I, like, scheduled it for December 22, I believe.

Q. And that was of this past year, 2022?

A. Yes.

Q. Did you then find out that the surgery wouldn't be covered?

A. I -- yes, I was told by the surgeon's office a couple weeks before the surgery date that Medicaid, like, rescinded their approval to cover the surgery. But I was already a bit off -- like, I had lost the, like, happiness for it already because the announcement for the ban on Medicaid covering transgender health care was -- came out the day after I got the approval. And so -- and that was in, I think, August. And so from that time to right before the surgeon's office told me that it wasn't going to be covered and that I would be having to pay out of pocket, I wasn't as excited for it as I should have been, because it was very uncertain if I was even going to be able to

get it. And it was scary and frustrating of just not knowing.
Q. So, Mr. Rothstein, were you able to obtain the top surgery?
A. Yes. I had a Go Fund Me set up, and it -- I was able to receive enough money through it to cover the cost of surgery, so I was able to get it.
Q. How did it make you feel that you had to raise money to pay for something that was medically necessary for you?
A. It's frustrating also because it was, like, previously authorized. And all of my other treatments for my dysphoria and just other treatments in general for my other health issues have -- have always been covered. My sister is also on Medicaid, and she's never had an issue with Medicaid covering any of her surgeries, and she's had a lot.
Q. So how did the procedure go?
A. It went well. There weren't any complications, and yeah.
Q. Are you happy with the results?
A. I am very happy.
Q. How has it impacted your daily life?
A. It's helped a lot. Like, it makes me feel more aligned with how I feel on the inside. It -- I still have gender dysphoria, but the treatments I've had have helped a lot in managing it and treating it.
Q. I presume you don't have to wear a painful binder anymore?
A. No, I don't.
Q. You mentioned this earlier, but you still go to therapy;

right?
A. Yes, I do.
Q. And you still take your testosterone?
A. Yes.
Q. Mr. Rothstein, do you ever fear for your safety as a trans man in the state of Florida?
A. Yes. I feel like it's -- I don't know if I want to say, like, the fear has worsened now because a lot of anti-trans, like, legislature and bans have been going through all over the country and also especially here in Florida. But, I mean, I've always had a fear, like, from when I was figuring myself out because I'm scared of -- I didn't know how the world would accept me, and also now, because I do pass pretty well and I feel comfortable in my body, but there are still people that don't see it that way, and I'm still scared.
Q. How would you feel if you had to stop your treatment for gender dysphoria because of the rule at issue that we're here about today?
A. I'm sorry. Could you repeat the question?
Q. What impact do you think it would have on you to have to stop your treatment for gender dysphoria?
A. I believe my mental health would take a very big hit, and I would probably be in a worse place than I was when I didn't even know I was dealing with gender dysphoria, because I was able to take the steps to treat it. And then I just have to go back on

it. And I also don't -- I'm also not sure, like, what physical effects it would have on me to suddenly stop testosterone and then my body go back to producing estrogen.

Q. Just a couple more questions, Mr. Rothstein.

How do you think it would have impacted you if you had been able to access gender-affirming care when you first were recommended to see Dr. Hart-Unger if you hadn't had to wait those few years because of the custody issue?

A. I probably would have been in a much better mental state. My anxiety and depression probably wouldn't have been as bad, and I wouldn't have -- I likely wouldn't have had to deal with such bad social anxiety growing up.

Q. So, in your opinion, has access to treatment for gender dysphoria improved your quality of life?

A. Yes, very much so.

Q. Just one last question, Mr. Rothstein.

How has the State's decision to ban this care for you and for other transgender Medicaid beneficiaries made you feel?

A. It makes me feel horrible and discriminated against because it is discriminatory. It's not right to pick and choose which people have access to certain health aspects of health care. And there's also things like -- gender-affirming care, cisgender people get that too. It's not only transgender youth and adults. My sister took -- my sister was prescribed puberty blockers at a point -- my sister is cisgender. She was

prescribed puberty blockers to delay her period because her doctors felt like she wasn't ready at the time to be dealing with that. And there was no question about it being covered or if she should have it or not. There was no issue with that.

And it's -- it's health care that shouldn't be denied, and yeah.

Q. Thank you so much, Mr. Rothstein.

MS. CHRISS: I have no further questions, Your Honor.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good afternoon, Mr. Rothstein.

I just wanted to get to know your medical records a little better.

Mr. Rothstein, in looking at your records, it says that you were diagnosed with major depressive disorder; is that correct, sir?

A. Yes, that sounds right.

Q. And autism; is that correct, sir?

A. Yes.

Q. And was it Dr. Lappin who diagnosed you with those two?

A. My autism diagnosis occurred in, like, the past year or so. And Dr. Lappin diagnosed me with depression. I don't know if it was exactly, like, major depressive disorder or, like, the specific terminology for it.

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023 /s/ Mohammad O. Jazil

No. 23-12159

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME VII OF XIII

Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
(850) 274-1690

Counsel for Defendants-Appellants Florida Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

Ashley Moody
Attorney General of Florida

Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
(850) 414-3300

Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

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Dated: September 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
Phone: (850) 391-0503
Facsimile: (850) 741-1023
mjazil@holtzmanvogel.com
mbeato@holtzmanvogel.com
Counsel for Defendants-Appellants Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

/s/Joseph E. Hart
Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
Phone: (850) 414-3300
henry.whitaker@myfloridalegal.com
joseph.hart@myfloridalegal.com
Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

Q. And it was -- so after you were done seeing Dr. Lappin, you saw Deborah Grayson?
A. There was a time where I was seeing both of them at once, a bit of an overlap. But, yeah, it was Dr. Lappin and then Dr. Grayson.
Q. And Dr. Grayson is the one who diagnosed you with gender dysphoria?
A. Yes.
Q. And in looking at the medical records, you'd agree with me that Dr. Grayson is not an MD; right?
A. I don't know.
Q. Well, does Dr. Grayson sometime provide unorthodox treatments as part of her practice?
MS. CHRISS: Objection, Your Honor; vague.
THE COURT: Overruled.
THE WITNESS: Do I have to answer that?
THE COURT: Yes. Yes. If you know, answer the question.
THE WITNESS: I don't understand what you mean by that question.
MR. JAZIL: Okay. Can we go to Plaintiffs' Exhibit 234, please -- not on -- well, not on the public screen, please.
I apologize, Your Honor.
THE COURT: That's all right.
MR. JAZIL: Page 170.

BY MR. JAZIL:

Q. So it says in her fee schedule that she provides hypnosis services for $200 for 60-minute sessions.

Do you see that, Mr. Rothstein?

A. Yes.

Q. Did Dr. Grayson, in fact, provide hypnosis services? Is that your understanding of her practice?

A. No, she never did anything like that with me. We only ever did, like, the individual therapy.

Q. Okay. Mr. Rothstein, you discussed with my friend some of the issues related to your renal failure and the one functioning kidney.

Is it my understanding that you spoke about those issues with both your endocrinologist and your nephrologist?

A. I -- it wasn't renal failure. It was renal atrophy.

Q. Okay.

A. Which it just meant that my other kidney didn't develop when I was born, so I only had one fully functioning kidney.

But both of -- my endocrinologist and nephrologist are aware of this issue, and I talked with them extensively, like, both of them, about this issue.

Q. And they discussed with you the effects that testosterone can have on your kidney as well; right?

A. I don't remember if there was a discussion on the specific effects of testosterone on the kidney, but we did discuss the

effects of testosterone on blood pressure and then blood pressure on kidney.

Q. Understood.

Mr. Rothstein, the puberty blocker you were prescribed is Lupron; right?

A. Yes.

Q. And am I correct in my understanding that before you were prescribed Lupron, your endocrinologist discussed with you the effects that Lupron can have on depression, making it worse?

A. I can't remember exactly if that was discussed, but she always -- Dr. Hart-Unger always made a very strong emphasis on how she wanted me to continue counseling, and I had letters from my doctor that I was, like, of sound mind.

Q. Understood.

Thank you, Mr. Rothstein.

MR. JAZIL: I have no further questions.

THE COURT: Redirect?

MS. CHRISS: No, Your Honor. Thank you.

THE COURT: Thank you, Mr. Rothstein. You may step down and return to counsel table.

That makes this the time for the lunch break. Let's come back at 1:50 by that clock.

(Recess taken at 12:48 PM.)

(Resumed at 1:50 PM.)

THE COURT: Good afternoon. Please be seated.

Please call your next witness.

MR. CHARLES: Good afternoon, Your Honor.

Carl Charles for the plaintiffs. And the plaintiffs call, Mr. August Dekker.

THE COURTROOM DEPUTY: Please stand and raise your right hand.

AUGUST DEKKER, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: August Dekker, D-e-k-k-e-r.

DIRECT EXAMINATION

BY MR. CHARLES:

Q. Good afternoon, Mr. Dekker.

How old are you?

A. I'm 28, about to be 29.

Q. When is your birthday?

A. June 23rd.

Q. And where do you currently reside?

A. Spring Hill, Florida.

Q. How long have you lived there?

A. Coming up on 19 years.

Q. Is that where you grew up?

A. I grew up in California, San Diego area.

Q. When did you move to Florida?

A. On my tenth birthday.
Q. Did you attend high school -- did you attend high school in Spring Hill, Florida?
A. Yes. I went to F.W. Springstead High School.
Q. Do you currently live with anyone in Spring Hill, Florida?
A. I live with my younger brother, Matthew.
Q. And are you currently employed?
A. No.
Q. Why not?
A. I'm legally disabled.
Q. And what is your disability?
A. I have juvenile onset rheumatoid arthritis.
Q. Do you currently take any medications for that condition?
A. Yes. I take methotrexate, m-e-t-h-o-t-r-e-x-a-t-e, celoxib, c-e-l-e-c-o-x-i-b, and Actemra.
Q. Will you spell that one, too?
A. A-c-t-e-m-r-a.
Q. Mr. Dekker, will you tell me what each of those medications does for your rheumatoid arthritis, please?
A. So my Actemra is a injection that I do every three weeks, and it helps manage the symptoms and halts the disease progression of my arthritis.
The methotrexate acts somewhat similarly; however, it's an oral pill that I take once a week.
And the celecoxib is for pain and inflammation.

Q. And how do you pay for those medications?
A. They are all covered through Medicaid.
Q. And so is Medicaid your health insurance coverage that you have?
A. Yes. I specifically have the Humana Plan.
Q. What's your understanding of why you qualify for Florida Medicaid health insurance coverage?
A. Well, I am currently receiving SSI, Supplemental Security Income, and anyone eligible for SSI automatically gets Medicaid.
Q. Do you remember how old you were when you first started receiving Florida Medicaid?
A. I believe I was around 22.
Q. Mr. Dekker, are your parents still living?
A. Yes.
Q. Do you have a relationship with either of them?
A. I have a relationship with my father.
Q. Tell me a little bit about your relationship your father.
A. It initially started off pretty rocky, mostly because we didn't really connect a lot. And especially when I came out to my parents for the first time as transgender, they didn't really understand what was happening or how I was, like, feeling, or what led me to know this about myself.

And my dad, over the course of the -- over five years since I've been out, has really made an effort to understand my identity and better support me as a trans person.

Q. I'm glad to hear that.

Mr. Dekker, just very briefly, why don't you have any contact with your mother?

A. She's emotionally abusive and does not support my transition in any way. I just find it better for my mental health to have no contact with her.

Q. Who would you say you are closest with in your family?

A. My brother, Matthew.

Q. Can you tell me a little bit about Matthew and why you describe him as your closest family member?

A. Yeah. We've basically been best friends since he was 2 years old. I'm the oldest brother, and we've always looked after each other. And he was the one person that I knew that I could go to with anything, and so he's the first person that I came out as trans to ever. And he took it in stride. He said that he wasn't necessarily surprised, but that he supported me 100 percent. And he's even, you know, at previous points defended me to our parents.

Q. Sounds like a pretty excellent brother.

A. Yeah.

Q. August, what was the sex that you were assigned at birth?

A. Female.

Q. And what is your gender identity?

A. Male.

Q. Do you have any early memories of an awareness of your male

gender identity?
A. Yes. So going back to when I was about 5 or so, I remember, you know, not really liking anything that was associated with girls. I didn't like the color pink. I hated wearing dresses and skirts. I wanted always to be in T-shirts and shorts. And I tried cutting my hair once. It came out awful because I was, like, 7, but -- and my mom fixed it and gave me a feminine haircut again, and I was very distressed about it at the time.

And when I would play in the backyard with my brothers, for instance, we would play Stargate. It's a sci-fi show that not a lot of people have watched. It's kind of goofy. And there's one character in it whose name is Samantha Carter, and she's basically the only female on the team. And my brothers would always be like, Oh, well, you play Carter. And I would be like, No, I don't want to play Carter. I want to play Daniel Jackson. He's another scientist.

But, yeah, those are some of my earliest memories with gender incongruence.

Q. Do you have any memories of experiencing distress related to the discordance between your sex assigned at birth and your gender identity when you were an adolescent?

A. Yeah. One particular thing that jumps out is when I first got my period. I think I was about 14. And by this time I had been explained to how -- the workings of a menstrual cycle and

was told that it would happen to me. But I didn't really count myself in that category. So I was like, Oh, well, I don't have to be afraid of that.

So when my period actually came, I was really confused, and I ran to my mom's room, and I was like, You have to take me to the hospital. I think I'm dying. Like, I'm bleeding. And she just was, like, kind of laughing at me. She's like, It's your period. It's supposed to happen. And I was like, Well, not to me. Like, that doesn't make any sense that I would have a period.

And in high school I continually kept having crushes on gay men, and I couldn't understand why they weren't interested in me. Because a couple of them had said that they would date me if I was, you know, a man. And I was like, Well, why are you putting me in that category? Like, I don't understand that.

Q. Did you feel like you could discuss your gender identity with your family as you were growing up?

A. Absolutely not. I would -- I wouldn't go so far as to say that my living environment was hostile, but it was certainly not conducive to me feeling safe to explore any gender feelings. My mom especially was -- is very unsupportive of the LGBTQ community at that point, and so was my church, who -- which I was heavily involved with, as my mom was the youth leader. And I just -- I didn't even want to consider the fact that I may be LGBT until I was out of the house.

Q. At what age did you come out as a transgender man?
A. Around age 22.
Q. And you talked about this a little bit, but can you tell me, how did your brothers -- you said you had more than one brother. How did your brothers react when you came out as a trans man?
A. I have three younger brothers. I initially told Matthew, and he was very supportive. And that gave me the confidence to come out to my other brothers. That was around the same time that I came out to my parents, maybe at the same time. I don't really remember. My parents reacted quite badly at the time. My brothers have always been nothing but supportive.
Q. So you came out as a transgender man at age 22.
What kind of -- what did that entail, other than telling people about your male gender identity? Was there anything that you did?
A. So when I was about 18, I decided to cut my hair short. In my mind I rationalize it as, Oh, I just like it better this way. But looking back, that was definitely dysphoria.
So immediately after I left my parents' house, I cut my hair off. And it wasn't until a couple of years after that that I started identifying with trans men more and decided to change my name and pronouns, start dressing in a more masculine way, and just live in a male identity.
Q. So you took some steps, it sounds like, socially as a part

of your coming out.

Were you still experiencing discomfort between the sex you were assigned at birth and your gender identity even after you came out?

A. Yeah. It may have actually gotten worse at a point, because I wasn't concerned with trying to push down those feelings anymore. And so I was -- it was hard for me to kind of put those feelings back into a box because they were already out. And so I -- yeah, my dysphoria was definitely not well managed with just social transition.

Q. Can you say a little bit more -- you've used the word "dysphoria." Are you referring to gender dysphoria?

A. Yes.

Q. So how would you describe how it felt to not be able to live as fully as the person you are?

A. It felt like I had this constant void in my chest. I know that sounds melodramatic, but it's true. It was like I was walking around with, like, a leaden ball in any stomach, and I couldn't find a way to get it out, and just I had to deal with it every day.

And that leaden ball in my stomach informed everything else that I did, and it just was unmanageable at a point. Like, I couldn't -- I didn't want to sleep; I didn't want to eat; I didn't want to do anything that was even remotely human because I was so disgusted with myself and, like, the way that people

perceived me.
Q. So is it fair to say that your experience of gender dysphoria impacted your day-to-day functioning in life?
A. Absolutely, yeah.
Q. Are there any examples of that that stand out in your memory?
A. Throughout high school I was pretty heavily suicidal. I had attempted suicide probably four times during high school, and, luckily, none of them worked.
But I was just at a point where I didn't yet know what was -- like, what was wrong, and so I couldn't attempt to fix it. But, like, that feeling was still there, and at the time it felt like I couldn't escape it, and so I resorted to dramatic measures for it to stop, because I didn't really know there were other options.
Q. And so thinking about the period of time after you came out socially and started to do some things with your gender presentation to walk in the world as a man, how did your gender dysphoria continue to manifest in your life?
A. So it definitely got less bad after I came out and after I started medical transition. However, I was still depressed; I was still anxious. You know, things were better, but they weren't, you know, completely all right.
Q. So did you take any steps to deal with that ongoing discomfort?

A. Yeah, I decided to -- a couple years into social transition I decided to try to pursue a medical transition, and I went through a center called Metro Inclusive Health in Tampa. I signed up for therapy there, because at the time you had to get a letter written to start hormone replacement therapy. And I was in therapy for about eight months before my letter was written, both due to my gender dysphoria and unrelated issues that I wanted to resolve before I started treatment.

Q. Okay. So you mentioned Metro Inclusive Health.

Do you remember approximately what year you first went and sought out therapy through that center?

A. I believe it was 2016.

Q. And so you mentioned that you received therapy focused on treatment for gender dysphoria.

Did you receive support related to anything besides gender dysphoria during that time at Metro Inclusive?

A. Yes, I did. I have a history of childhood sexual assault and -- as a victim, and I wanted to address that before I even started thinking about hormone therapy. It got to a point where I was confident in my ability to deal with that trauma, and probably two months after that is when I was given my letter.

Q. So you mentioned PTSD. Do you have a PTSD diagnosis?

A. Yes, I was diagnosed at Metro Inclusive.

Q. So beside gender dysphoria and your arthritis and PTSD -- well, actually, sorry. Let me back up.

Who diagnosed you with PTSD?
A. Ashley Hancock.
Q. And did Ms. Hancock have specific therapies that she engaged in with you or strategies to help you feel, as you described, able to manage that diagnosis?
A. Specifically with my PTSD, we talked about my triggers and how to avoid them and also how to cope with them if I ran into them in, you know, daily life. Luckily, my triggers are fairly uncommon, and I don't really run into them that often.
Q. Mr. Dekker, will you do me a favor and just speak a little bit more loudly?
A. Yeah. Sorry.
Q. No problem.
So would you say that the treatment that you received was helpful?
A. Yes. It allowed me to deal with my trauma in a way that felt like a resolution.
Q. And did your PTSD diagnosis interact with your gender dysphoria at all?
A. I don't think so, no.
Q. Did your therapist tell you that the treatment for PTSD would impact any therapy that was happening for gender dysphoria?
A. No.
Q. And do you have any other diagnoses that you're aware of?

A. I have -- well, I was diagnosed with major depressive disorder and generalized anxiety disorder.
Q. And when abouts did you receive those diagnoses?
A. 2018.
Q. And do you recall who provided you with those diagnoses?
A. It happened during the time that I was inpatient at a behavioral health center. I don't know who exactly diagnosed me.
Q. And why were you receiving inpatient care?
A. I was having suicidal ideation related to a relationship at the time.
Q. And during those inpatient stays, were you receiving medical treatment for gender dysphoria?
A. No, I was not.
Q. How has your depression diagnosis interacted with gender dysphoria, if at all?
A. I would say my dysphoria informs my depression and not the other way around. My -- the way I experience depression and anxiety now, consistently on hormones, is that it's entirely situational, and there's none of that underlying malaise that was there when I was not able to transition. Of course, you know, everyone gets sad or anxious sometimes, but I'm no longer at that level where it's a majority of my life. It's only in cases where, you know, something bad has happened or, you know, something very impactful has happened.

Q. And what about anxiety? How do you -- how would you describe how that has interacted with gender dysphoria, if at all?

A. I would say my gender dysphoria and anxiety were correlated in the idea that -- my anxiety is mostly related to how people perceive me and my gender. So if I'm experiencing anxiety, it's likely because I'm afraid that I'm being perceived as a woman in public, for instance, or, you know, by a friend. And that has grown a lot more manageable the longer I have been in transition, and it's basically nothing now.

Q. Do you take any medications to manage the symptoms of either depression or anxiety?

A. I take mirtazapine, m-i-r-t-a-z-a-p-i-n-e, and that's prescribed to me as a sleep aid. But it does have antidepressant properties. And I take hydroxyzine, h-y-d-r-o-x-y-z-i-n-e, as needed for anxiety.

Q. Okay. So let's back up a little bit.

You initiated care at Metro Inclusive Health in 2016, and you said you were in therapy with Ashley Hancock for a number of months.

At what point did she diagnosis you with gender dysphoria?

A. It was about eight months from our first appointment.

Q. And did you all discuss and did she recommend that medical treatments would be appropriate to treat your gender dysphoria?

A. Yes. She wrote me a letter recommending that I start

testosterone therapy.

Q. Okay. So you got a letter from your mental health care provider.

What was the next step in the process?

A. The next step was getting cleared by the MD team at Metro Inclusive, the medical doctors. That involved blood tests, a physical exam, probably some other stuff I'm forgetting. And then when I was cleared, then I was able to get my testosterone prescription, and the first injection was actually done at the clinic so they could show me how it was done and, you know, what to avoid during an injection.

Q. You said you got some lab work done.

Do you remember what the lab work showed?

A. I don't remember exactly what it showed, but they totally cleared me to start HRT.

Q. And before you started testosterone -- sorry. Let me back up a little bit.

How old were you in 2016?

A. I was 22, I think.

Q. Before you started testosterone, were you advised about the risks and benefits of that treatment?

A. Yes.

Q. And can you -- do you recall that conversation and what was discussed?

A. Yes. So the risks -- some of the risks included a decrease

in fertility, male pattern baldness, possible cardiac issues, higher blood pressure, possible decrease in organ function, specifically with kidney and liver. And that's all I can remember right now.

Q. And what about the benefits?

A. The benefits included, for me at least, the normal things that you would associate with male puberty: Increased facial and body hair, deepening voice, body fat redistribution, increase in muscle mass. Just general man things, I guess.

Q. When you started testosterone, were you told anything about how that medication might interact with your medications for your arthritis or -- your arthritis broadly?

A. I wasn't told at the time because I wasn't on the medications that I'm currently on. I was only taking celecoxib at that time, which had no interactions with testosterone.

Q. Okay. So no medical professional advised you that there was a problem with you starting testosterone while having rheumatoid arthritis?

A. No.

Q. So if I'm doing math sort of correctly, it seems like you first started testosterone in 2017; is that right?

A. Yes.

Q. And did you notice any impact on your symptoms of gender dysphoria?

A. Almost immediately, actually. I felt more confident pretty

much the week after I got my first injection. I don't know what's in my genes, but I started getting a little hint of a mustache, like, a month in. I was super excited about that. And as, you know, the months went on, you know, I was making videos of my voice changing and posting them for my friends to see. And it was just, like, a process that changed the entire way that I interacted with the world.

Q. Did you find that once you started testosterone some of that day-to-day distress diminished?

A. Yeah, for sure. I definitely felt a reduction in my depression and in -- sorry -- anxiety, and, you know, life just felt easier. It felt more manageable.

Q. And -- I'm sorry. Just a second.

Did you experience any negative side effects of taking testosterone?

A. I sweat a lot. That's kind of annoying sometimes. But otherwise, no.

Q. And did you observe any issues between testosterone and the celecoxib I think you said you were taking?

A. Yes. And, no, I did not notice any interactions.

Q. So from 2017 forward, did you continue taking testosterone to treat your gender dysphoria?

A. I continued taking testosterone for about eight or nine months, and then I was coerced by the partner I was currently with to stop my testosterone therapy.

Q. When you stopped taking testosterone for the treatment of your symptoms of gender dysphoria, what happened to those symptoms?

A. They returned with a vengeance. I was depressed to the point of not wanting to get out of bed. I had to physically, like, almost hit myself to try to get myself to take a shower, because I didn't want to keep looking at my body. And I stopped hanging out with friends. I didn't want to even go out to the store to get groceries. I was that, you know, unhappy with my body at that point that I didn't want anyone to see it. I didn't want anyone to perceive me as a woman and -- because, like, seeing people perceive me that way would have done even more damage to my already fragile mental state at that time.

Q. You said you stopped taking testosterone because a -- the partner you were with at the time coerced you.

Can you say a little bit more about why you decided to take that break?

A. So it was a long-term abusive relationship. We were married at the time. And basically she told me, I don't like you being on testosterone anymore. If you continue to take it, I'm going to leave.

And I was extremely codependent with her up to that point because I am disabled and I could not work. I could not earn money for myself. I had no way to survive other than her, because she had also isolated me from my family. And so when

she gave me that ultimatum, I didn't believe there was a choice for me if I wanted to continue to survive.

Q. Did you know that your symptoms of gender dysphoria would probably come back if you did that?

A. Yes.

Q. At what point -- I'm sorry.

Did you ever start testosterone again?

A. Yes, I restarted testosterone in June 2019, after my separation with my wife.

Q. And have you been taking testosterone consistently since June of 2019?

A. Yes.

Q. And what happened to your gender dysphoria symptoms after you restarted testosterone in June of 2019?

A. Almost immediately they became much more manageable again. I was happier. I was more secure in myself. I was confident. I wanted to go outside and meet people. I wanted them to know who I was and how -- wanted them to see how I presented myself, because I felt proud of myself and who I was.

Q. And have you observed any issues between your testosterone therapy and your medications to treat your arthritis since you've been back on testosterone?

A. No. I guess maybe there is one -- anecdotally, I wouldn't say this for everyone who is taking testosterone, but just for me, personally, I have noticed, as a positive, that while on

testosterone some of the symptoms of my arthritis are diminished. I think that's because testosterone helps with some connective tissue disorders, and my rheumatoid arthritis is somewhat related to connective tissues since that's what your joints are. And so the stronger my connective tissue is, the less symptoms that I have for my arthritis, and yada, yada.

Q. Do you see a doctor specifically for your rheumatoid arthritis, Mr. Dekker?

A. Yes. I've been seeing the same rheumatologist since 2021.

Q. Does he do any monitoring of your disease progression?

A. Yes, I get multiple labs done every eight weeks.

Q. What do those labs include?

A. I get a CBC with differential done. I have a test for my organ function, my kidney, liver, my red blood cell count, my platelet count, white blood cells, and my blood pressure is tested every time I go to the office. Basically everything under the sun that they can test for, I've probably had it done.

Q. You said that happens every eight weeks?

A. Yes.

Q. And has he noted any issues in that lab work about your disease progression and the treatment of your gender dysphoria with testosterone?

A. No. Whenever something comes up in my labs, he personally calls me. The last time was because my white blood cell count was a little low, and we just decided to switch up the length of

time between my injections. And the time before that was my vitamin D level was critical. So he gave me some prescription-strength vitamin D for that. But nothing has come up about my testosterone or my gender dysphoria.

Q. When you say your injections, are you referring to the injectable medication you take for your arthritis?

A. Yes, Actemra.

Q. Actemra. Okay.

Mr. Dekker, how do you pay for your testosterone prescription?

A. It's been covered by Medicaid.

Q. As a part of your experience of gender dysphoria, did you ever experience dysphoria related to your chest?

A. Absolutely. I think most of my dysphoria was centered around my chest, especially after I started testosterone, because the happier I was with, like, my face and other aspects of my body, my chest really stood out to me as the one thing that caused me the most distress. And I have been dreaming about top surgery since I was initially coming out as a trans man.

Q. Did you ever wear what's referred to as a chest binder?

A. Yes. When I first came out as a trans man, I bought one. It was a very poor material one off of Amazon. I quickly, thereafter, got a better quality one.

And -- however, with my arthritis, it was difficult for me

to bind for the length of time that I wanted to, and so personally I only felt safe to wear my binder about one or two days a week. So I would have to kind of structure my errands around that and try to get everything done in one day if I wanted to go outside and feel comfortable, and that was kind of a pain. And I never wore my binder for more than the recommended eight hours because I didn't want to do damage to my bones, because they are already fragile, but I wanted to. And I thought about it a lot. And at points I was very frustrated with my body that it was not allowing me to -- to wear the binder as much as I wanted.

Q. So you mentioned this a little bit, but did your chest dysphoria go away with the testosterone treatment?

A. No. If anything, it maybe got a little worse because it was, like, what I was focusing on the most, because my other concerns have kind of been taken care of through testosterone therapy.

Q. So in conversations with your medical providers, was it ever indicated that it was appropriate for you to receive top surgery as treatment for your gender dysphoria?

A. Yes. So I talked about it a lot with my therapist. And probably up to a year before I actually started to schedule surgery, I was talking about it with her, making sure that I was ready, making sure that this was the right option for me, and, you know, just talking about what would come after as well,

because surgery is a hard thing to go through, especially for someone with a complicated medical history. And we wanted to mitigate every possible harm that could be done or complication that I could have.

Q. So you said you talked with your therapist for about a year before top surgery.

What steps did you have to take once -- after your conversations it was indicated that that was an appropriate treatment for you, what came next?

A. So I started researching the requirements of Medicaid to get top surgery covered through Medicaid. That involved getting a referral from my primary care doctor, a letter of recommendation from a mental health provider, and I believe my surgeon's office also required one year on hormones to schedule a consultation. I had to get all of this before I could even schedule a consultation.

Q. Okay. So you mentioned letters.

Can you talk to me a little bit about that?

A. Yes. So I got my first letter of recommendation from my psychiatrist that I have been seeing since 2019, Troy Pulas. And I additionally got a second letter just to make working with Medicaid a little bit easier, maybe, you know, get an approval in, you know, maybe a little bit quicker time. And that second provider was someone I had not seen before because they wanted an independent evaluation from someone who I was not in care

with.
Q. So you were only -- as you understood it, you were only required by Florida Medicaid to get one letter?
A. Yes.
Q. So once you had, as you said, sort of compiled these requirements, what did you do next?
A. I scheduled the consultation, and there's -- it was a two-hour drive. But I go to that hospital anyway. My rheumatologist is at the same hospital, so I'm familiar with the hospital and the network of doctors there.
So at my consultation we spoke about what my goals were for the surgery, the risks and benefits of the surgery, what we could do to minimize any complications I might have with healing, because I am on immunosuppressants. Actually, in the office my surgeon emailed my rheumatologist and asked him what the best course of action would be for my current medication. And he replied pretty quickly with a plan and links to studies about -- why stopping one would be beneficial and the other one isn't needed. And I think she took a couple of pictures of my chest. And that was about it for the consultation.
Q. Let me back up a little bit.
You said the hospital was two hours away. What hospital did you go to for your consult?
A. The University of Florida, Shands.
Q. And what was the name of the surgeon that you had a

consultation with?
A. Sarah Virk.
Q. You said that you spoke with Dr. Virk about risks and potential complications. Did you also talk about benefits?
A. Yes.
Q. Can you tell me what you remember about that conversation: The risks, the potential complications, and the benefits of top surgery?
A. So benefits would be a huge reduction in my gender dysphoria and just improving my quality of life. You know, the risks come with any surgery. It's, you know, infection, bleeding, hematomas, edema, which is swelling, fluid buildup -- any number of things that can happen with any surgery. And my specific complications that she was trying to mitigate were issues with healing. And I was given what is called a negative pressure dressing, or a wound vacuum, to mitigate the healing issues that may have occurred due to me being on immunosuppressants.
Q. Okay. So is that what you referred to earlier as the plan that she came up with with your rheumatologist?
A. Yes. I was also advised to pause my Actemra for two weeks before and two weeks after surgery because that is my main immunosuppressant.
Q. When -- did you have top surgery?
A. Yes.

Q. When did you have that surgery?
A. April 19, 2022.
Q. And did you experience any complications?
A. Not really. I mean, there were a couple very small spots along my incisions that reopened, but I was able to just cover them with some Neosporin and a Band-Aid, and they healed up about a week after that.
Q. How was the surgery paid for?
A. As far as I know, it was covered through Medicaid.
Q. Can you describe for me, Mr. Dekker, your feelings after the procedure?
A. I felt like the world had been lifted off of my shoulders. Like, it felt like this was the way things were supposed to be all the time. It felt natural, and I didn't -- I'm wearing a white shirt today. And before top surgery, my closet was entirely black because I was trying to hide any evidence of my chest. Just the simple fact that I can wear a white or, like, a beige-colored shirt now has done wonders for me, mental health-wise. It's also expanded my wardrobe quite a bit.

And just the confidence I have now in my body, in my chest, being able to take my shirt off when I go swimming, to the beach, being able to roughhouse with my brother without worrying about my chest getting in the way -- like, these are things that I should have been able do when I was growing up. And I'm so glad that I get to do it now because it's been life changing.

It's probably the best thing that I've ever done for myself.

Q. That sounds really positive. Thank you for sharing that.

Mr. Dekker, what would it have meant for you to not have obtained testosterone therapy and top surgery?

A. I would be completely -- I wouldn't be a person. I would be a statistic. I would be dead from suicide, probably, and if not suicide, then substance abuse or any number of things where that -- that people do to destroy themselves, because I didn't like myself when I was -- when I thought I was a girl.

And now I have so much love for myself. Like, it's crazy how much that I want to live now and how much that I want to see the world change and make this -- like, make it a better place. And if you told high school me that, like, I would be where I am now, they wouldn't believe you. Like, I never -- growing up I didn't expect to live past 20. And now I'm almost 30, and that's the best gift that I've ever given myself is the will to live through gender-affirming care.

Q. Thank you, Mr. Dekker.

So can you please tell me, why are you participating in this lawsuit?

A. I want to ensure that I still have access to this care. It's important to me to continue my testosterone therapy. I want to grow old and bearded and fat and happy, and I want to do that, you know, as a man in the company of men that I love. And I can see a future for myself now, and that started with

gender-affirming care.

Additionally, I'm thinking about every trans person here in Florida on Medicaid and trying to be who they need right now, because I know I'm strong enough to do this, but other people might not have that strength right now considering how much we are being attacked right now. And I want to do everything I can to make it so that they don't have to fight, because I can fight. I can fight for them, and I can fight to help them gain access or continue accessing care that they need.

MR. CHARLES: No further questions, Your Honor.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good afternoon, Mr. Dekker.

I wanted to follow up on a few of the questions from my friend about your medical history.

You were talking to my friend and you testified that before you started using testosterone you discussed the associated risks and the benefits with your physicians.

Did I understand that right?

A. Yes.

Q. And my understanding is that that discussion took about 20 minutes or so?

A. 20, 25 minutes, yes.

Q. Now, Mr. Dekker, you discussed with my friends the letters

you got before you sought your top surgery.

Do you recall that testimony, sir?

A. Yes.

Q. The second letter that you mentioned, you said that you got that letter from someone you hadn't seen before.

Did I understand that right?

A. Yes.

Q. Was that someone named Abbie Rolf?

A. Yes.

Q. I'd like to --

MR. JAZIL: And this is not for the public screen. I'd like to pull up Plaintiffs' Exhibit 237A.

BY MR. JAZIL:

Q. Mr. Dekker, would you mind taking a look at that letter? And let me know if you'd like us to scroll down. It's two pages.

Sir, is that the letter you received, the second letter?

A. Yes.

Q. And it says here on the top: *My name is Abbie Rolf, MA, Registered Mental Health Counselor Intern.*

Do you see that, sir?

A. Yes.

Q. It goes on to say, last sentence of the first paragraph: *I have personally completed 10 hours of training specifically related to assessment and letter-writing for gender-affirming*

medical interventions and provide training to others on the same.

Do you see that, sir?

A. Yes.

Q. The last paragraph on the first page, it says that: *It is my professional opinion that in this way, he meets the diagnostic criteria as defined in the Diagnostic and Statistical Manual Fifth Edition.*

Do you see that, sir?

A. Yes.

MR. JAZIL: Mr. Dekker, thank you for your time. I have no further questions.

THE COURT: Redirect?

MR. CHARLES: Just briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. CHARLES:

Q. Mr. Dekker, do you still have that letter on your screen?

A. No.

Q. Okay. We'll just pull that up, Plaintiffs' Exhibit 237A.

MR. CHARLES: Not on the public screen. Thank you.

BY MR. CHARLES:

Q. Okay. Mr. Dekker, do you see the beginning of that letter there?

A. Yes.

Q. It says: *My name is Abbie Rolf, MA, Registered Mental*

Health Counselor Intern.

A. Yeah.

Q. Do you see that?

And it says: *I am practicing under the supervision of Dr. Christina McGrath Fair, LMC (MH14339) and Nick Marzo, MS LPC, LMHC, CPCS, CST, NCC, CCMHC.*

Do you see that?

A. Yeah.

Q. Okay.

Did I read that correctly?

A. Yeah.

Q. Okay.

Is it your understanding at the time that Ms. Rolf wrote this letter that she was practicing under the supervision of Dr. Christina McGrath Fair and Nick Marzo?

A. I honestly was not aware at the time. I think Abbie Rolf made some mention that she was working with some other practitioners; however, I didn't remember their names.

Q. And if you'll look down -- hold on.

Okay. Do you see on the bottom left-hand side, Mr. Dekker, Abbie Rolf's signature there?

A. Yes.

Q. And do you see the other blacked-out box where --

A. Yes.

Q. -- there is another signature block?

Sorry. Do you see that, Mr. Dekker?
A. Yeah.
Q. And you see it says: *Licensed Mental Health Counselor?*
A. Yes.
Q. And the license number there?
A. Yes.
MR. CHARLES: Nothing further, Your Honor.
THE COURT: Thank you, Mr. Dekker. You may step down.
(Mr. Dekker exited the courtroom.)
THE COURT: Please call your next witness.
MS. DeBRIERE: Yes, Your Honor. Plaintiffs call Jade Ladue.
(Ms. Ladue entered the courtroom.)
THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

JADE LADUE, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.
THE WITNESS: Thank you.
THE COURTROOM DEPUTY: Please state your full name and spell your last name for the record.
THE WITNESS: Jade Ladue, L-a-d-u-e.

DIRECT EXAMINATION

BY MS. DeBRIERE:
Q. Good afternoon, Ms. Ladue.
A. Good afternoon.

Q. Where do you live?
A. I live in Sarasota County, Florida.
Q. Have you always lived in Florida?
A. Nope. Lived in Massachusetts and just moved down here about three years ago.
Q. And who do you live with?
A. I live with my husband and our five children.
Q. And what do you do for a living?
A. I work as a teller at a bank.
Q. How about your husband, what does he do?
A. He's disabled.
Q. Can you tell me a little bit more about that?
A. He has a venous malformation in his leg, which is an active aneurysm that keeps him from moving it. You know, he can't bend it, so if he bumps it or hits it hard enough, then it can be life-threatening for him.
Q. How long has he had that condition?
A. Since birth.
Q. And does he receive any benefits as a result of that condition?
A. Yes, he does. He gets SSI Disability.
Q. And where is your husband today?
A. He's here.
Q. You mentioned you also live with your children. How old are they?

A. We have 6, 13, 14, 16, 16.
Q. And are you the biological mom of all of the children?
A. No. So we are a blended family. Both -- my husband has two daughters with a previous marriage; I have my two sons, and then we have one son together.
Q. Is your son a plaintiff in this lawsuit?
A. Yes, he is.
Q. And what is your son's initials?
A. K.F.
Q. Where is K.F. right now?
A. K.F. is back home with his other siblings and my mother-in-law.
Q. Does your mother-in-law typically live with you?
A. No. She actually flew down to visit with them and help us out while we are here.
Q. Is K.F. enrolled in Medicaid?
A. Yes, he is.
Q. Are your other children enrolled in Medicaid?
A. Yes, they all are.
Q. Do you know why your children are eligible for Medicaid?
A. Yes. We are considered on the lower end income-wise, so we do qualify for it. Also, my job does not allow me insurance, so I wouldn't even be able to put them on if I wanted to.
Q. Does your husband have insurance through his disability benefit?

A. Yes, he has Medicaid.
Q. Is he able to add the children to that benefit?
A. No, he is not.
Q. Does K.F. receive his Medicaid through managed care?
A. Yes. It's through Humana.
Q. Ms. Ladue, can you describe K.F. for us?
A. He's amazing. He's your typical 13-year-old boy. He's very active with his friends. He's very active in sports, family, our church. He's a big part of the youth program there at our church, and really just loves being around his friends and family. It's really important to him.
Q. Can you just describe -- I don't know -- a typical day in your household?
A. So we wake up. We are up usually pretty early. We like to get up early and have our coffee, before we get the kids up, to have a little quiet time and just kind of reflect on the day. We'll get them up, get them ready for school. I get ready for work. Some of them take the bus; my husband takes some of them to school, and off to work I go. And usually after school consists of a lot of sports between all of them, or some kind of activity. Home for dinner, bed, and do it all over again the next day.
Q. That sounds familiar.
How would you describe K.F.'s relationship with Joshua?
A. It's great. Joshua has been in K.F.'s life since he was 3

years old, so that's his father. He calls him Dad. That's, you know, the person he looks up to.

Q. And, I'm sorry. Who is Joshua?

A. Joshua is my husband. Sorry.

Q. My fault.

How about K.F.'s relationship with his siblings. Can you describe that a bit?

A. Yeah. They get along really well. I guess they have their typical sibling moments where they butt heads, but for the most part they get along great. They're all pretty close in age, the four older ones. We have that little age gap with our younger guy. But they really do get along great; they do.

Q. Switching gears.

What was K.F.'s assigned sex at birth?

A. Female.

Q. Is K.F. transgender?

A. Yes, he is.

Q. What is K.F.'s gender identity?

A. Male.

Q. And when did you first learn about his gender identity?

A. He came out to us when he was 7 years old. So it's been quite a few years that we've been on this journey.

And he actually came out to my parents on -- my parents would take all the kids every summer on, like, a long weekend camping trip. We look back at it now, he's tried to tell us

many times, and I think we brushed it off. But came out to my mother originally at the pool on the camping trip.

Q. When you say that K.F. tried to tell you, what do you mean by that?

A. So for the couple years before -- and he'll tell you up until this point he's known since he was 4 years old that he was supposed to be a boy.

When he came out, he told my parents. And when they got back, we had a nice long conversation about it and, you know, told him that we'd love and support him no matter what, and that we just want him to be healthy and happy. And I think it caused a lot of anxiety and issues. And some of the things he would tell us was, you know, we'd go school clothes shopping and he'd want to shop in the boy's section, and I'm like, No, shop over here in the girl's section. And he would run around with no shirt on in the house and wear his big brother's *Star Wars* pajamas, and say, Look, I'm the boy.

And I think those are all just kind of little things that we look back now, and we're like, it makes sense. I think he was kind of trying to tell us at that point.

Q. Why do you think he came out to his grandparents first?

A. He's always had an amazing relationship with them, especially my mother, his grandmother. We lived with them for a little bit when he was really young, and just had that really close bond with my mom and dad. And I think -- I think he just

had that comfort level and knew that no matter what, Grandma wasn't going to be, like, No, no, no, you are not a boy; you are a girl. And I think that's why.

Q. And what was your -- what were the grandparents' reaction to K.F.'s disclosure?

A. At first -- so, it actually started with they were at the pool at the campground, and there was a little boy that was wearing this American flag bathing suit that he really liked, and he's like, Grandma, I want that bathing suit. And my mom was like, Well, they make girl ones, and we can look and see if maybe we can get you one. And he's like, No, I want that one. And he was very persistent about it. And he's like, You guys keep wanting me to be a girl, but I'm a boy.

And my mom is, like, What do you mean, and kind of was starting to pick his brain a little bit about it and ask questions. And brought him over to the side and just talked to him about what was going on. And he was very adamant that for years he's a boy and that we keep trying to make him a girl.

Q. And so when did you learn about this incident that happened while K.F. was camping with his grandparents?

A. So I did get a call, and she pretty much said, my mother, his grandmother did say that, you know, We need to have a conversation about something that happened. And, of course, I thought something maybe bad happened.

And, you know, once we picked him up and then we, you know,

had a good probably 45-minute conversation about everything they talked about and what happened. And, you know, then after that, I mean, they were okay with it. And I think they were a little shocked, a little taken back by it. But, once again, they are amazing and are supportive no matter what. So they just want to see their kids and grandkids, you know, happy, I think is the most important part.

But then when we got home, we had a long conversation with just myself, my husband, and K.F., and really just kind of asked, you know, What's going on? Grandma tells us that you had this conversation about how you have known for years that you are a boy and we keep making you a girl. What's going on? And he pretty much said everything that he told my mom, just that, you know, I'm supposed to be a boy, and I'm not a girl, and you guys keep wanting me to dress like a girl and act like a girl and I'm not.

We asked him how long he's been feeling that. He said, Years. He said, Four. He's like, I'm going to grow up and I'm, Going be a dad. I'm going to have facial hair and muscles, and just kind of went into all of these -- like he had this whole plan that we knew nothing about at the time. But, you know, we told him we were a little, you know, shocked, I think, by it. But now that we look at it, like I said, it makes sense, all these pieces have come together over the years.

And we told him the same thing. We were, like, you know,

we'll support you. I'm like, I'm going to get online. I'm going to do some research, and I'm going to, you know, see what we can do and kind of go from there. But I'm, like, We love you and no matter who you are, as long as you are happy and healthy, that's what's important to us. So that's kind of where we left it at that.

Q. At the time that K.F. had disclosed this to you, did he have any access to social media?

A. No. Nope. No phones, no tablets, nothing. Actually, the only thing he had was a little LeapFrog video game thing with ABCs, and kind of -- I call them little kid games, but nothing -- no social media whatsoever.

Q. Remind us how old he was at the time?

A. 7.

Q. And prior to coming out, did K.F. have any awareness of a transgender identity, what that meant?

A. No. Actually about a week later, after doing some research and -- you know, I did, you know, sit down and talk to him and, you know, let him know there is something called transgender. He had no idea. Completely clueless to what it was and what it meant. And I was like, you know, There's a group of people, kids, adults that, you know, are born in one sex but identify as the opposite sex. And he was -- it was mind blowing to him. He was like, Oh, my goodness, there are other people out there like me. He was just very -- I think a sense of comfort knowing that

he wasn't alone. So, yeah, he was actually really excited about it.

Q. So you'd mentioned that after he came out to you, you went online and did some research.

And then what happened next?

A. So literally right when our conversation was done, I'm Googling -- you know, I've heard of transgender people. I wasn't really familiar with them. I wasn't sure if kids this young can identify as transgender. I knew older people did.

So doing research, I did realize that there was a lot of young -- even younger than 7., and found a therapist that was local to us, called her office. Ilene her name is. And we pretty much got right in there. I think it was within a week we had an appointment.

And, you know, like what any parent would do, you want to get your child help; you want to make sure that they're getting the treatment that they need and just to make sure there wasn't anything else going on that maybe we didn't know about.

Q. So at the time what state did you live in?

A. Massachusetts.

Q. Thank you.

Can you describe that first appointment with the therapist that K.F. had?

A. It was great. We were there for quite awhile. She was really nice. She actually works with adolescents and teens,

transgender or gender dysphoria. And she was very knowledgeable.

She, you know, just gave us a lot of reassurance that, A, you are doing the right thing by reaching out and trying to meet with a counselor, therapist. She gave us some resources such as PFLAG, which is a, you know, support group, which we did find one local to us, and also mentioned that there was a couple of hospitals in Boston that also had gender programs that we could maybe try to get on the list for there.

Q. Backing up just for a second, Ms. Ladue, prior to age 7 did K.F. have any mental health issues that concerned you?

A. Yeah, we had a lot. We had for years what at the time we were kind of calling night terrors and upset stomachs. When his anxiety gets really high, he would always get upset stomachs. He has a fear of throwing up, so it would trigger a whole new ballgame there.

And we met with neurologists. We had EEGs done, sleep studies done, gastroenterologists. We had him on, you know, an upset -- antacid kind of medicine for a little bit, which did help a little bit but not anything -- once he actually came out, I think it was, like, a big weight off his shoulders that, All right. They know who I am and who I'm meant to be. And I think that was kind of, you know, the turning point for his anxiety. It really did help, so --

Q. So -- I'm sorry to interrupt that.

So going back to this first appointment, did you talk about any of those issues with the therapist?

A. Yes. Yep, we did talk about them because the night terrors were the big thing. Every night he was up having what they thought might have been some kind of sleepwalking seizures or -- you know, they weren't sure what it was. That's why we did the EEG and sleep studies.

But, you know, we did talk to her about that, and, you know, she did let us know that a lot of kids who aren't out yet to their family and friends do suffer a lot of anxiety and depression, and it could be a part of it. But she's, like, You know, that's not for me to necessarily say. You've got to kind of see how things go and meet with psychologists and -- but she's like, I see it all the time in the young adolescents and teens, that she works with.

Q. Did K.F. have any questions for the therapist -- for Ilene?

A. Yeah, he did have a couple. I guess his first thing was that, you know, he's excited that there was other people like that, because she did explain that she works with kids that are kind of going through the same thing that he's going through, and he was very excited about that and really wanted to kind of get into a group with other kids that were like him. That was really important, which we had a lot of trouble finding groups at that age. A lot of it was 13 and up, like, teens and stuff. So he was pretty bummed about that. But, you know, when he was

going to get facial hair, like all those kind of, you know, questions and, you know, What's next and when do I get to see the doctors? Stuff like that.

Q. So after that first meeting, how often did K.F. go to therapy?

A. Weekly. We did see weekly until we got into Boston GeMS Hospital, which is their gender program, and then we kind of started seeing her occasionally and still kept in touch, you know, for a while via text message. She just wanted to see how he was doing and just some updates once he got, you know, plugged in with generals.

Q. What was the space -- how much time between when he first had the meeting with the therapist and getting into the GeMS program?

A. It was only a couple months. They had a cancellation. We were on almost a year waitlist, and they called me, and they were like, We have an appointment next week. I'm like, I'll take it.

Q. During that time between the first therapist meeting and going to GeMS, he met with the therapist weekly?

A. Yes, yep.

Q. What did the therapist conclude about K.F.?

A. She did say K.F. did have some gender dysphoria, and that, you know, although he is young, he's definitely presenting transgender and, you know, with that gender dysphoria and the

fact that he was very convinced that this is who he was and that he was a boy and -- but, you know, she was like, Time will tell. He's young, so, you know, you've just got to kind of see, you know, how it goes over the next couple of years and go from there.

Q. Other than GeMS, did the therapist make any other kind of recommendations about K.F.'s treatment?

A. Not really any recommendation other than, like, meeting with -- PFLAG is a parent support group, because it was important for me to reach out to other families that were kind of going through the same thing I was and -- which PFLAG was amazing.

And she did say that she wanted us to meet with the doctor and psychologist; that maybe there is some kind of medication that they can give him to help him out with his anxiety and depression. So that's definitely something we followed up on when we were at GeMS.

Q. What grade was K.F. in at the time that he met with the therapist?

A. It was actually the summer going into second grade.

Q. Okay. Did the therapist have any recommendations about that following school year?

A. Yeah. She actually -- she actually recommended setting up a meeting with the school and -- just to let them know kind of what was going on, because K.F. did go there for kindergarten

and first grade and presented more female, and he was very adamant that he wanted to use "he" and "him" pronouns. That was a huge thing for him.

So she actually went with me, and we went to the school and met with the principal, the assistant principal, the school nurse, and the school psychologist, and just kind of let them know a few weeks before school started, like, you know, this is, you know, K.F. and that, you know, he's now presenting male. You know, he's dressing more male; he has got a shorter haircut and really wants to use the he/him pronouns and for people to use male pronouns when addressing him. And the school was great.

She actually goes around Massachusetts and advocates at schools, so she was very knowledgeable and was able to give us some insight, which luckily his school was great. We didn't really have many issues at all. You know, they said he can use the gender neutral bathrooms or the teacher bathrooms that are, you know, both sexes, and once he's comfortable using the boy's room, that's okay. He can use the boy's room. So it was a really smooth transition for us, I think.

Q. And just to be certain what about what you said.

So when he was in first grade, he was identifying female still?

A. Yes.

Q. But in the second grade he started identifying --

A. As a male.
Q. -- with the gender he aligns with; is that right?
A. Yeah.
Q. How did that school year go? How did that second grade year go?
A. It was probably one of the best years he's had. He loved it. And I think kids, when they're that young, they are so -- that doesn't matter. It doesn't matter if you're wearing different clothes or have a short haircut. That's just -- they are, like, Hey, K.F., let's go. Let's go play. You know, they're so, I think, naive at that age that that doesn't bother them. I think, you know, middle and high school gets a little more tricky with stuff like that, but his friends are really supportive. He had an amazing teacher that was supportive, and K.F. had a great year that year.
Q. Did K.F. have a different name at birth?
A. Yes.
Q. When did K.F. start using his preferred name?
A. Well, K.F. had a nickname that we kind of all in the family called him anyway, and that kind of stuck. You know, the siblings, my husband and I, even friends would call him that. So we just kind of kept with it and just kept it, and it kind of worked.
Q. Well, I mean, so your child is going through a lot; right? They're changing the way they dress; he's cutting his hair; he

changes his name.

So what reaction are you and your husband having to all of this?

A. I mean, we -- we support it. We -- and from day one, we've told him, you know, he's the same person. He's totally the same person he was before, other than he has short hair and he dresses more manly. He's got the same personality; he's bubbly; he's outgoing; he has got a lot of friends. Like, it's just -- you know, the hair grows back. You can change your clothes. That -- it's just -- yeah, it was okay.

You know, I think the hardest part for us was, you know, the pictures, you know, because at one point he did ask us to take down the girl pictures and that he didn't want those up there anymore, and we did. You know, we got some new family pictures and, you know, some new pictures that we put up around the house, and that just made him really happy.

Q. So you had mentioned the Boston Children's Hospital GeMS program.

Can you tell us a bit about that?

A. Yeah, it's -- I forget exactly what it stands for, but it's a gender program. They have doctors and psychologists there or nurse practitioners that work under doctors and psychologists, and it's really great.

Our initial -- first appointment was what they called the two-hour psych evaluation, where we went in there and met with

their psychologist, Colleen, who was amazing. She pretty much brought us all in, talked to us, you know, talked to my husband and I separate, then talked to K.F. separate, then, you know, brought us in again and worked a lot with -- I think they call it play therapy with coloring and, you know, just trying to see what's going on and, you know, see if there is any other underlying issues that might have been going on.

And, you know, what kind of concluded from that was -- you know, Colleen has worked with transgender kids even younger than K.F. and, you know, he definitely was very adamant and persistent that this is who he is, and that, you know, he's going to grow up and be a dad; and, you know, he never was a girl so -- but where he was so young, she even said, you know, this is something we've just got to see how the next couple of years go and, you know, just follow up with us and the doctor here and just kind of take it slow and just, you know, hope that everything goes smoothly.

Q. And, again -- I'm sorry for this -- remind me K.F.'s age when you first started at GeMS.

A. He was 7. I think he, like, just turned 8 or was about to just turn 8, yeah.

Q. Okay. And what was K.F.'s reaction to this first appointment?

A. He was actually really excited. You know, he always was very afraid of doctors and needles and all that stuff, but I

have to say for someone who gets blood work pretty much every six to eight months, he goes in there and is like, Let's do this. This is going to help get to where I need to be. And just the confidence knowing that there was going to be a good outcome with it I think made him feel more positive that -- and made us -- reassured us that we were doing the right thing, because, you know, we'd have to drag him into the doctor's office before, and now it's like, Let's go. So I think it was really helpful.

Q. And who did K.F. primarily seen at GeMS?

A. Colleen, the psychologist, and then Sarah Pilcher, which is the nurse practitioner there.

Q. And how long did K.F. receive therapy at GeMS?

A. Let's see. '17 -- so probably like four or five years, until we moved to Florida. '17, '18, '19, '20 -- yeah, very well five years. I had to think about that. Sorry.

Q. Did you receive any other kind of treatment at GeMS?

A. We did have -- in August of 2020, he did have his first hormone blocker put in.

Q. And how old was he in August of 2020?

A. Almost -- right before his 11th birthday.

Q. So tell me about what led up to that. What kinds of discussions did you have with what providers at GeMS?

A. So we were on a regular basis, every couple of months, meeting with the psychologist and the nurse practitioner, Sarah,

there. You know, we did a little -- in the beginning, it was mainly just meeting with them, checking for, like, breast development. In our family, female puberty starts pretty young, and, you know, I did tell them that. And he was very afraid of that, of getting his period, getting boobs. So when he started turning 10, we would start doing blood work.

We also did -- I think it's called a DEXA scan and his hand X-rayed to see where his growth plates were at, and then once he got to that Tanner Stage 2 is when they said that he is now ready for the hormone blocker.

Q. Okay. I think you mentioned he received an implant; is that --

A. Yes, a Supprelin implant.

Q. Do you know why they recommended a Supprelin implant for the blocker?

A. The Supprelin implant was going to be a little bit easier for him versus coming in every couple of months for a shot. That way we can kind of put it in, get a few years out of it, and not have to drive into Boston. We were a little ways from the hospital, so, you know, we didn't want to have to go there more than needed, I guess you could say.

Q. And, Ms. Ladue, I'm sorry for this, but I just want to go back to when K.F. initially met with Colleen when he was 7, almost 8.

Did Colleen provide any kind of diagnosis to K.F -- for

K.F.?

A. Yeah. She did say that he did have some gender dysphoria. He was very afraid of turning into a girl, as he used to say, and that was a big thing. She's worked with a lot of kids very young and, you know, said that he was definitely presenting more transgender and gender dysphoria, so -- but where he was so young, it was just a matter of kind of following up, because there was no major interventions or medications at that age. It wasn't until years later that we had to worry about that.

And then when time came, they actually provided a whole seminar on the different kinds of blockers that they had. They, you know, told us about the different ones. There was the psychologist doctors and nurse practitioners at this seminar. So they let us know the good, the not so good, you know, the risks, the side effects, the -- you know, the rare side effects. It was a really thorough thing that my husband and I went to, which was very helpful for us too.

Q. Do you remember any of the side effects or risks that they talked about at that seminar?

A. Yeah. Some of the side effects and risks long-term could be osteoporosis, you know, bone developing, growth developing you know, infections, you know, body rejecting it, you know, and then, you know, some of the rare side effects that could lead to a lot worse.

Q. Did anybody have a conversation with K.F. about the

potential for side effects with the Supprelin implant?
A. Yes. Actually, the doctor and Sarah Pilcher, the nurse practitioner, and Colleen, the psychologist, both did have a conversation, a couple of them actually, before it was decided.
Q. And did K.F. have any questions or concerns for either the doctors or you?
A. Yeah. I think, you know, K.F.'s big thing, was it going to hurt, you know, and, Am I going to feel anything? And, you know, sometimes they do it in office, but they did give him -- I forget if it's like a local, pretty much put him to sleep local, so -- and he was in and out of there in probably 10, 15 minutes and woke up and didn't feel anything.
Q. After receiving the initial Supprelin implant, did K.F. show any side effects?
A. Nope, no side effects. The only thing that -- until this day is you can't touch it, because it feels likes a spaghetti noodle in his arm and he gets all freaked out. But other than that, there is no side effects. He's actually -- his anxiety is a lot less. He's such a happy kid, and I think that just kind of reassures us that we're making the right decision; that this is who he is and what he needs so that, as he says, he doesn't become a girl.
Q. What is your understanding of what the Supprelin implant does?
A. Pretty much just blocks the female hormone and -- so he

doesn't develop female puberty.
Q. And how long does a Supprelin implant last?
A. Usually anywhere between a couple to a few years. It just depends. And like I said, we follow up every, like, six to eight months with blood work just to make sure that his hormones are still being suppressed.
Q. This implant that occurred at GeMS in Massachusetts, how did you pay for that implant?
A. It was actually Mass Health, which is like Florida Medicaid, covered it.
Q. When you decided to move to Florida, did you do anything to plan for K.F.'s continued care here?
A. Yes, we did a lot of research. We actually wanted to move down years before, but, you know, with K.F. coming out, we really wanted to stick with the doctors and with everything that we had there.
So when we decided -- you know, started talking about moving down here, I did a lot of research of all the hospitals, a lot of online support groups that I'm a part of, just to try to make sure that we could find the right one, which we did at John Hopkins All Children's Hospital in St. Pete, which is where we found Kevin Louis, who is currently K.F.'s doctor.
Q. How much time passed between when K.F. received his initial Supprelin implant and moving to Florida?
A. We had that implant done just a few months before moving

down here.
Q. And what -- just so I can keep it straight in my head, what month was that?
A. I want to say it was August of -- or July -- it's either July or August of 2020 we had it done, the implant, and then we moved down here at the end of September, beginning of October.
Q. You just mentioned Kevin Louis at John Hopkins All Children's Hospital. Do you know what kind of credentials Mr. Louis has?
A. Yeah, he has a doctorate in NP, nurse practitioner.
Q. Describe the care at John Hopkins that you received.
A. They were great. They have -- well, I should say they did have a gender program up until this past fall when they closed it down just due to all the legislations and bills that have been going on.
He works under an endocrinology department. They've been great. Their whole team is amazing. You know, they specialize in working with transgender and gender dysphoria kids.
So pretty much our first -- initial appointment was just in there kind of getting to know each other, you know, have all of our records from Boston Children's sent down, and just kind of getting to know them, and then we followed up six months later. And, you know, he was great, very informative, very helpful and -- yeah.
Q. Yeah. Has K.F. had another implant since moving to

Florida?
A. Yes, he did just have his second one put in in April of last year.
Q. Kind of similar to what you described to us for GeMS, leading up to that second implant can you tell me what you talked about with the providers, what steps you had to undertake?
A. Yeah. So we had some blood work. They thought it was a little different that, you know, he only had it for about a year and a half, but it looked like his hormone levels were elevating a little bit, which made them nervous, meaning that the blocker wasn't working as good as they'd like it to. So that's when we started submitting everything for insurance to get Humana Medicare to pay for it. And we did blood work -- same thing. They did the hand X-ray too just to make sure that -- it was, you know, a couple year difference from his last one that he had.
Q. And, Ms. Ladue, I heard you just say "Humana Medicare."
Was it Humana Medicare that covered K.F.'s implant?
A. Medicaid. I always get them fixed up. I apologize.
Q. That's fine. A lot of people do.
After the second implant, were there any concerns that you had about it or that K.F. had about it?
A. No. The doctor was -- we were a little concerned because the initial implant that he had was actually disintegrated in

his arm, which they said does happen, not often. So that does mean that he may need to have more than what -- you know, more often versus, you know, some people get years out of it. And we only had about two years.

Q. You know, I'd like to know -- so throughout this whole process, you've been discussing the risks associated with the treatment that K.F. is receiving, in particular the Supprelan implant.

Why did you decide to have K.F. receive the implant? Why did you consent to it?

A. Because the benefits really outweighed the risks. This was someone who suffered a lot of anxiety, a lot of sleep issues. It was to the point where I was getting a call at work three days a week saying he can't be in school because his anxiety is through the roof.

And I think, yeah, you look at long-term effects of maybe some osteoporosis or some of the effects that they do talk about, but I think it was really important for not only his mental health, but to reassure him that I'm not going to let him go through female puberty if we can help it.

Q. Now that Medicaid has stopped covering his Supprelin, how are you going to be able to pay for it?

A. I don't even know. As a lot of people know, Supprelin implants are very, very expensive, and financially we just wouldn't be able to afford that.

So now that we are just over a year -- it was about this time, you know, about a year and a half in, that we realized his other one wasn't working well, and we actually just had his last appointment with Kevin Lewis last week. They are no longer going to be able to see any transgender kids anymore.

Q. Is K.F. ready to start hormones?

A. Yes. He was actually supposed to start them this month, and, unfortunately, with their gender clinic closing down, they are no longer able to see him. They won't prescribe it. And you know, he felt horrible. You know, I think the whole -- Kevin Lewis and everyone that works with him are just as mad and outraged about everything that's going on. But there is no point of him starting it to potentially not get it next month. So, you know, we got to wait to see what happens and just pray for a good outcome.

Q. And if K.F. can access hormones in Florida, how will you pay for them?

A. Hopefully through insurance.

Q. If you didn't have Medicaid coverage for K.F., would you be able to pay for the hormone?

A. No. We'd be forced to leave the state.

Q. You earlier testified that your other children are Medicaid enrolled.

Are they able to receive all the health care their providers have recommended for them?

A. Of course, yes, they are.

Yep, they can receive everything no problems. You know -- and it's very unfortunate that just because someone has gender dysphoria or transgender that they can't receive the medication that's necessary for them.

Q. Does K.F. know why you and your husband came to Tallahassee this week?

A. Yes. Yes, he does.

Q. How does he know?

A. Before we even agreed to do any of this, we sat down with all the kids and talked to them and let them know that, you know, if we try to fight this, we can hopefully make a change and, you know, get the help and the care that he needs. And he was actually like, Let's do this. Like, he wanted to be here today, but we really -- I didn't feel comfortable with him, you know, being a part of it all, so he is back home. But, yeah, they are all very aware of why we're here and what we're doing.

Q. So do his siblings know about what's going on here too?

A. Yep. Yes.

Q. And how do they feel about it?

A. They are fine. They are, like, you know, Go you. Yeah, they're really excited that we're, you know, trying to fight this. And, you know, I think it's important because -- not only for K.F., it's also for transgender people. I mean, everyone deserves to have the medication -- the lifesaving medicine that

is necessary for them.

You know, as you just heard all this talk -- like, all the stuff that you go through and all the heartbreak and the body dysphoria and -- you know, I've been very fortunate that K.F. came out at a younger age, that, you know, we are able to get him these blockers so that he doesn't have to go through that. And it's so important.

Q. If K.F. couldn't access this care, what do you think would happen to K.F.?

A. I don't even know. I think he would be very upset. I can tell you right now if he had to go through female puberty, he would be devastated. And I just pray that I never have to witness or see that.

Q. Ms. Ladue, one final question.

What do you hope -- as K.F.'s mom, what do you hope for his future?

A. I just want him to be happy, and -- sorry.

I think they deserve to be who they are. And, you know, no one that is not in our situation should be able to dictate what medical care and what medicine is good for them. That is between us, the parents, the person, and the doctors, and I think it's so important that people remember that, you know.

And, unfortunately, a lot of it comes down to politics, and it's just -- I just want to him to be happy and healthy, and that's all I care -- I don't care who he dates. I don't care

who he is, because he's the same person. He just looks a little different.

So I think everyone -- everyone needs to realize that, because this is not a choice for them. This is who they are, and I think that's just something people need to know.

Q. Ms. Ladue, thank you so much for your time today.

A. Thank you.

Q. I'm going to sit down, and Mr. Jazil will stand up.

A. All right. Thank you.

THE COURT: Cross-examine.

MR. JAZIL: No questions, Your Honor. Thank you.

THE COURT: Thank you, Ms. Ladue. You may step down.

(Ms. Ladue exited the courtroom.)

THE COURT: It's probably time for the afternoon break. Tell me where we are.

MR. GONZALEZ-PAGAN: Your Honor, with apologies to the Court, we are actually a little bit in a holding pattern. The only witnesses we have left are the ones that are -- that we mentioned earlier today that we have reset for Wednesday of next week.

THE COURT: If it was a jury trial, I'd say, So you rest? But that's fine.

So you're through today?

MR. GONZALEZ-PAGAN: We're through, and then we will be presenting our next three witnesses on Wednesday that we have

rescheduled. And then my friend's side can present their case.

THE COURT: That work?

MR. JAZIL: Yes, Your Honor.

THE COURT: Yeah. It works better. The people on the other side are the ones in town, so they can go back and work on something else. I understand Mr. Jazil has another case or two.

So Wednesday morning, 9:00 o'clock.

And then you've got -- so give me a heads-up what that means in terms of the whole case. I think I've got sentencings the week after that. And then they, of course, take back seat to trials, so they can easily get moved if they have to. But I try to give people as much advance notice as I can.

MR. JAZIL: Your Honor, I have four expert witnesses and two fact witnesses. One of the fact witnesses will be rather short. The other fact witness I expect to take the better part of the day.

So --

THE COURT: The experts, you were saying maybe half a day?

MR. JAZIL: Yes, sir.

THE COURT: That's probably on the high side.

MR. JAZIL: Half a day each. I'll try to streamline as much as possible, Your Honor.

MR. GONZALEZ-PAGAN: We thought they would be a half a day each ourselves.

THE COURT: It sounds like it's possible we'll finish next week and possible we won't.

MR. JAZIL: Yes, Your Honor.

THE COURT: That's probably as good an estimate as anybody can make at this point.

Very good. Have a pleasant weekend, I guess. For those of you, if you are traveling, travel safe, and we'll see you back here Wednesday morning.

(Proceedings recessed at 3:33 PM on Thursday, May 11, 2023.)

* * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy is noted within the transcript.

/s/ Megan A. Hague 5/11/2023

Megan A. Hague, RPR, FCRR, CSR Date
Official U.S. Court Reporter

I N D E X

E X H I B I T S

Doc. 229

Dekker v Weida: 4:22-cv-325

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE, FLORIDA

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
vs.	)	Tallahassee, Florida
	)	May 17, 2023
JASON WEIDA, et al.,	)	9 A.M.
	)	
Defendants.	)	
_____	)	

VOLUME IV
(Pages 712 through 251)

TRANSCRIPT OF FOURTH DAY OF BENCH TRIAL
BEFORE THE HONORABLE ROBERT L. HINKLE,
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiffs,

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.org
120 Wall Street
19th Floor
New York, New York 10005

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

APPEARANCES: Cont'd

For the Plaintiffs:

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: SHANI RIVAUX
Attorney at Law
shani.rivaux@pillsburylaw.com
600 Brickell Avenue, Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall, Suite 1800
Sacramento, California 95814

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: WILLIAM C. MILLER
GARY J. SHAW
Attorneys at Law
william.c.miller@pillsburylaw.com
gary.shaw@pillsburylaw.com
1200 17th Street NW
Washington, D.C. 20036

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorneys at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DeBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

National Health Law Program
By: CATHERINE ANNE McKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

APPEARANCES: Cont'd

For the Plaintiffs:

National Health Law Program
By: ABIGAIL K. COURSOLLE
Attorney at Law
coursolle@healthlaw.org.
3701 Wilshire Boulevard
Suite 315
Los Angeles, California 90010

For the Defendants:

Holtzman Vogel Baren,
Torchinsky & Josefiak, PLLC
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(Call to order; all parties present.)

THE COURT: Good morning. Please be seated.

MR. GONZALEZ-PAGAN: Good morning, Your Honor. Omar Gonzalez-Pagan for the plaintiffs. Ms. Rivaux will be conducting the examination.

THE COURT: Please call your next witness.

MS. RIVAUX: Good morning, Your Honor, we will be calling Dr. Edmiston.

DEPUTY CLERK: Please raise your right hand.

ELLIOT KALE EDMISTON, PLAINTIFFS' WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: My name is Elliot Kale Edmiston, E-l-l-i-o-t, K-a-l-e, E-d-m-i-s-t-o-n.

DIRECT EXAMINATION

BY MS. RIVAUX:

Q. Goo morning, Dr. Edmiston. Can you please state your profession.

A. I'm a neuroscientist and an associate professor of psychiatry.

Q. And can you please describe for the court your education and training.

A. Certainly, yes. I received a Bachelor's degree focused

in the cognitive science from Hampshire College. I then went on to the Yale School of Medicine for three years of additional training in a lab focused on mood disorders and adolescents.

I then attended Vanderbilt University, where I completed a Ph.D. in neuroscience. I went on then to China Medical University for a postdoctoral fellowship, returned to the United States, completed an additional postdoctoral fellowship at the University the Pittsburgh, and in 2019 I was promoted to assistant professor of psychiatry at the University of Pittsburgh.

Q. And what positions do you currently hold?

A. Currently I am an associate professor of psychiatry at UMass Chan Medical School.

Q. And what type of work do you do in your current role?

A. I run a research lab that focused on human subjects research in mood anxiety disorders, particularly in young adults, adolescents, and youth, and I'm interested in the neurobiology of mood and anxiety disorders as well as risk factors associated with them, like stress.

Q. Have you published any scholarly articles?

A. Yes.

Q. And are they peer-reviewed articles?

A. Yes. I've published approximately 50 peer-reviewed articles.

Q. And in addition to the works that you published, are there any other professional works that you've authored relating to transgender health issues?
A. Yes. I have published two book chapters related to transgender health. I was also a coauthor of the adult assessment chapter for the WPATH Standards of Care, Version 8; and I currently have two publications that are under revision related transgender health. One is an article discussing how stress affects the mental health of trans youth, and the other is an article about impulsivity in adolescent decision-making as it pertains to gender-affirming hormone care.
Q. Are you being compensated for your time here today?
A. Yes.
Q. And does your compensation in any way depend on the outcome of this litigation or your testimony?
A. No.
Q. And, Dr. Edmiston, did you provide a copy of your CV with your expert report in this case?
A. I did.
Q. And is that CV a present and accurate summary of your qualifications and professional activities?
A. Yes.
MS. RIVAUX: Dr. Edmiston's CV is Plaintiffs' Exhibit 357. It's among the stipulated exhibits, and I would

like to move that into evidence.

THE COURT: Plaintiffs' 357 is admitted.

(PLAINTIFFS' EXHIBIT NO. 357: Received in evidence.)

MS. RIVAUX: At this time I move to have Dr. Edmiston qualified as an expert on adolescent decision-making and the effect of gender-affirming care on the brain.

THE COURT: Questions at this time?

MR. BEATO: No, Your Honor.

THE COURT: You may continue, but before you do, let me ask a question before I forget it.

The last article I think you mentioned was adolescent decision-making as it pertains to transgender care. If I understood it right, that is under submission. Does that mean it's submitted for peer review but not yet peer-reviewed and published?

THE WITNESS: It's currently being peer-reviewed, so it's been submitted but not published yet, correct.

THE COURT: You may proceed.

BY MS. RIVAUX:

Q. And so, Dr. Edmiston, I would like to talk to you. The Court has heard a little bit about adolescent decision-making.

And in your field of work, are you familiar with a body of research pertaining to decision-making by adolescents?

A. Yes, I am.

Q. In adolescent decision-making, what does the research tell you about the importance of the context and the circumstances surrounding the decision-making?

A. The context with regard to impulsivity and adolescent decision-making is incredibly important. So we do know that adolescents in certain contexts tend to be more impulsive than adults, but the context is really important here.

So in a cold context, a context where there is time to make a decision, a context where the decision-making is being supported by adults, the research shows that adolescents are capable of adult-like deliberative decision-making.

Where we see the impulsivity come into play is in these hot contexts. So that would be a context where there is pressure to make a decision quickly or when the adolescent is surrounded by peers. So these would be things like driving recklessly or using substances or alcohol. Those would be the hot contexts where adolescents tend to be more impulsive.

Q. How does this research that you work with regarding adolescent decision-making relate to the context of adolescents making decisions regarding gender-affirming medical interventions?

A. So gender-affirming care, medical decision-making is not a hot context. It's a cold context. It's a context where decision-making unfolds over an extended period of time, and that decision-making is supported by caregivers and medical

professionals.
Q. Can you describe for the Court a little bit more about the type of research that's been done about adolescent decision-making in the medical context?
A. So there has been research as it relates to gender-affirming care, decision-making adolescence. There is a study by Bauer, et al., that demonstrates that on average, adolescents take about three years between when they realize that they are trans and when they come out to their parents. And so to me, that's quite a long bit of time. That's not an impulsive decision.

There's also been some qualitative research interviewing trans youth, their parents, and their medical providers about the decision-making process. That's a Daily 2019 article. And it shows that adolescents really value the input of adults when they are making these medical decisions, and that parents feel that the ultimate decision is really up to them.
Q. Can you explain a little bit --

THE COURT: Let me stop there just to keep the record. It's "really up to them."

THE WITNESS: I'm sorry. The parents feel that they have the authority to make the decision, the final decision.

THE COURT: The parents do?

THE WITNESS: The parents do, yes.

BY MS. RIVAUX:

Q. And this protracted time frame, what is the significance of that particularly in the context of gender-affirming care?
A. Well, it just demonstrates that it's not an impulsive decision. It's a decision that unfolds over an extended period of time. So, you know, on average, three years between realizing that one is trans and coming out to a parent; and then from there, the parents and the child have to have, you know, a conversation about what to do with that information, you know, and that could take months or even years depending on sort of where the parent is at.

And then from there, they have to navigate the healthcare system, you know, find a provider, make an appointment. And then from there, they are going to be evaluated for their readiness for treatment by the provider. So that can also take months or potentially years. So it's really an extended process.

Q. And the defendants in this case make a claim that adolescent brains are insufficiently developed to make medical decisions in the context of gender-affirming care or with their caregivers and professionals.

How do you respond to that claim?

A. I would say certainly that the adolescent brain is still developing, but the studies show that it's really in this hot context where we are seeing this sort of difference developmentally between adolescents and adults. So I don't

think the evidence supports that claim.
Q. Is there any scientific literature that supports the proposition that, when it comes to adolescents making healthcare decisions for treatment for gender dysphoria, that they are actually making an impulsive medical decision?
A. No.
Q. So I would like to turn -- the Court heard a lot of testimony about puberty blockers, GnRHa, and I would like to talk to you a little bit about that right now.
Are you familiar with the body of scientific literature that studied the effect of puberty blockers on the brain in adolescents?
A. I am. There's animal studies and also some human studies.
Q. And when we are talking about these studies, are these all studies in peer-reviewed scientific literature?
A. Yes.
Q. And before we turn -- because I do want to talk to you about the animal studies and the human studies, but before I turn to that, I want to ask you:
Based on your assessment of the literature, is there any basis to suggest that there's -- that you could conclude that the effects on the brain are harmful?
A. No.
Q. At the same time, can you say that GnRHa or puberty

blockers have no effect on the brain?
A. No. These are medications that have an effect on the brain, that have an effect on the body, and the effect that they have is the intended effect, that it reduces sex differences.
Q. And defendants have suggested that we need more studies in this field. Does that mean doctors should not prescribe puberty blockers based on your assessments of the scientific literature?
A. No. As a scientist, we tend to be very curious, and we always want to do more research. But the preponderance of the evidence suggests that this is a safe medication that should be used.
Q. And are you familiar with any literature that talks about the impact on the brains of adolescents of untreated gender dysphoria?
A. I'm sorry. Could you repeat that?
Q. Sure. I was asking if you're familiar with the body of scientific literature that discusses the effects on the brain of untreated gender dysphoria?
A. So we know from the literature that untreated gender dysphoria is associated with anxiety and depression, and that treated gender dysphoria is associated with an improvement in anxiety and depression symptoms and a reduction in suicidality.

We also know that, when anxiety and depression are left untreated, particularly during adolescence, a time of neural plasticity that this can be associated with detrimental effects on the brain. Specifically, the brain is flooded with stress hormones, and the stress hormones can damage the brain and also set these adolescents on a developmental trajectory where they are more likely to experience repeated depressive episodes.

So this is called the "kindling effect," and it's the idea that, with each successive depressive episode, you are more likely to experience episodes in the future, and that's because of the effects of this on the brain.

Q. I want to turn now if we can shift gears to talk about some of the specific studies. You mentioned that there were animal studies that looked at the effects of GnRHa on the brain.

Are you familiar with those studies?

A. Yes. There are some sheep studies, a rodent study, and also a nonhuman primate study.

Q. And when we talk about the animal studies, are there known limitations when assessing animal studies?

A. Certainly. All studies have limitations; and that's why, as a scientist, we look at the literature as a whole to draw conclusions.

In particular, animal studies have the limitation that --

you know, rodents don't really have the complex social identities that humans do, so we can't really model a trans identity in a rodent, because they don't have a sense of themselves as being a particular gender.

At the same time, we can't necessarily directly measure things like anxiety and depression in animals. You know, in a human study, the type of work that I do, we can just ask people directly about their mood and about their level of anxiety. But for animal studies, we have to observe their behavior and project humanlike traits onto animals. So that's why in animal studies, it is important to always that a behavior is anxiety-like, because it's not really clear that a mouse experiences anxiety the way that a human does.

Q. Let's talk more specifically about those animal studies, then.

Are you familiar -- you mentioned some sheep studies. Can you talk to the Court a little bit about what the sheep studies looked at and what they concluded?

A. Certainly. So there are a series of sheep studies from a single group, and they were interested in assessing the effects of GnRHa on spacial cognition. So in these studies, they had half of the sheep treated with the GnRHa and half were untreated, and then they built a maze for the sheep and had them navigate the maze, and timed how long it took them to complete navigating the maze as a measure of their spacial

cognition.

And those studies show that there is no effect of GnRHa on spacial cognition, and that there is no effect of GnRHa on learning. So they had -- in one study they had the sheep navigate the maze repeatedly in a short period of time, and they showed that all of the sheep were able to navigate the maze faster with each attempt.

There was one finding in one of the studies that looked at long-term memory for the maze, and they had the sheep complete the maze at 27 weeks and then again at 41 weeks. And at the 27-week mark, they found that there was one area of the maze where the GnRHa-treated sheep spent a little bit longer in that part of the maze.

They also found that the GnRHa-treated sheep were vocalizing more in that part of the maze. And so they weren't able to conclude necessarily that this was due to an effective GnRHa on cognition, that there were alternate explanations that were also possible as well.

Q. And you mentioned that they did this same experiment at the 27 weeks and again I think you said 41 weeks.

Was there any difference in the 27 and the 41 weeks?

A. Yes. The difference was no longer present at 41 weeks, so it resolved.

Q. You mentioned also a rodent study. Can you tell the Court about the rodent study and what they studied and what

the conclusions were of that study?
A. Yes. That was the Anacker study, and they were interested in assessing the effects of GnRHa on behavior in rodents. So in that study, they had male and female rodents and they treated half of them with GnRHa and half were left untreated; and then they ran a series of different behavioral assays that are very common in the rodent literature. And what they found was that GnRHa did exactly what we would expect it to do.

Specifically, that in the untreated male and female mice, there were sex differences in their behavior, and that those sex differences were reduced with GnRHa treatment. So, again, this medication that is intended to reduce sex differences reduced sex differences.

Q. And so can you explain a little bit what that means by "sex differences"? There are some -- some of the defendants have claimed that -- the experts have claimed that these are side effects. Can you explain a little bit more about what those sex differences are and what you -- how you respond to the claim of these are side effects?

A. Yeah, certainly. So, medications have effects, and the determination of what is an intended effect and what is a side effect is contextual. So in the case of GnRHa treatment for trans youth, the purpose of the medication is to minimize or reduce side effects or reduce sex differences. And so

when we see that in the rodent study, that's not a side effect. That's the intended effect of the medication.

Q. And the defendants have used this rodent study and some of the sheep study to suggest that GnRHa shouldn't be prescribed because of these side effects. How do you respond for what they claim to be side effects?

A. I would respond that these aren't side effects, and that the medication is working as expected and as intended.

Q. You mentioned also a primate study. Can you tell the Court a little bit about what was studied there and what the findings were?

A. Yeah. So that would be the Godfrey 2023 study. That study is very complex. But in that study, they took advantage of the fact that nonhuman primates form social hierarchies that are more akin to humans. So they live in groups, and there are some of the monkeys that are dominant and some monkeys that are subordinate that are essentially bullied by the more dominant monkeys.

And in this study they gave half of the monkeys GnRHa treatment and half were left untreated. They had them do an MRI scan, did a bunch of different sort of social behavioral assays, and then repeated an MRI scan later.

And the primary finding from this study is that for the socially-stressed bullied monkeys, GnRHa rescued them and reduced the effect of stress, the negative effects of stress

on the brain. So GnRHa protected them from the negative consequences of chronic social stress on brain development.

Q. You mentioned there were also human studies of GnRHa and the effects on the brain. Can you talk to the Court a little bit about what types of studies have been done on humans?

A. Yes. There are several human neuroimaging studies. So these are studies that use magnetic resonance imaging or MRI, and there are a couple of different techniques within MRI that we can use. So one is functional MRI, and this technique allows us to present an individual with a task; that they complete this task while in the scanner and were able to measure the relative concentration of oxygen in the blood to determine what parts of the brain are activated while they complete this task.

There is also structural measures that allow us to assess things like regional brain volumes or the integrity of white matter in the brain -- "white matter" being the fibers that connect different regions of the brain.

Q. And in any of the studies, was there any findings of a negative effect on cognition?

A. No.

Q. And in any of these human studies, was there a finding of any negative effect on executive function?

A. No.

Q. And just for a little further explanation, what exactly

is "executive function"?
A. So executive function is a subset of behaviors under sort of the umbrella of cognition. And executive function are the behaviors related to planning or goal-directed activity.
Q. And so let's talk a little bit about some of those human studies you mentioned.
Are you familiar with a study by Staphorsius in 2015?
A. Yes.
Q. Can you tell the Court about that study and what they found in that study?
A. So that is a functional MRI study. And in that study, they had individuals complete a Tower of London task in the scanner, which is a planning task, a task of an executive function. And they had a group of GnRHa-treated trans adolescents, untreated trans adolescents, and then cisgender boys and girls; and they showed that there was no effect of GnRHa on performance of this Tower of London task.
Q. Are you familiar with a study by Solman in 2016?
A. Yes. That's also an fMRI study. This was a study of emotional processing. And in that study, they compared again GnRHa-treated and untreated youth, and they found that there was no relationship between GnRHa treatment and brain activation during this emotional processing study.
Q. And are you familiar with the Van Heesewijk study in 2022?

A. Yes, the Van Heesewijk study is a structural study, and it uses a technique called "Diffusion Tensor Imaging" or DTI, and this allows us to measure the coherence of these white matter tracks that connect different parts of the brain. And so if the white matter track is more coherent, it forms more of a straightforward bundle, then we would say that the transfer of information from one region to another is more efficient.

And in this study, they found that the trans youth overall actually had more coherent white matter than the cis youth, and they found one region where there was a difference in the trans boys, but it was such that GnRHa treatment made that white matter bundle more like the cisgender boys. So again, that it was having the expected effect.

They also looked at correlations between duration of GnRHa treatment and white matter integrity, and they didn't find any relationship between GnRHa treatment and the outcome measure of white matter integrity.

Q. And for a layperson like me, can you explain the significance of these studies?

A. These studies suggest that GnRHa treatment doesn't have any negative effect on cognition, and that the few findings that are related to -- that showed differences in the brain show us that the medication is doing what we would expect; that it is making the brain more consistent with the gender

or reducing sex differences.

Q. A point of clarification. In the Solman 2016 study, was that a study involving transgender adolescents?

A. Yes.

Q. Are you aware of a study that looked at the effects of GnRHa on the brain in treatment for precocious puberty?

A. Yes. That would be the Wojniusz 2016 study, and that was a study of emotional regulation, looking at girls treated with GnRHa for central precocious puberty and controls who did not have that condition, were not treated.

And they had them perform an emotional regulation task. They showed that there was no difference in performance in emotional regulation. And while they performed this task, they also collected EKG data. The collected heart rate data and also heart rate variability data.

Heart rate variability is an indirect measure of parasympathetic nervous system function or rest-and-digest function. And they found that the GnRHa-treated girls showed optimal physiological regulation during this emotion task such that they had a lower heart rate, which would indicate that they were more relaxed, and a higher heart rate variability, which is a positive outcome. It indicates that they are relaxed, and that their parasympathetic nervous system is engaged and active, and that they are ready to respond flexibly to the environment. So this is an optimal

emotion regulation result associated with GnRHa.

Q. And defendants cite a study as a reason not to use GnRHa.

Is there any support for that conclusion?

A. No.

Q. Defendants also suggest that GnRHa should not be used because it could have an impact on IQ.

Is there any support in the scientific literature that suggests that there is an effect on IQ by using a GnRHa in adolescents?

A. No, there isn't.

Q. Many of the defendants' experts argue that GnRHa is experimental because there is insufficient research on long-term effects of GnRHa.

How do you respond to this claim?

A. So GnRHa is a medication that's been used safely for decades. So we know from the experience of clinicians and from the research literature that it's a safe medication that is not associated with long-term harm.

Q. Is the fact that there is a smaller body of literature render the treatment for gender dysphoria experimental?

A. No. As a scientist, we would never rely on any one study to draw conclusions, but we look at the research literature as a whole. And the research literature as a whole shows that this is a safe and efficacious medication.

Q. The defendants' experts also opine that there is

insufficient research suggesting that the gender-affirming hormones alleviates gender dysphoria.

Are there any studies that actually look at this issue on the brain?

A. There are two studies in trans adolescents that look at effects of testosterone on the brain. So two studies of transgender boys. Those are both fMRI studies that use negative emotional face paradigms, so they are presenting them with angry or fearful faces in the scanner. And one of those studies showed that activity in the brain with testosterone treatment became more typical of a cisgender boy. So, again, what we would expect.

The other study looked at anxiety and depression symptoms as well as suicidality and body image satisfaction. They found that with testosterone treatment, there was a reduction in anxiety symptoms, depressive symptoms, and suicidality; and that this was explained by an improvement in the body image in these boys.

They also showed that there was increased coupling between the prefrontal cortex and the amygdala while they were looking at these negative emotional faces.

So what we think of in terms of amygdala prefrontal coupling is that this is a marker of regulation of emotions, and they actually showed that there was greater coupling between these two regions in the testosterone-treated boys --

so that's a positive outcome -- and that the amount of coupling was correlated with the reduction in their anxiety symptoms. So that the individuals that had more coupling showed a greater reduction in their anxiety symptoms. So, again, a positive outcome.

Q. And do the limitations -- excuse me.

Can you talk a little bit about whether there are limitations to these studies?

A. There are always limitations. Every study has limitations. It's not really possible to address every potential concern. There is always limitations of resources of time. You know, I do human subjects neuroimaging, and it's a very expensive and -- it takes quite a bit of time to do it well. So there's always limitations. And that's why, again, we would not rely on any one study to draw our conclusions. We look at the literature as a whole.

Q. And the limitations you mentioned, do they render the care experimental?

A. No.

Q. You mentioned a little bit earlier about the harms to the untreated brain and the effects of -- I think you called it "the kindling effect."

A. Uh-huh.

Q. Can you talk a little bit more about that and explain a little bit more what that means and what the impact is for a

gender-dysphoric adolescent?
A. Right. So we know from the literature that adolescents with gender dysphoria have higher rates of depression and anxiety and suicidality. We also know that they are more likely to be bullied, and they have more chronic stress. And we know from the literature that these things are all associated with negative effects in the brain.
So the release of the stress hormone cortisol, for example, when that stress hormone is chronologically released and the brain is flooded with cortisol repeatedly, this actually shrinks the size of neurons and is associated with more depressive symptoms, more anxiety symptoms. And we know that over time, there is a cumulative negative effect of this process on the brain structure and function.
Q. And is there evidence in the scientific literature that withholding treatment would have a negative effect on brain development?
A. So we know that access to treatment is associated with an improvement in mental health and a reduction in mood anxiety symptoms, and we know that untreated depression and anxiety is associated with harm to the brain. So being able to access the treatment can circumvent some of those harms.
Q. Based on your review of the literature, is there any scientific basis to exclude coverage for GnRHa in adolescents to treat gender dysphoria?

A. No.
Q. Is there any basis to exclude coverage of gender-affirming hormones in adolescents to treat gender dysphoria?
A. No.
Q. Based on what you testified to today, is there any support for the claim that the provision of GnRHa is experimental?
A. No.
Q. Based on what you've testified today, is there any support for the provision of cross-sex hormones as experimental?
A. No.
Q. And one last question. Some of the studies that you talked about, the human studies in transgender adolescents, were those cited by any of the defendants in their expert reports if you can recall?
A. No, they were not cited.
Q. And do you know if they were cited in the GAPMS report?
A. They were not.

MS. RIVAUX: Thank you.

THE COURT: Cross-examine?

MR. BEATO: Yes, Your Honor.

Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. BEATO:

Q. Good morning, Dr. Edmiston.

A. Good morning.

Q. Just a few questions.

Doctor, on direct you testified about adolescent decision-making, correct?

A. Yes.

MR. BEATO: I would like to pull up DX16.

BY MR. BEATO:

Q. And you should see it on your screen. We also have physical copies if you need it.

A. Okay.

Q. What is this document?

A. This is the WPATH Standards of Care, Version 8.

MR. BEATO: And I would like to go to WPATH 45, please.

BY MR. BEATO:

Q. Doctor, is this the adolescent chapter?

A. Yes.

Q. I would like to go to the next page, please, first paragraph under the bolded "For clarity," nine lines down starting with "However."

If you can just read the section starting with "however" and ending "different from that of older individuals."

A. You would like me to the read it out loud?

Q. No. You can read it to yourself, and just let me know when you are finished reading.
A. Okay.
Q. Do you agree with the section?
A. I agree with this section in terms of it's -- you know, that it's true in the specific context that I discussed in my direct.
Q. Understood.
I would like stick with the WPATH Standards of Care. Can we go to WPATH 63, please. Top right, paragraph 14 lines down, and hopefully we be blow that up, starting with "gender-diverse youth."
Gender-diverse youth should fully understand the reversible, partially reversible, and irreversible aspects of the treatment, as well as the limits of what is known about certain treatments, e.g., the impact of pubertal suppression of brain development.
Do you see that, Doctor?
A. Yes.
Q. And you'd agree that there is limited knowledge of the impact of pubertal suppression on brain development, correct?
A. I would say that there's sufficient evidence that this is a safe medication. It's been used for decades; and, you know, we know from the literature as a whole that it's safe and effective.

Q. Okay. Can we go to WPATH 67, please. Second paragraph under the bolded "consideration of ages," second sentence, starting with "There is."

There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth.

Do you see that, Doctor?

A. Yes.

Q. Do you agree that there is limited data on long-term neurodevelopmental outcomes in youth who receive gender-affirming interventions?

A. I would say that the data that we have supports the use of these medications.

Q. Same page, right column, first full paragraph, 18 lines down, starting with "Puberty is a time."

Puberty is a time of significant brain and cognitive development. The potential neurodevelopmental impact of extended pubertal suppression in gender-diverse youth has been specifically identified as an area in need of continued study.

Do you see that?

A. Yes.

Q. Do you agree with that statement?

A. I would say that, again, as a scientist, we always want

to do more studies. No scientist ever says, well, we've solved that question, we know everything there is to know. We always want to do more studies. I would also say that they qualify this as an extended pubertal suppression. So that is also worth noting.

Q. Understood. And, Doctor, you're aware of the Endocrine Society's clinical practice guidelines and treatments for gender dysphoria, correct?

A. Yes.

MR. BEATO: DX24, please.

By MR. BEATO:

Q. Doctor, what is this document?

A. These are Endocrine Society guidelines.

Q. And can we go to ES19, please. I believe that's ES23, ES19. First full paragraph:

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function, but animal data suggests there may be an effect of GnRH analogs in cognitive function.

Do you see that, Doctor?

A. Yes.

Q. And do you agree with this section?

A. Well, I would qualify it, because this was a document that was written in 2017. So there has been quite a bit more

research since then. I would also say, this Citation 108, this was one of the sheep studies that I referenced, the one that found a cognitive difference -- or a potential cognitive difference. They weren't entirely sure how to explain it, that they found that the sheep were spending more time in this particular part of the maze at 27 weeks, but that difference went away over time. So I think that, you know, it's important in clinical care to cite all of the potential risks, and also to consider the potential benefits, so they are just being completely thorough.

Q. And, Doctor, you mentioned 108, that particular study, correct?

A. Yes.

Q. That would be Q?

A. Yes.

Q. The title is "Spatial memory is impaired by peripubertal GnRH agonist treatment in testosterone replacement in sheep"?

A. Yes.

Q. And, Doctor, you also talked about the mice studies, correct?

A. Right.

Q. That's the Anacker study?

A. The -- yeah, Anacker, yeah.

Q. And you would agree with me that the authors found that puberty blockers have profound effects on female behaviors

that are commonly interpreted as depression-like?
A. They found that the females with GnRHa treatment showed a reduction in the sex difference that didn't exist or existed before treatment.
You know, I would again highlight the fact that they used the term "depression-like." The literature that we have in humans shows that -- I very clearly repeatedly over and over again that this is treatment is associated with improvement in depression. So I find a human study of depression much more compelling than a mouse study.
Q. Understood. And you also agree that the authors found pronounce differences in locomotion and social preference in males and increases in neuroendocrine responses to mild stress?
A. Again, they did find these differences, but it's a matter of the comparison group. So they have four groups in this study. They have untreated male and female and treated male and female. So there are differences when you compare the treated female rodents to the untreated female rodents, but there are no differences between the untreated male and the treated female.
So because the purpose of this medication in this context is to reduce sex differences, the medication is doing exactly what it should be doing.
Q. And moving away from animal studies, are you aware of a

study by Schneider called "Brain maturation cognition and voice pattern in a gender-dysphoric case under puberty suppression"?

A. I'm not entirely sure. Do you have a copy that I could look at?

Q. Would it be help if I refresh your recollection?

A. Yes, sure.

MR. BEATO: Your Honor, may I approach?

THE COURT: You may.

THE WITNESS: Yes, I am familiar with this study.

BY MR. BEATO:

Q. And you are aware that this study observed an IQ decrease in a gender-dysphoric individual who took puberty blockers?

A. Yeah. So a couple of things about this study. So first off, it's a case study. So we would consider this the lowest quality of evidence in terms of study design. Case studies can be useful to illustrate a common clinical phenomenon for teaching purposes or to suggest an area for, you know, additional work. But they can't be used in isolation to make policy decisions or clinical guidelines. A case study really isn't generalizable to the broader population.

The other thing about this study is that the particular transgender girl that they studied already had a low IQ prior to starting GnRHa. So she is really not a representative case of the effects of GnRHa because she has an intellectual

disability.
Q. Understood. And just to highlight something you said. It's your belief that low-quality evidence should not be used to make policy decisions?
A. So, again, I think that all evidence should be taken into account and evaluated it as a whole. But a case study, to me, in insolation is not compelling evidence.
Q. And, Doctor, just to stick with that study for a second.
A. Uh-huh.
Q. The individual who had gender dysphoria, did she show an IQ decrease after receiving puberty blockers?
A. So I believe so, but let me check.
Q. Sure. Take your time.
A. So there is a difference in her IQ; but, again, we can't say that this is necessarily due to GnRHa because she had an IQ of 80 prior to initiation of GnRHa, which is a significant intellectual disability.
Q. And did it go down after receiving puberty blockers?
A. It did go down, but it's important to remember that's why we also have cross-sectional studies. So, for example, the Wojniusz 2016 study did not find any differences in IQ with GnRHa, and because they had a group of individuals, they are able to perform a statistical test to see if that difference is due to chance or if it's a real difference.
Because this is a study of only one person, we can't do

that kind of statistical testing. So the IQ varies to some extent with repeated testing, and so we can't tell from this case report if the amount of variation here is due to chance.

Q. And, Doctor, you also mentioned a series of MRI studies, correct?

THE COURT: Let me stop and ask a couple of questions about the one you just dealt with. Nobody asked what the IQ test showed after the treatment.

What did the case study show after the treatment?

THE WITNESS: So they showed that the IQ was -- the global IQ was 71 after treatment. So, you know, these are both borderline-to-low-average IQs before and after treatment.

THE COURT: That case study, is that peer-reviewed?

THE WITNESS: It is, yes.

THE COURT: I see IQ results not in studies, but in individual cases where intellectual functioning is important including, for example, in death penalty cases and other kinds of criminal cases. I see that kind of variation frequently. I certainly haven't made any study of the cases I happen to have gotten, which would just be a random assortment anyway.

THE WITNESS: Sure.

THE COURT: How unusual is it to have successive IQ tests with the amount of variation shown there?

THE WITNESS: I would say that that is very typical.

THE COURT: If you really wanted to see what was

going on, would you rely on the single test or is that a test you would repeat?

THE WITNESS: Do you mean in terms of determining the real IQ, you would repeat the test?

THE COURT: Yeah. If, for example, there were a lawsuit involving that change in IQ -- a change from 80 to 71 on test -- and the question was exposure to some chemical that led to a lawsuit claiming that that was what was caused by a chemical, is that the kind of thing where an expert in your field would look at the one test and the one test and say, this is a real change in IQ, or would you need to do more tests to find out whether there was really a change or whether this was just a variability between two tests?

THE WITNESS: I would certainly want to do more tests. So they used the WISC IQ test, and I would want to do more targeted neuropsychological assessment to really get into what components of cognitive function are, you know, there are very specific components of cognitive function. So I would want to do a full neuropsychological workup.

THE COURT: What, if any, conclusions would you draw about the effects of GnRHa based on that case study?

THE WITNESS: I wouldn't want to draw conclusions of the effects of GnRHa on the basis of a case study. I would use the Wojniusz 2016 study to draw conclusions because that actually looked at a group of individuals and compared them

statistically. That allows us to really get a sense of, you know, is this a real difference, is this a significant difference. And that study didn't find any significant difference.

MR. BEATO: Thank you, Your Honor.

BY MR. BEATO:

Q. Doctor, you also mentioned MRI studies, correct?

A. Yes.

MR. BEATO: Can we pull up PX351, please.

BY MR. BEATO:

Q. Doctor, is that one of the MRI studies?

A. Yes.

Q. And this study observed 22 individuals with gender dysphoria?

A. I can't exactly read it. Yes, it looks like 22.

Q. And this is not a longitudinal study?

A. It's a cross-sectional study.

MR. BEATO: Can we pull up PX352, please.

BY MR. BEATO:

Q. Doctor, this is another one of those MRI studies?

A. Yes.

Q. And --

A. I'm sorry. I was just going to say, this is the Solman study that I mentioned, yes.

Q. And this study observed 21 individuals with gender

dysphoria?
A. Yes, it did.
Q. This is not a longitudinal study?
A. No. It's a cross-sectional study, and cross-sectional studies are important. They have value in terms of our ability to draw conclusions. And, you know, again, that's why, as scientists, we use lots of different approaches and methods to assess a particular question from lots of different angles.
Q. Understood.
MR. BEATO: And can we pull up PX354, please.
BY MR. BEATO:
Q. Doctor, that's another one of the MRI studies?
A. Yes. That's the Van Heesewijk study, the DTI study.
Q. If we can look at the background section, fourth line:
Knowledge about the effects of puberty suppression on the developing brain of transgender youth is limited.
Do you see that, Doctor?
A. Yes.
Q. Do you agree with that statement?
A. I think that this is a common approach to structuring an introductory paragraph. So, you know, as a scientist, we are trained to sort of have the first sentence be what is the concern we're addressing, and the last sentence of the background section is always, this is what we don't know yet;

and that's why I did this study, and this study is going to help us understand what we don't know.

So this is saying -- this is giving a justification for the performance of this particular study.

Q. Understood. And this article came out in 2021, I believe?

A. I can't see, but -- yeah, uh-huh.

Q. Last few sets of questions.

So just so the record is clear, you are not a medical doctor?

A. That's true. I have a Ph.D. in neuroscience.

Q. You never diagnosed anyone with gender dysphoria?

A. No, I don't diagnose individuals with gender dysphoria.

Q. And, Doctor, is it true that to form your expert opinion in this case, you partly relied on your work as a contributing author of WPATH Standards of Care 8?

A. Yes.

Q. And you helped draft Chapter 5, the adult chapter?

A. I did, yes.

Q. What was the drafting process like?

A. So the drafting process, which is publicly available on the WPATH website, involves each team of chapter co-authors generating a list of questions. We send those out to an external review that does an extended peer review allowing us to see what evidence there is to answer those questions.

And then from there, the co-authors of the chapter draft statements, and we use the language of "recommend" or "suggest" that's based on the strength of the peer-reviewed literature with regard to that particular recommendation.

From there, then that -- those -- those statements are evaluated by all of the authors.

Q. Did the authors of Chapter 5 include any individuals who were not medical professionals?

A. Yes.

Q. Who were they?

A. Oh, there were several therapists, and the chapter lead is a medical doctor.

Q. To your knowledge, do all of the individuals who assisted in the drafting of Chapter 5 approve of gender transition treatments to treat gender dysphoria?

A. I think that we all base our opinions on the evidence. And so, you know, our recommendations are that people be evaluated for the appropriateness of the treatment, and this needs to be done on a case-by-case basis.

Q. And what feedback did you receive from the WPATH board of directors?

A. I'm sorry?

Q. I'm sorry. What feedback did you receive from the WPATH board of directors?

A. Feedback regarding?

Q. The drafting of Chapter 5.
A. So the particular statements are all voted on by all of -- by everyone, and then once all of the statements -- once there is a consensus, then the chapter co-authors draw -- start drafting the explanatory text that goes underneath those statements; and then we work very closely with the chapter editor to ensure that there is consistency in the document. So we receive feedback from the chapter editor.
Q. Did any of the authors of Chapter 5 not feel comfortable with the recommendation in the finalized Chapter 5?
A. All of the recommendations are based on consensus of all of the authors of not just the chapter but the entire document.
Q. So did individuals feel not comfortable with the particular finalized recommendation?
A. No. If someone felt uncomfortable with that finalized recommendation, then, you know, we would come to a consensus.
Q. And just to backtrack a little bit, the WPATH board had to approve the draft of Chapter 5, correct?
A. Yes, it's a consensus-based document.
Q. And were there any disagreements between the authors?
A. In drafting anything like this where we have diverse opinions, we have to have discussions and come to a consensus. So, yes, sometimes there were.

Q. Did you contribute to any other chapter in Standards of Care 8 aside from Chapter 5?

A. I was only a co-author on Chapter 5, but because it's a consensus-based document, we all contributed or many of us contributed in different ways to different chapters.

MR. BEATO: One moment, Your Honor.

No further questions.

THE COURT: Redirect?

MS. RIVAUX: No questions, Your Honor.

THE COURT: Dr. Edmiston, the lawyers haven't asked you or the other witnesses this, and that may be because the answer is "I don't know" or there's no scientific evidence of that, and if that's the answer, tell me that.

THE WITNESS: Of course.

THE COURT: But it seems to me that one of the questions that -- at least under the surface in some of the submissions, is something like this:

Let's posit just a 12-year old who is trans or who says, although my sex assigned at birth, my physical sexual characteristics make me a boy, in fact, I'm a girl; I identify as a girl.

It seems to me that some of the defense suggestion is, that's not really so. That's just something the person is deciding to do just as if one would decide to wear jeans or slacks or long pants or short pants on some day to go out in

public.

What, if anything, can you tell me about whether this is really a thing, whether there are people who not as a matter just of choice but as a matter of their identity, their personhood, actually identify with the opposite gender from the gender assigned at birth or whether this is really just something they decide to be?

THE WITNESS: Yeah. That's a great question, Your Honor. So I would say a couple of things.

I would say, first off, that transgender people have existed throughout history; that there is records of transgender people all over the world throughout history. And that the analogy of deciding whether to wear jeans or slacks, that the social consequences of changing one's gender or changing one's sex to be consistent with one's gender are enormous.

If you think about how much of the social world is structured by people's perception of your gender, you know, people risk losing support of their family and friends. We know that they are bullied and ridiculed. So the decision to come out and live as one's authentic self requires an enormous amount of bravery and conviction. You know, it's not a decision that anyone would just make on a whim, because it's a very challenging life.

THE COURT: I understand that. Aside from that kind

of reasoning, is there any scientific literature, any evidence based that bears on that question?

THE WITNESS: Yeah. There is literature showing that, when the cross-gender identification is persistent and consistent, that those people over time do -- you know, that they stay, that it's a consistent desire. It's not a thing that fluctuates over time, especially when you're talking about someone that is 12, maybe. It would be perhaps a little different if you have a three-year-old boy that likes to play with Barbies. That would be a different scenario, right?

So by the age of 12, if someone is consistently saying, "I'm the opposite gender," then there are longitudinal studies that show that that is a consistent desire.

We also know that the rate of regret -- we know from the scientific literature that the rate of regret for these sorts of interventions is very small.

So I think for some -- some studies have shown a 97 percent satisfaction rate with these sort of interventions, which is much, much higher than you would see for most other medical interventions.

THE COURT: Questions just to follow up on mine?

MS. RIVAUX: No questions, Your Honor.

MR. BEATO: One moment, Your Honor.

One question, Your Honor.

RECROSS-EXAMINATION

BY MR. BEATO:

Q. Is there any study anywhere that identifies something in the brain as the basis for a transgender identity?

A. Yes.

Q. What is that?

A. So there are a number of studies in adults that have looked at -- you know, the neuroimaging studies that have looked at differences in the brain between trans and cisgender individuals, and they found differences in the -- particularly in the somatic motor and sensory motor cortices, and these are regions in the brain that are responsible for one's sense of one's own body.

So there is actually quite a bit of literature. I actually wrote a peer-reviewed review of this literature. So there is quite a bit of literature.

MR. BEATO: No further questions.

THE COURT: Thank you, Dr. Edmiston. You may step down.

THE WITNESS: Thank you.

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Thank you, Your Honor. Mr. Little will call our next witness, Ms. Hutton.

MR. LITTLE: Plaintiffs would call Kim Hutton to the stand.

DEPUTY CLERK: Please raise your right hand.

KIM HUTTON, PLAINTIFFS' WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: Kim Hutton, H-u-t-t-o-n.

DIRECT EXAMINATION

BY MR. LITTLE:

Q. Thanks for being with us, Ms. Hutton.

Can you tell us why you are here to testify today?

A. I'm here to testify about a conversation that I had with one of the witnesses for the State, Dr. Paul Hruz.

Q. Is there anything else you here to talk about with us today?

A. Just my experience as the mother of a transgender child.

Q. Okay. Before we get to that, can you briefly tell me your familiarity of this case, generally, a brief description of what you know?

A. I understand it has something to do with Medicaid coverage for transgender-related healthcare.

Q. Okay. And you came here from out of state today, correct?

A. I did.

Q. Where are you from?

A. The Greater St. Louis area, Missouri.

Q. So you mentioned you are here to testify for two

purposes. We are going to go to the second one first, regarding your family.

Would you mind just telling me a little bit about your family and we'll go from there?

A. Sure. So I am the mother of two sons. I have a 35-year-old son and a 20-year-old son who is transgender. My transgender son actually first expressed to me that he was a boy at the age of two and a half. I had him in out bathroom sink, as I did every day, ponytailing his long blonde hair, and he looked in the mirror. I was standing behind him ponytailing his hair, and he looked up in the mirror at my reflection and said, "I a boy."

I remember, like, tilting my head and thinking I must have heard him wrong, and I said, "What did you just say?"

And he said, "I a boy."

I said, "Oh, okay." And I finished his ponytail and I put him down and he ran off and played.

But I remember feeling very nervous about what he had said. I had been around children my entire life, babies, toddlers my whole life, and I never had a child tell me that they were the opposite gender. So I was pretty nervous.

That night my husband got home, and I told him what happened. And he is like, "Well, you know, they're two." And we talked about it and decided that, you know, they were confused or something, you know, didn't do anything about it,

really, and life went on.

For my child, they started expressing that they were a boy every day after they initially told me. And, you know, within six months, all of his baby dolls, even if they were in pink and dresses became boys. They were suddenly boys. And all of his stuff animals were boys, and they were given boy names. And, you know, it just became really clear that this was not going to, like, go away on its own.

And so I think he was about four and a half or five years old, and we kind of taken the approach of, like, "Oh, no, sweetheart, like, you're a girl; you have a body like mommy's," and just tried to gently redirect him. But he was very insistent that he was a boy.

And I think he was a four and a half or five years old when he had a complete breakdown one day and said, "Am I going to have breasts some day like you?

I said, "Well, some day, but that's a long ways away."

And he just melted into the floor sobbing and crying, and I couldn't understand what he was saying. So I scooped him up, and I'm like, "Hey, what is going on?"

And he's like, "When they come, can you take me to the doctor and can they cut them off?"

I soothed him as best I could, but, like, it was a very, very difficult time in our house. And I told my husband that we needed to try to find some outside help to figure out what

was going on. And there were no therapists in St. Louis that had treated a child like ours, you know, such a young child.

But I did find a therapist who treated adult transgender people, and so I made an appointment. And they told me to let him wear boy clothes in the house, but don't let him wear them outside of the house. And if he went to a birthday party, to make him take the blue balloon -- or the pink balloon, even if he wanted the blue balloon. She advised us that he would get picked on and bullied if he left our house expressing himself as a boy.

So it was kind of like asking him to live in two worlds. You know, he could dress the way he wanted in our home, but he had to look differently when he left our home.

And that advice only led to our child getting tremendously depressed. I just watched the sparkle and shine in his eyes just drain out.

So eventually, I said to my husband, you know, we need to find a different doctor, this is not working, and I called a therapist. I read something in the newspaper and found a doctor in California, and I called her and begged her to work with us over the phone, and she did.

And then over time, she connected me to a research doctor in Washington, D.C., who is studying children like mine. And I told him what was going on; and, you know, that my son wouldn't look in a mirror. Like, he wouldn't even look in a

mirror to brush his teeth.

And he -- the research doctor told me that that was one of the primary signs, that he would likely go on to be a transgender adult.

And so we spoke with that doctor several times, and then they eventually connected us to a therapist in St. Louis who had seen a child at one point in their career. She treated my husband and I. We were all therapy. There was a lot therapy in our house.

And my husband and I saw that therapist, and then she referred us to a child psychologist to meet with my son who at the time was between six and six and a half. They recommended that we get a complete psychiatric evaluation of our child, which we did.

And they wrote up a report, and they did diagnose him with -- at that time it was called "gender identity disorder," and they told us that, to make him live his life as a girl would be cruel and inhumane; that he knows who he is; and that we should let him wear boys' clothing, get him a boy haircut, give him a boy name, use boy pronouns, and find a school that would support him, which back then was going to be really difficult, but we did.

And with these small changes, like, my son was just happy again and, like, all of the life came back in his personality, and he was just, like, cheerful and happy and

engaging with his friends. And we put him in this new school.

And he could have gone in without anyone knowing that he was transgender, but he told them at first day at Community Circle that he was a boy, but he didn't have a boy body. And just the nature of the school allowed him to express himself, for people to know him for who he really was. And he had millions of friends, invited to every birthday party, and just -- his confidence just grew. And it was probably for the next even three years the happiest years of his life.

And so, yeah, I think it was around between nine and ten that puberty struck and breasts started developing, which was his biggest terror in life, was having breasts.

So at that time we sought an endocrinologist at St. Louis Children's Hospital, and we talked about the hormone blocker therapy. And I remember -- you know, I remember her saying things like, you know, we'll have to do lab work, blood work, I think every six months or something like that. And we'll do x-rays of his hands, and we'll watch for the growth plates to open -- or to stay open or closed, just kind of monitoring him while he was on this.

I also knew that they had used this type of treatment for children with precocious puberty for many, many years, decades I think I heard, before my child was on it. And so I felt like, you know, they've been using it in other ways on

children, you know, it seems like it's okay. And knowing how our child felt, we absolutely wanted it for him. He would have been devastated to have endured female puberty and to have breasts. And so for us it wasn't really even a question about doing it.

And once he had the blocker implanted, and the minimal development that had happened on his chest went away, he was happy again, full of life, and engaged with his friends and just did great.

Q. That's good to hear.

The facility where your son received puberty suppression hormones, did they have a gender clinic or a specialized gender facility?

A. They did not.

Q. How were the next few years like after beginning the puberty suppression?

A. They were great. I mean, his confidence just continued to soar. He's smart, his grades were excellent, his circle of friends was huge. He's well liked and just an all-around happy kid, and just really living a very regular boy life.

Q. And then at a certain point, did your son ever progress to any other kinds of gender-affirming care in addition to the suppression hormones?

A. He did. I think he was almost 15, right around 15, and he started with a very tiny dose of testosterone. And over

time, I think it was actually over a year, a year and a half to get to the full dose. And so he experienced the type of puberty I think that he wanted where he had facial hair. He had talked to us since he was three years old that he was going to have a beard when he grew up, you know.

So for him to get facial hair and things of that nature from the cross-hormone therapy just made his day. He was beyond ecstatic. He was delayed in puberty. Most of his peers, his guy friends had already gone through that. He was catching up to them and just -- he was beyond thrilled with everything that was happening.

Q. Where did your son receive testosterone from?

A. So he started on testosterone at Cardinal Glennon Children's Hospital, and then ultimately, when he was older, transferred to the St. Louis Transgender -- Washington University Transgender Center, Pediatric Transgender Center.

Q. Okay. So you talked a bit about the observations you had seen in your son since taking testosterone. How is your son doing day?

A. He is doing great. He just completed his freshman year in college. I'm so proud of him. He did really well. He's an A-B student. Again, he took off for school, and he created this whole new social circle. It's really large. When I talk to him on the phone, when he's away at school and he's walking across campus, countless people are yelling his

name and saying hello. I mean, it's wonderful.

He could have gone into a dormitory that was for anybody that was on the gender spectrum, and he's like, no, I'm just going to let them place me where they place me.

And so the guys that he roomed with in his dorm didn't know right away that he was transgender, but he told them about that within a few months. And everybody loves him, and they protect him and they stick up for him where needed. And he's just a great kid. He's so happy.

And it's been kind of rewarding as a parent because recently, because I'm sure he's growing up and maturing and he's looking across life, and he said, you know, mom, I will never be able to thank you and dad enough for loving me, supporting me, and getting me the medical care I needed to live this life. He goes, I don't even know what kind of person I would be today if I hadn't gotten the hormone blockers and the cross-hormone therapy. He said, I know friends who are transgender who didn't have access for a variety of reasons and didn't have loving and supportive parents, and he said, they're living a very difficult life.

And so it's kind of -- it's been really nice to get that appreciation from our son and recognition, I guess. But obviously, as parents, you just want to make sure that your children are healthy and happy, and that was our goal.

So, yeah, he's doing great.

Q. That's really wonderful to hear.

And we'll circle back to that before we end, but just spend a few minutes talking about the other matter you came here to testify about.

You mentioned you were familiar with one of the defendants' experts. Can you tell me a bit more about that?

A. Yes. So in 2010 I started this small not for profit called "Transparent," and it is a support group for parents who are raising a transgender child of any age. And as a part of that and then also raising my child, I was doing all kinds of reading and trying to find resources and help for children like mine in our community.

I ran across information on a Dr. Norman Spack, and I found out that he actually started a pediatric transgender center at Boston Children's Hospital. And I was like, oh, my gosh, there's a center, like there's a place that does, like, full care for children like mine, I couldn't even believe it.

So I called him. I didn't think he would take my call, but he did. I introduced myself, and I told him how we're really struggling in St. Louis. We didn't have a center like this; that it would be like my dream to someday have a center like that in St. Louis.

And I said, you know, our doctors are just starting to talk about this. They are not really educated on what our children need, and I said, you've got these standards of

care. Do you think you would ever consider coming to St. Louis and sharing what you know about treating transgender children with our medical community. He's like, sure. He said, I'm going to be in Kansas City -- this would have been October of 2013 -- and he goes, I'll just come in a couple of days early, and I'm happy to speak in your area.

So I arranged presentations at the Washington University School of Medicine and the St. Louis University Medical School. And when Dr. Spack gave his presentation at Washington University School of Medicine, Dr. Hruz was in the audience. And then after the presentation -- after the presentation, there was a small private meeting where doctors met with Dr. Spack privately, I'm sure, to ask him more detailed questions; and Dr. Hruz was a part of that small meeting. And so --

Q. Go on.

A. And so Dr. Spack came out of that meeting, and he reconnected with me, and he said, Dr. Hruz would like to meet with you. I'm like, oh, okay. I thought that would be a good thing, because I understood that Dr. Hruz had an important position within the endocrine department at Washington University School of Medicine. So I thought it would be a good thing. And Dr. Spack seemed concerned, and when I asked him about that, he said, he's a very, very religious person.

Q. Was he referring to Dr. Hruz?
A. To Dr. Hruz.
MR. PERKO: Objection, Your Honor. Under Rule 610 evidence of someone's religious beliefs is not admissible to support or --
THE COURT: Or oppose their credibility. Is that what the rule says?
MR. PERKO: Yes.
THE COURT: I won't consider it for that purpose.
BY MR. LITTLE:
Q. Go on.
A. So I -- he said he'll reach out to you, and he did. I got an email from Dr. Hruz. I think it was the same day, I think. It was right around -- it was very close to the presentation. I wrote him back and told him that I was happy to meet with him and we scheduled a lunch.
Q. Can I ask you what he said in his email?
MR. PERKO: Objection, Your Honor. Calls for hearsay.
MR. LITTLE: It's Dr. Hruz's email that we are referring to, not Dr. Spack.
THE COURT: Dr. Hruz is going to testify?
MR. PERKO: Yes.
THE COURT: He can be impeached with his statement, can he not?

MR. PERKO: Yes, sir.

THE COURT: I'll allow the testimony. If it turns out it's not properly impeaching testimony, we will double back and I won't consider it. He'll need to be confronted and given an opportunity to explain it, but that can be done when he testifies.

MR. PERKO: Thank you, Your Honor.

THE WITNESS: So his email said that he was very interested in meeting me because he had questions that he thought that I would be able to answer based on my experience raising a transgender child. He said that he had done some research, but that -- he had done some reading, but it wasn't exhaustive, and he just felt like he could learn some things from me. He said that he wouldn't try to debate me or change my views.

But there were a couple of terms in the email that caused me concern. He talked about morals and spiritual needs of the children, and I thought that was interesting because I didn't know how that really impacted the medical care that my child needed. But I made the meeting and we had lunch I think the same week of the presentation.

And when I got there, I sat down and I started to talk about my son, telling him about my son, and I was going to go on to tell him about my family's experience, but he stopped me pretty quick. And he said, I looked at the

transparent brochure, and I know that your goal is to normalize the transgender experience. And he said, your child is not normal, and they will never be normal. And he said, surgeries -- surgeries that attempt to change a person's gender are, like, against God's will or God's plan.

And I listened. There were other things that were said during this period of time. And I said, you know, men have top surgeries. If they develop breasts, men have top surgeries. He goes, well, that doesn't matter because men's breasts serve no purpose. Women's breasts lactate and provide nourishment for babies, so they could not have top surgeries.

And he went on to say, if you would read Pope John Paul's writings on gender, I would understand God's plan for gender. And I said, well, you know -- because he kept coming to this -- to religious, like, he even said the thing about reading Pope John Paul's writings probably five or six times in our conversations.

So because he kept going down that vein, I said, you know, the Bible also says that God created women from the man's rib, and I go, you know, maybe this whole transgender thing started right then, like mixing man's DNA over into women, and like maybe the transgender experience is actually God's design.

And he snapped at me and said, not all of the stories in the Bible are true or accurate. And I said, how do you --

MR. PERKO: Can I have a standing objection to --

THE COURT: You can have a standing objection to whatever Mr. Hruz said.

MR. PERKO: Thank you.

THE WITNESS: He said, not all the stories in the Bible are true or accurate. And I said, well, how do you decide what to believe and what to follow? And he said, your child is a girl, and they will never be a boy. And I said, do you know that children like mine have a 40 percent risk of suicide if they don't have the love and support of their parents? And he said, some children are born into this world to suffer and die.

And then he said, you think I don't ask myself why people die of cancer? And I said, well, people with cancer, you will give them every known medical treatment available to save their lives, and he said -- he stood up at that point and he said, there will never be a transgender center at St. Louis Children's Hospital. I will never allow it, but I'll pray for you, and I'll pray for your family. And I said, and I'll pray that you change your mind.

BY MR. LITTLE:

Q. Was there ever a transgender center opened at the children's hospital?

A. There was.

Q. When did that open?

A. 2017.
Q. You mentioned a few aspects of the meeting. At any point did Dr. Hruz express to you an interest in discussing the science behind gender-affirming care?
A. No.
Q. Did it seem to you that his mind was already made up on that topic?
A. Oh, yeah. Yes.
Q. What do you think his purpose was in meeting with you?
A. I think he wanted me to stop asking about a transgender center. I think he wanted to make it clear. He had his --
THE COURT: Let me just say, if you have particular objections -- this testimony is obviously objectionable. If you have objections other than the 610 objection you made earlier, then you need to make it.
MR. PERKO: Yes, Your Honor.
THE COURT: But, otherwise, I'm just going to listen. I can tell all of you, I really don't care what Ms. Hutton thinks Mr. Hruz' purpose was. It is admissible what Mr. Hruz said. The rest of this, we can just give her an open mike and let her talk, but --
MR. PERKO: Yes, Your Honor. Objection as to speculation.
THE COURT: Sustained.
MR. LITTLE: It's the last question on that line of

inquiry.
BY MR. LITTLE:
Q. Okay. That was all I had to ask regarding Dr. Hruz. I just have one final question for you.
Oh, right. Did Dr. Hruz ever examine your son or your son's medical records?
A. Never. No.
Q. Was it your impression that Dr. Hruz was uninterested in learning about your family's experience?
MR. PERKO: Objection, speculation.
THE COURT: Sustained.
BY MR. LITTLE:
Q. Okay. One final question unrelated to the meeting with Dr. Hruz.
You already talked about the benefits you've observed from your son receiving gender-affirming care. Is there anything else you want to add for the record about your experience as a mother raising a transgender child and what you've observed through that experience?
A. Just, I would say that the fact that my son expressed that at the age of two and a half for -- and across his entire life, he has never once ever identified as female, it makes me believe that he was absolutely born this way.
I think it's a -- his brain is wired in this way. It's who he is. He's never once identified as female ever. And

he's living an incredibly successful life. He's productive, he's happy, he's funny, he's smart. It's -- for our family, it was absolutely the right decision to make, and even my son is confirming that, like, continues to confirm that as he continues to grow.

MR. LITTLE: Thank you so much for sharing with us today.

THE COURT: Cross-examine?

MR. PERKO: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. PERKO:

Q. Just briefly, Ms. Hutton. You mentioned that a gender clinic did open at Washington University in 2017; is that correct?

A. Yes.

Q. Now, that clinic --

THE COURT: I'm sorry. I thought it was at the children's hospital, and maybe that's associated with WashU. So before you ask your question, let me just straighten it out.

Are those affiliated entities?

THE WITNESS: They are affiliated. St. Louis Children's Hospital is affiliated with Washington University School of Medicine.

THE COURT: Got it.

BY MR. PERKO:

Q. That's the clinic I'm speaking of.

That clinic is currently under investigation by the Missouri Attorney General's Office based on allegations of improper treatment practices; isn't that correct?

A. That's correct.

Q. And those allegations were made by a case manager who worked at the clinic?

A. Yes.

MR. PERKO: That's all I have, Your Honor.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. LITTLE:

Q. Ms. Hutton, are you familiar with the findings of the investigation at the children's hospital?

A. I did read a report that they were all unfounded and unsubstantiated. I did read something about that.

Q. Are you aware, a rule promulgated in the state that was recently going to be enforced by the Attorney General in the state? Are you aware of that rule?

A. I'm aware of that rule, and I heard yesterday that that has been dropped.

MR. LITTLE: No further questions.

THE COURT: Thank you, Ms. Hutton. You may step down.

Tell me where we stand. We'll probably take the morning break. Give me the lineup for the day.

MR. GONZALEZ-PAGAN: We have our next witness prepared. He would be the one joining the Zoom. So if we can take our morning break now.

THE COURT: That's good. We will start back at 10:50 by that clock. And you can have the connection made by then, that will be good. Thank you. We're in recess.

(*A recess was taken at 10:32 a.m.*)

(*The proceedings resumed at 10:50 a.m.)*

THE COURT: Please be seated.

MR. GONZALEZ-PAGAN: Your Honor, the plaintiffs would call Dr. Aron Janssen.

THE COURT: Dr. Janssen, let me start by asking you a question about logistics. Are you there in a room by yourself?

THE WITNESS: I am.

THE COURT: If anyone comes into the room, if you would just let us know, we'll deal with it; but, otherwise, we will assume for the whole time you are there by yourself.

Please raise your right hand.

ARON CHRISTOPHER JANSSEN, PLAINTIFFS' WITNESS, DULY SWORN

THE COURT: Please state your name for the record.

THE WITNESS: My full name is Aron Christopher Janssen, J-a-n-s-s-e-n.

THE COURT: Thank you. You may proceed.

DIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, what is your profession?

A. I'm a child adolescent and adult psychiatrist.

Q. Where are you currently employed?

A. I am currently the vice chair of clinical affairs of the Ann & Robert H. Lurie Children's Hospital of Chicago and an associate professor of psychiatry at Northwestern University.

THE COURT: We're not hearing you terribly well. If you would speak up nice and loudly for us, you may be able to get closer to your microphone. Thank you.

THE WITNESS: Got it. Will do.

THE COURT: Much better. Thank you.

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, in this capacities, what is your role within Lurie Children's Hospital and Northwestern?

A. My job is comprised of clinical care, and the clinical care I provide is primarily with youth and young adults with gender dysphoria. In addition, I do administrative work, research, teaching, systems-based advocacy.

THE COURT: Say the last thing again.

THE WITNESS: Systems-based advocacy, building services for patients with mental health concerns.

BY MR. GONZALEZ-PAGAN:

Q. And prior to your role at Lurie Children's Hospital, where did you work?
A. Prior to Lurie Children's, I was on faculty at New York University.
Q. And what was your role there?
A. I was the founder and director of gender and sexuality service and the co-director at the pediatric consultation liaison service.
Q. Could you please describe your practice at present?
A. At present?
Q. Yes.
A. Presently, my clinical work is almost exclusively with transgender and gender-diverse young people and young adults, and I have a particular niche in the world of co-occurring mental health issues among this population.
THE COURT: Dr. Janssen, I may have made this worse rather than better when I told you to get closer to your microphone. We're getting some echo. Let's start farther away from the microphone but still speaking up loudly.
BY MR. GONZALEZ-PAGAN:
Q. Dr. Janssen, about how many gender-diverse children and transgender adolescents and adults have you worked with throughout your career?
A. I have worked with over 500 patients.
Q. And you mentioned that most of your practice deals with

gender-diverse children and gender adolescents.

About what percentage of your practice is dedicated to that population?

A. Approximately 95 percent of my practice is dedicated to that population.

Q. Is there any particular conditions that you treat in your practice working with this population?

A. In working with this population, I treat the whole gamut of co-occurring psychiatric disorders, and my area of focus that I have published on is with co-occurring mental health issues among transgender and gender-diverse youth and young adults.

Q. Do you make any diagnoses or provide treatment for gender dysphoria?

A. I routinely make diagnoses and provide treatment for gender dysphoria.

Q. Are there any clinical guidance that you utilize in your work?

A. I use the WPATH Standards of Care, the World Professional Association of Transgender Health Standards of Care, as guidelines for my practice, in addition to the standard review of all updated scientific literature on the topic and my previous history and training.

Q. How long have you been providing care to gender-diverse children and transgender adolescents and adults?

A. For approximately 15 years.
Q. You said that you spent --
A. I began on faculty in 2011, so since that time. But I did work with transgender and gender-diverse young people and adults in my training a well.
Q. Thank you. You mentioned that you spend some of your time doing also research.
What are the specific areas of study that you research?
A. The specific areas I study are transgender mental health, so co-occurring mental health issues with gender dysphoria, suicide prevention, and system development.
Q. Have you published any research or scholarly articles related to the treatment of gender dysphoria?
A. Yes, I have.
Q. How many articles?
A. On last count I have published, I think it's about 24 peer-reviewed articles on gender dysphoria.
Q. And have those been in peer-reviewed journals?
A. Yes.
Q. And you mentioned that you utilize the Standards of Care from the WPATH.
Did you have any role in the promulgation or development of the Standards of Care, Version 8?
A. I was involved in writing two of the chapters, the chapter on children and the chapter on adult mental health.

Q. Are you member of the WPATH?
A. I am.
Q. Are you on the board of WPATH?
A. No.
Q. Are you a member of any other medical organizations?
A. I'm a member of the American Academy of Child and Adolescent Psychiatry.
Q. Did you submit a curriculum vitae as an attachment to your report in this case?
A. I did.
Q. And does that curriculum vitae accurately reflect your professional background and experience?
A. It does.

MR. GONZALEZ-PAGAN: Your Honor, Dr. Janssen's curriculum vitae is one of the stipulated exhibits, Plaintiffs' Exhibit 364.

THE COURT: Plaintiffs' 364 is admitted into evidence.

(PLAINTIFFS' EXHIBIT NO. 364: Received in evidence.)

MR. GONZALEZ-PAGAN: Your Honor, at this time I will ask that Dr. Janssen as a psychiatrist and researcher be qualified as an expert on the study, assessment, diagnosis, and treatment of gender dysphoria.

THE COURT: Questions at this time?

MR. PERKO: No questions, Your Honor.

THE COURT: You may continue.

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, there has been testimony in this case already about the nature of gender dysphoria and gender identity, but I want to ask specifically a little bit about your clinic experience and understanding of the recommendations and guidelines with regard to this diagnosis.

What is your understanding of the diagnosis or assessment of children or adolescents with gender dysphoria?

A. Well, first, it's important to note that there are two different diagnoses in the DSM-5. So there's gender dysphoria in children and then gender dysphoria in adolescents and adults.

For both, gender dysphoria refers to the incongruence between the sex assigned at birth and one's gender identity and significant distress in multiple areas of functioning that result from that incongruence.

Q. And are the diagnostic criteria for children and adolescents different?

A. The diagnostic criteria for children require more elements in order to make the diagnosis.

Q. And you mentioned that these are diagnoses that are contained within the DSM-5.

Is the DSM-5 the Diagnostic and Statistical Manual of mental disorder published by the American Psychiatric

Association?
A. That is correct.
Q. And is it something that you routinely utilize in your work?
A. It is.
Q. Are there any medical interventions associated with the diagnosis of gender dysphoria in children prior to the onset of puberty?
A. There are no medical interventions for gender dysphoria in children.
Q. Some of the State's designated experts and even the State suggest that allowing a child to socially transition puts them on a path to needing interventions in the future or that it makes them more likely to persist in their transgender identity.
What is your response to that?
A. There's no evidence to support that claim. The best data we have about persistence in social transition is that it is likely the kids who have the most intense amount of gender dysphoria who are both likeliest to socially transition as well as likeliest to persist.
Q. And what is your understanding of what "gender identity" is?
A. Gender identity is a complex construct, but that at the end of the day it's about how one identifies their own sense

of gender.

Q. Is gender identity a sex-related characteristic?

A. It is one of the multiple sex-related characteristics.

Q. And once an adolescent hits the onset of puberty, is it likely that they would desist from their gender identity?

A. The data on persistence and desistance is specific to a diagnosis of gender dysphoria. The best data we have suggests that children who meet criteria for the diagnosis of gender dysphoria in childhood, when heading to Tanner Stage 2 of puberty, so the initial stages of puberty. For those children who persist in that diagnosis, that diagnosis is highly likely, more than 95 to 99 percent likely, to persist through adulthood.

Q. We have been discussing young people that have experienced gender dysphoria or were diagnosed with gender dysphoria in childhood and then go on to receive medical care after the onset of puberty.

What about young people who present for treatment after they have initiated puberty? Is that a different phenomenon or is their gender identity more likely to persist?

A. There are multiple developmental processes, and when we talk to transgender adults and ask them about their early experiences, we hear a myriad of trajectories in terms of when folks recognize their identity.

By and large, even the people who are presenting

postpuberty had some sense of differentness around gender identity prior to that period. And there is no indication that we have from the scientific literature that those individuals are any less likely to persist after that.

THE COURT: Let me make sure I understood the answer clearly. You said "prior to that period." I want to make sure I know what "that period" was that you were describing. That may require you to go back and remember exactly how you said.

THE WITNESS: Yeah.

THE COURT: That may be asking a lot. Tell me again what you said about people who first present after -- I take it, it was after puberty, when they're telling you when they first recognized this, tell me again.

THE WITNESS: Sure. Most individuals can point to a period of time in childhood in which they recognized there was a difference in their gender identity, but it was not something disclosed at the time or clearly articulated. It is not any less likely that those individuals are going to not persist or persist, like they are just as likely to persist as those individuals who clearly articulated in early childhood.

Does that answer the question?

THE COURT: It does, and now I have one more question about that. You said people recognize something in childhood. And when you say "childhood" there, are you referring to

prepuberty?

THE WITNESS: Correct. There are many people who present for initial care postpuberty or even in adulthood or later adulthood who nevertheless have some recognition of difference prior to puberty. There are others who present with distress related to puberty. So that is another common trajectory that is not atypical in this population.

BY MR. GONZALEZ-PAGAN:

Q. Thank you, Dr. Janssen.

You've been discussing some this multiple or different pathways by which a person comes to understand their gender identity and present for care for gender dysphoria.

Can a person develop gender dysphoria based on social influences?

A. Social influences cannot create gender dysphoria just like they do not create other medical diagnoses or psychiatric diagnoses.

Q. Some of the State's designated experts have spent a great deal of time discussing a theory that an increase in the number of transgender boys in late adolescence presenting to gender clinics for treatment for gender dysphoria is a result of peer pressure or social contagion.

What is your response to that?

A. I have a few different responses to that.

First, it is a normal developmental process for

adolescents to seek out peers with shared experiences. This is not unique to transgender and gender-diverse young people. We see this with all types of minoritized youth where they seek out affinity groups with those that share their experiences.

So it is my experience working in this population that transgender youth seek out those social connections. It's not the social connections that leads to the identity, but it's the experience of the incongruence and the identity that leads to seeking out these social groups.

Q. Dr. Janssen, you've worked at two major institutions in two large states in different parts of the country.

Do you have an awareness of or keep up with the practices of other child and adolescent psychiatrists or other mental health professionals outside these institutions?

A. I've had the privilege of presenting and participating in conferences and events all over the country and the world, and in every event that I have been in, I have had opportunities to speak with practitioners and colleagues. And I've also had the opportunity to collaborate with a number of national and international colleagues in the work that I have done.

Q. One of the State's designated experts asserts that psychiatrists believe that social media has influenced the rise in gender dysphoria.

What is your response to that?

A. Well, first, there is no evidence to suggest that social media has led to an increase in identification as transgender among our youth.

The second is that there is no evidence to suggest that this is a widely-held belief of most child psychiatrists. In fact, in the spaces that I've worked in where I have a lot of opportunity to engage with and collaborate with child psychiatrists, I always have a robust discussion with folks after I've given a talk, and there's never been this significant groundswell of concern that this etiology that folks express concern.

Q. The State's designated expert also references conversations that he has had to argue that most psychiatrists admit that they not only believe that social media has contributed to a rise in gender dysphoria, but also that they will not speak in public on the subject because of how sensitive it is.

How does that accord with your experience?

A. I have had the pleasure of working in ACAP in a number of different committees including the sexual orientation and gender identity committee. As I mentioned, I have had opportunities to present on gender dysphoria in multiple fora. I have never had any concern about people raising opinions that differ from prevailing opinions of the time,

and we welcome robust debate and discussion about best practices and improvements and evidence-based care for these youth.

Q. You mentioned ACAP. By this, do you refer to the American Academy for Child and Adolescent Psychiatrists?

A. That's correct.

Q. Dr. Janssen, what is your understanding of what causes gender dysphoria?

A. Gender dysphoria is likely to be caused by a multifactorial etiology. We have some data that suggests there's a genetic component to this, and that monozygotic twins are more likely to share the diagnosis of gender dysphoria than dysototic twins versus siblings. There is some data on structural changes that we see within the brain, but we don't have a single entity that causes gender dysphoria, and like many psychiatric illnesses, it is likely to be quite multifactorial.

Q. Does the fact that someone's understanding of their gender identity change over time mean that their gender identity has changed?

A. It does not. It is a common process for individuals to evolve, and how they understand, how they label and how they express their gender identity does not mean that gender identity has changed.

Q. Some of the State's designated experts point to a shift

in the ratios of the patients that have been presenting for care as evidence that gender dysphoria is socially influenced or that we're dealing with a different phenomenon.

What is your response to that?

A. If we look at prevalence data, what we see in adulthood is that there's generally a 1-to-1 ratio of individuals assigned male at birth and assigned female at birth who identify as transgender or who have a diagnosis of gender dysphoria. Throughout the time in this field, we have seen wide variations in differences of sex ratio in childhood. When years ago it was a 5-to-1 ratio in some clinics of assigned males at birth presenting comparatively to assigned females at birth, we would anticipate that there would be some changes --

Q. Dr. Janssen, you sort of -- we lost you a little bit. You sort of disappeared a little bit in the last sentence. If you can just speak loudly and restate what you were stating.

A. Sure. What we saw is 20 years ago the sex ratios were quite different with significantly more assigned males at birth presenting for care than assigned females. That rate of adults who identify as transgender has not changed. So while social influence may impact who is seeking out care or how that distress is experience, it's not an influence in defining how people are identified.

And the other important note is that care was widely unavailable prior to the last 10 to 15 years, and so we would anticipate an increase in rates of seeking care in the context of that care being available.

THE COURT: Before you move on to something else.

Doctor, I'm not sure I heard properly or followed the description of 20 years ago, the 5-to-1 ratio, and what the ratio is now, and what point you were making with all of that. Back up and walk me through it again.

THE WITNESS: Sure. So, if we look at just who is showing up to clinics, it's going to be a sample of kids that's not always representative of the national population of individuals who are transgender, and that there are factors that are going to influence which kids present to which kind of care at what time. It doesn't mean that that is creating gender dysphoria more for boys than it was for girls 20 years ago or more recently now, that it's creating gender dysphoria more for assigned females at birth than assigned males at birth. It just means there's a lot of variability and that social context influences who is seeking care.

THE COURT: So what was the situation 20 years ago? Tell me what you know about the ratio of trans boys and trans girls. And I guess I should get you to tell me whether we are talking about the whole trans population or just boys and girls or all males and females.

Tell me what the ratio was between those presenting for care 20 years ago, and those who had the condition 20 years ago, if that's something you know, and then bring that forward to today and tell me what the same situation is today.

THE WITNESS: Sure. So 20 years ago, what we saw in the major pediatric gender clinics was that it was a much significantly more likely scenario for a kid assigned male at birth, so somebody who identifies as female but was born with assigned male gender, to present for care in the opposite.

What we are seeing now is that it is more likely to see folks who are assigned female at birth than folks assigned male at birth.

The challenge is the structure of those clinics, who had access to care and what was the social context of the time. Throughout that period, 20 years ago and today, we haven't seen changes in the sex ratio difference in transgender adults, and so what we're looking at is really a difference in who is presenting for care as opposed to a difference in the characteristics of the population.

THE COURT: How do you know that difference isn't related to fluidity in identification?

THE WITNESS: My answer for that would be on an individual level. A part of our assessment is recognizing what is and isn't fluid, how symptoms persist over time, the amount of distress that that leads in the social context in

which that assessment occurs. It's inherent to the practice of mental health that we are assessing social context as a part of a diagnostic evaluation, and that's not the experience that I've had or that my colleagues who do this work has had that there is a difference in etiology or a difference in mechanism or fluidity that's leading to these changes.

THE COURT: So when you referred a minute ago to the adult trans population by gender, was that based on people presenting for treatment or some kind of study in the population at large?

THE WITNESS: Those are population-based studies.

THE COURT: So if I understand what you told me, the population-based studies showed the same results 20 years ago as today, but the treatment patterns for children were different 20 years ago than today.

THE WITNESS: Correct. And treatment availability was different 20 years ago from today. And so there were a number of folks who would not present for care because there was no treatment available. As treatment becomes available, you have people presenting for care.

THE COURT: So the conclusion you draw from all of that is that what I would call social factors including the availability of treatment is what explains the difference in the ratio of children presenting for treatment, but not that there was any change in the 20 years in the number of trans

individuals. Is that --

THE WITNESS: Correct.

THE COURT: Got it. All right. You may continue.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

BY MR. GONZALEZ-PAGAN:

Q. Thank you, Dr. Janssen.

One argument that has been made is that providing medical care for adolescents diagnosed with gender dysphoria essentially ensures that they will persist in their transgender identity.

What is your response to that?

A. There's no evidence to support that assertion. We are not making recommendations for individuals to pursue medical treatment until they have met very clear criteria and there has been a thorough assessment of appropriateness and medical necessity of that intervention.

Q. Similarly, an argument has been made that allowing a minor, whether a child or adolescent, to socially transition ensures that they will persist in their transgender identity.

What is your response to that?

A. That is a claim that there is no evidence to support, and the preponderance of the evidence actually says the opposite. When we followed kids that socially transitioned, those that accessed care versus those that did not access care, have no difference in the persistence rates among those groups.

So it's not that your medical care leads to persistence. That persistence is going to persist. If you have a transgender gender identity that will persist regardless whether or not you have access to care.

Q. You've talked a little bit about the assessment done of adolescents before obtaining medical treatment.

What does the assessment for an adolescent for gender dysphoria entail?

A. Sure. The primary components of an assessment are, one, a full diagnostic evaluation. What we want to understand is that the presence, the diagnosis of gender dysphoria has been persistent, and that the diagnostic criteria are met.

This diagnosis is made not just with an interview with the patient themselves but also looking at other criteria, other informants.

The second is any co-occurring mental health and psychiatric disorders, how they may or may not influence the diagnosis of gender dysphoria.

The third is making sure we have a very clear understanding, both the patient themselves and whoever the caregiver or the parents may be of the specific risks, benefits, and alternatives, which include both the known and unknown risks of whatever that intervention is.

The fourth is recognizing the social context in which the treatment happens.

So that's all the components of an evaluation in this context.

Q. Dr. Janssen, the State's designated expert point to the rates of other psychiatric diagnoses among people presenting with gender dysphoria as a reason to not provide gender-affirming medical treatment because presumably this diagnoses make identifying someone who is really transgender more difficult.

What is your response to that?

A. A child who presents to a psychiatric clinic with a diagnosis of ADHD is more likely to have a co-occurring mental health diagnosis than somebody presenting with gender dysphoria. And yet we are able to make a diagnosis of ADHD plus any other co-occurring diagnoses and make treatment plans that are based upon the diagnoses -- all of the diagnoses that an individual presents with.

So if an adolescent presents with gender dysphoria and co-occurring mental health conditions, we are making all of those diagnoses and coming up with a comprehensive treatment plan to address each of those individually.

Q. Do the clinical practice guidelines and standards of care make any recommendations of how to deal with the presence of co-occurring conditions?

A. They do. It's important that co-occurring conditions are treated. And if co-occurring conditions impair the

individual's capacity to understand the interventions in question, we have to treat those conditions before any medical care for gender dysphoria would be initiated.

Q. Is there any evidence that addressing a co-occurring condition on its own leads to the resolution of a person's gender dysphoria?

A. No. There is no evidence that treating co-occurring mental health conditions resolves gender dysphoria.

Q. And why not?

A. It's a different diagnosis. In the same way that we wouldn't expect that treating anxiety is going to get rid of ADHD. Treating anxiety is not going to get rid of gender dysphoria.

It is a separate diagnostic entity with different etiologic factors. We would hope that as you treat co-occurring mental health conditions that quality of life improves, but we would not anticipate any impact on the gender dysphoria that is present.

Q. We talked a little bit about the assessment of the diagnosis of gender dysphoria. Backing up, I'm sorry.

Does the presence of co-occurring conditions among transgender people with gender dysphoria surprise you?

A. It's in no way surprising. There are a number of reasons:

Number 1, one out of five individuals are going to have a

diagnosable mental illness that requires care prior to graduating from high school. Transgender folks aren't different from the population --

Q. Dr. Janssen, if you can restart and just enunciate and be a little bit louder.

A. Of course. Sorry about that.

In the general population in the United States, one out of five individuals will have a diagnosable mental illness by the time they graduate high school that requires care.

So we would anticipate transgender folks in addition to that are also subjected to what we call minority stress. There is a theory that says that the daily stigma and experiences of bias influence mental health outcomes and lead to increased rates of things such as depression and anxiety.

So many kids are struggling with mental health right now. Transgender kids have the additional burden of managing stigma and bias and often family rejection.

Q. Can you tell me a little bit about the role of the medical health professional in deciding whether to -- whether a patient should undergo gender-affirming medical care?

A. Of course. The process of the mental health professional is to do that evaluation that I articulated the components of earlier to assess the readiness and appropriateness of an individual to proceed with medical care or surgical care.

Q. In your practice, have you provided letters of assessment

in support of medical interventions?
A. Yes, I have.
Q. Have these letters been for deprivation of puberty-delaying medications?
A. Yes.
Q. What about hormones?
A. Yes.
Q. And surgery?
A. Yes.
Q. Specifically, with regards to puberty-delaying medications, when discussing the risks and benefits of the medical intervention with the patient and their parent or guardian, as part of deciding whether to provide an assessment letter recommending that medical intervention, what is the process that you undergo with the patient and their parent or guardian?
A. The process involves a comprehensive assessment or evaluation. Again, we want to understand:
Is there a diagnosis of gender dysphoria that is present that has been persistent over time.
Does it lead to distress in multiple areas of functioning?
Are there any co-occurring mental health conditions that would cloud that diagnosis or make it inappropriate to proceed with medical care?

And is that medical care necessary?

And if it is, can the child understand and articulate to the best of their ability the risks, benefits, alternatives of that intervention, and can the parents provide consent for that intervention?

So it's a very comprehensive evaluation that involves discussions with multiple components and multiple individuals to look at how these symptoms present across multiple social contexts.

Q. And that would be similar with regards to hormones and surgery?

A. Presumably, the adolescents and young adults who are seeking out hormones and surgery are older, so the process by which you elicit that information will be different, but it is analogous in terms of the components of that assessment.

Q. In your experience, is this a process that mental health providers qualified to do assessment and diagnosis for gender dysphoria follow as well?

A. It is the standard of care, and it is my experience that practitioners follow this, yes.

Q. You mentioned that as part of the informed consent process that you engage in with your patients that you have to be aware of the risk and benefits of the treatment and that you also do some research in this arena.

Are you familiar with the body of research with regards

to the efficacy of gender-affirming medical intervention to treat gender dysphoria?

A. Yes, I am.

Q. In your opinion, what does the body of research tell us about the efficacy of the puberty-delaying medications to treat gender dysphoria?

A. Well, what we see is an improvement in the quality of life, mental health outcomes, and some relief of symptoms related to gender dysphoria.

Q. How does this accord with your clinical experience?

A. It's a little drier when talking about it from the data perspective comparatively to the profound positive impact we see when kids get access to this care.

One thing that is frequently not discussed in the delivery of gender-affirming care is the risks of not intervening and how terrifying pubertal development is for transgender youth with gender dysphoria.

And the relief that kids and young people experience when they are able to have puberty-blocking medications initiative initiated is quite profound.

Q. In your opinion what does the body of research tell us about the efficacy of hormones to treat gender dysphoria?

A. We see improved body congruence, improved quality of life, improvement in mental health symptoms, and improvement in gender dysphoria symptoms.

Q. And how does that accord with your clinical experience?
A. Again, I see a tremendous benefit from these interventions. You have individuals who blossom and are able to express and live their lives according to their experienced gender, and you see so much joy and improvement in functioning when kids get access to this care.
Q. In your opinion, what does the body of research tell us about the efficacy of surgery to treat gender dysphoria?
A. The preponderance of evidence that it is safe, it's effective, improves quality of life, improves mental health outcomes. And for some people, it's actually curative of the gender dysphoria. We see significant improvements in gender dysphoria symptoms.
Q. And how does this accord with your clinical experience?
A. Similarly, I see patients who are able to live their lives more freely, more openly, and with more satisfaction and significant improved mental health.
Q. And you stated that you work with the spectrum both from children, adolescents, young adults and adults in providing care.
When we're talking about adolescents, what are the surgeries we are talking about?
A. Primarily, we're talking about top surgery. "Chest masculinization" is another name to describe it.
Q. When we're talking about adults, people over 18, do you

have experience with patients who have obtained surgery as well?
A. I do, yes.
Q. And can you tell us a little bit about that experience?
A. Sure. So, in addition to the chest masculinization, patients can opt for vaginoplasty, phalloplasty, facial feminization surgery, et cetera, and I work with patients who have had all of those procedures.
Q. And what have you observed in your patients that have had those procedures?
A. The patients for whom those procedures are medically indicated and medically necessary see tremendous benefit, both in their symptoms as well as their quality of life and functioning.
Q. Let me ask you this:
Is there any evidence that psychotherapy alone is sufficient to resolve a person's gender dysphoria?
A. There is no evidence to suggest that. In individuals for whom medical care is necessary, there's no substitute for that medical care, and there is no role for psychotherapy in eliminating those gender dysphoria symptoms in those patients.
Q. The State's designated experts have testified about how the provision of puberty-delaying medications is purportedly a one-way road to further medical interventions.

I think you've covered some of this ground, but what is your response to that assertion?

A. That assertion is not backed up by the evidence. When we look at children who have socially transitioned, their rates of persistence of that identity are independent of whether or not they have access to puberty-blocking medications.

Q. Is there any evidence that puberty-delaying medications access some type of switch by which children go on to persist in a transgender identity?

A. No.

Q. Some of the State's experts argue that mental health professionals believe that a patient who suffers gender dysphoria based -- let me restart that.

Some of the State's experts argue that mental health professionals believe that a patient suffers gender dysphoria simply by relying on the patient's self-report and taking it at face value without any scrutiny.

What is your response to that?

A. I think that opinion belies what mental health care is and how we provide that care. In our training of all mental health professionals, we recognize that the patient's individual history in psychiatry just like in other aspects of medicine is but one component of the diagnostic evaluation. We are looking at exam findings. We are looking at other historical elements. We are looking at other

informants to describe experiences across multiple contexts to get the most accurate diagnosis that we can make.

Q. One of the State's experts criticizes the American Academy of Child and Adolescent Psychiatry for taking, what is according to him, inconsistent positions regarding the capacity of minors. Specifically, he points to an *amicus* brief filed by the Academy arguing that an adolescent's mental capacity should be taken into account when the adolescent is being adjudicated for criminal sentencing, but then supporting the provision of gender-affirming medical interventions for adolescents in the same age range.

What is your response to that?

A. This is a bit of an apples-to-oranges comparison. In one case, we are talking about an individual being exposed to legal consequences that will follow that patient throughout their life in an incident that happens in the moment; whereas, with gender-affirming care, a part of our assessment is understanding the maturity level, a cognitive step -- of these actions. And these are not --

THE COURT: You froze on us there, so --

THE WITNESS: Sorry.

THE COURT: Back up.

THE WITNESS: I saw my connection was unstable for a moment. I apologize. I can restart, if that works.

BY MR. GONZALEZ-PAGAN:

Q. If you don't mind restarting, that would be great.
A. Sure. So, as I was saying, it's a bit of an apples-to-oranges comparison. In the one case we have individuals who are participating in an alleged act that is going to have lifelong legal consequences for them.

For gender dysphoria care, it is inherent to our assessment that we are evaluating an individual's cognitive capacity, capacity to understand, ability to think through potential consequences. And these are discussions and assessments that occur longitudinally over time, and that these are decisions that children and family are making over a long period and not in a moment. So it's a very different process.

Q. Dr. Janssen, does the presence of clinical depression or other psychiatric co-occurring conditions affect the capacity of an individual to providing informed consent or assent to medical care?
A. Capacity is a time- and decision-specific evaluation. And so there is no one blanket to say yes or no. However, it would be highly unlikely, very, very rare for depression or most psychiatric diagnoses to lead to an incapacity to consent to this care. Even among our most severely mentally ill patients with chronic psychotic disorders, a vast majority of those individuals retain capacity to consent to specific medical care.

Q. Dr. Janssen, some of the State's designated experts criticize medical organizations for taking positions in support of gender-affirming medical care and state that the taking of these positions delegitimizes and politicizes medical care.

What is your response to that?

A. It is common for medical and professional organizations to make statements in support of what is the best and most evidence-based interventions for any particular condition. It would be not atypical and very appropriate for an academy to support this evidence-based care.

Q. Some of the State's designated experts say that these organizations' positions lack legitimacy because they have been discouraging or silencing diverse or opposing viewpoints.

What is your response to that?

A. In all of the organizational meetings and conferences that I have been present for, I have never seen a stifling of academic debate about best practices in this population.

Q. One of the State's designated experts opines that, even transgender adults and the parents and caregivers of transgender adolescents are unable to provide informed consent because there is no full accounting of all the potential risks associated with gender-affirming medical interventions.

What is your response to that?

A. One of the things that I value most about my profession of medicine is that we are constantly learning new information. There is not a single medicine, not a single procedure, not a single surgery, not a single intervention for which every risk or potential risk is known. It is a part of our informed consent process that we talk about what is known but also what is not known. If we were to hold up this standard that unless we knew every single potential risk, there would not be a single medicine, a single procedure or a single surgery we would ever be able to get consent.

Q. Dr. Janssen, I would like to talk about the harms that people may experience for not having access to care.

Can you tell me a little bit about what effect the lack of access to gender-affirming medical interventions has on transgender people with gender dysphoria?

A. Sure. I would put this in two different buckets.

The first is the lack of access to care itself. And so we have treatments that are effective and safe for gender dysphoria; and if you don't treat the gender dysphoria, the gender dysphoria will get worse, and that will lead to increasing, to health consequences; and, unfortunately, we see things such as increased rates of suicidal ideation and attempted suicide.

The second bucket is the changes in the physical habitus. As individuals who are transgender and have gender dysphoria do not have access to care, their bodies are going to proceed through puberty in a way that's unaligned with their identity. That creates a tremendous amount of distress.

And finally, lacking access to care in and of itself creates like a pathology among youth. Kids who have experienced and young adults who have experienced discrimination or in states in which laws have been passed that bar access to care, we see increased rates of suicide attempts, we see increased searches for suicide online. So there is a number of consequences that are quite profound when kids lack access and young adults lack access to this care.

Q. Dr. Janssen, did you have an opportunity to review the regulation at issue in this case?

A. I did.

Q. And did you have an opportunity to review the GAPMS report in support of that regulation?

A. Yes.

Q. Did the GAPMS report take into account any of those harms you just discussed?

A. It did not.

Q. Dr. Janssen, in your opinion is the provision of gender-affirming medical intervention to treat gender

dysphoria experimental?

A. It is not experimental. It has a robust evidence base and is safe and effective.

MR. GONZALEZ-PAGAN: Thank you, Dr. Janssen.

No further questions, Your Honor.

THE COURT: Cross-examine?

MR. PERKO: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. PERKO:

Q. I guess it's still morning, Dr. Janssen. Good morning. I just have a few questions.

A. Good morning to you.

Q. I just have a few questions for you.

Dr. Janssen, you're a psychiatrist, correct?

A. That is correct.

Q. You're not an endocrinologist?

A. Correct.

Q. And you're not a surgeon?

A. Not a surgeon.

Q. And the opinions you just expressed are based at least in part on your experience as a clinician. Is that fair to say?

A. In part, yes.

Q. And that would include personal observations?

A. Correct.

Q. It also include discussions with colleagues?

A. Correct.
Q. Moving on: You have been a member of WPATH since 2011; is that correct?
A. That's correct.
Q. And you served on the revision committees for the child and adult mental health chapters of Version 8 of the WPATH Standards of Care?
A. I did.
Q. And the adult chapter is Chapter Number 5; is that correct?
A. I believe the adult chapter is actually 18, but I don't have it in front of me, so I don't know the specific number. But it's the last chapter.
Q. And the chapter on children is Number 7?
A. Number 7 is correct.
Q. For those two chapters, did the authors include any individual who is not a medical profession?
A. In the child chapter, yes.
Q. And what was that author's field?
A. She was the parent of a transgender child and also ran a charity in the United Kingdom supporting transgender youth.
Q. To your knowledge, do all the individuals who assisted in drafting Chapter 18 approve of gender transition treatments to treat gender dysphoria?
A. Yes.

Q. Would the same be true for all the individuals who assisted in drafting Chapter Number 7?
A. Medical transition and surgical transition is not an indicated treatment for gender dysphoria in children, so it was not relevant to that specific chapter.
Q. Fair enough.
Now, these both chapters had to be ultimately approved by the board of directors of WPATH; is that correct?
A. It was approved through a Delphi process of all of the co-authors and involved the board, yes.
Q. Now, moving on. Doctor, you diagnose people with gender dysphoria, correct?
A. I do.
Q. And you counsel people before they are prescribed puberty blockers?
A. It depends upon the context in which we are engaging in care, but counseling is an important part of any informed consent decision. So if I'm involved in any way in the process of assessing readiness for a puberty-blocking medication or any other medical or surgical intervention, counseling is inherent to that process.
Q. And so you engage in counseling for patients if they are prescribed cross-sex hormones?
A. Yes.
Q. And surgeries also?

A. Yes.
Q. Now, your conversations on these issues, you discuss the risk and benefits of the treatments?
A. We do.
Q. And that conversation usually lasts more than 20 minutes, doesn't it?
A. It does. I think for many of the youth that I work with, I have been lucky enough to have a longitudinal relationship with many of the patients that I work with, so these discussions are happening over months to years as opposed to in a single session or two.
Q. And you said that you write letters in support of a person's decision to have surgery for gender dysphoria.
Did I understand that correctly?
A. You did.
Q. Now, Doctor, you've had years of training and experience to recommend surgeries, right?
A. Yes.
Q. And more than ten hours?
A. Yes.

MR. PERKO: I have nothing further, Your Honor.

THE COURT: Redirect?

MR. GONZALEZ-PAGAN: Just one question, Your Honor.

REDIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, you were asked if there was a non-health professional involved in the drafting of the chapters that you were a co-author for with regard to Standards of Care 8.

Do you recall that line of questioning?

A. Yes.

Q. Is it inappropriate for a non-health stakeholder to be involved in the drafting of practiced guidelines?

A. No. It's actually a tremendous value. We want to have stakeholder experiences as a part of these processes to understand the real-world impact of the recommendations that are made and the insights from people who are actually experiencing the disorder around which we are making guidelines. And this, again, is not atypical to transgender health. This is relative standard of practice among many medical illnesses.

MR. GONZALEZ-PAGAN: No further questions, Your Honor.

THE COURT: Dr. Janssen, I have a question just to make sure I understand correctly what you are saying.

You said, I think when Mr. Perko was asking you questions, that medical and surgical intervention isn't indicated for children. This goes back to what you and I were talking about earlier. By "children" there you mean prepuberty.

THE WITNESS: Correct. And that is the -- the child

chapter was specific to prepubertal.

THE COURT: Questions just to follow up on mine?

MR. PERKO: No questions.

MR. GONZALEZ-PAGAN: No questions, Your Honor.

THE COURT: Thank you, Dr. Janssen. We are going to disconnect your transmission at this point. Thank you.

THE WITNESS: Thank you. I'm sorry I couldn't be in person.

THE COURT: Tell me where we stand on the plaintiffs' side.

MR. GONZALEZ-PAGAN: Apologies, Your Honor.

Your Honor, we are primarily done with witnesses. There is an open question about records custodian from the defendants -- from the agency. We're in conversations about that. I know that they are trying to get one for today. It's been on our list. We alerted them yesterday about it, but --

THE COURT: What do we need a records custodian for? If it's just to authenticate things, let's find out whether there's an authentication objection.

MR. GONZALEZ-PAGAN: My understanding is there is no authentication objections to the exhibits.

THE COURT: So why do we need -- if you just got exhibits to offer, offer the exhibits, and I'll find out if there is an objection.

MR. GONZALEZ-PAGAN: Your Honor, our understanding

was there was no authenticity objections to the exhibits, but then when we were going through the list, they included a lack of foundation for them. Based on our understanding, covers authenticity, and so we are still working on that. That said, we also do have a number of exhibits that we are going to moving to admit into evidence.

THE COURT: Okay. Move them.

MR. GONZALEZ-PAGAN: But I don't know if my friend would like to address this point about the records custodian.

MR. JAZIL: Your Honor, we were asked to provide a records custodian after 5:00 p.m. yesterday. I haven't been able to locate one for today.

THE COURT: Well, offer the exhibits. I'll hear any objections, and then we'll deal with what the objections are.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

Your Honor, there are a couple of buckets, if you will. I will be handling some, and some of my colleagues will be handling others.

THE COURT: All right.

MR. GONZALEZ-PAGAN: Specifically, Your Honor, I first wanted to clear up -- I wanted to clear up one particular admission of an exhibit. The GAPMS report, the Court admitted both the GAPMS report as plaintiffs' exhibit which didn't contain the attachments last week, as well as the a defendants' version which included the attachments --

THE COURT: Got it.

MR. GONZALEZ-PAGAN: -- for the purposes of completeness as I understand it. We just wanted to clear up that the attachments were not being admitted for the truth of the matter asserted. We consider them to be hearsay within hearsay, and none of those experts have been called to testify, nor are they published peer-reviewed articles. They were just unpublished reports attached to the GAPMS report.

THE COURT: Well, they're certainly admissible to show what was done and the contemporaneous explanation of what was done. That's correct, isn't it?

MR. GONZALEZ-PAGAN: The fact that they were done, yes, Your Honor. I wouldn't consider these to enter -- we would posit that they shouldn't be entered to the truth of what the report states. I don't see how they are any different from any scholarly article that is actually peer-reviewed and cited within the GAPMS report for that matter.

THE COURT: Mr. Jazil?

MR. JAZIL: Your Honor, number one, it is a reflection of what the agency did.

THE COURT: I'll admit them for that purpose, surely.

MR. JAZIL: And if the point is that they are not expert opinions in and of themselves because no one has testified to that, Your Honor, we will be putting experts on

our own, to the extent that they rely on the particular GAPMS report and an attachment to the GAPMS report.

THE COURT: All true. If you put on witnesses, then they will testify. And if there is an objection to their testimony, we will deal with it when they testify. But I certainly anticipate that you will have experts who are allowed to testify and will give opinions that will be admitted into evidence.

If they issued a report and it said in an attachment the average height of individuals from England is 6 feet 5 inches, I would admit it to show what the agency did and what explanation was provided at the time. That may be a nonhearsay purpose; and, in any event, that would probably come in under 803(8) as a report of what the agency did, the report of its activities.

I would not admit that as substantive evidence that the average height of people in England is 6 feet 5 inches. It's just not. And the fact that the agency attaches some report where somebody makes an untrue, uncorroborated statement that would not itself be admissible doesn't make it admissible to show the truth of the matter. For that purpose, it seems to me it's inadmissible hearsay.

Is that analysis correct?

MR. JAZIL: Agree, Your Honor.

MR. GONZALEZ-PAGAN: That's --

THE COURT: The attachments are admitted as evidence of the office's activity under 803(8), and as relevant for a nonhearsay purpose; that is, to show what the agency did and the explanation it provided at the time.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

My colleagues, Ms. DeBriere and Ms. Dunn will handle the next update and admission of exhibits.

THE COURT: All right.

MS. DeBRIERE: Good morning, Your Honor, and thank you.

So I'll just be handling the exhibits that defendants have objected to, going line by line through each. Starting with Plaintiffs' Trial Exhibit 24, and I believe Ms. Gonzalez will help me by pulling them up for Your Honor.

THE COURT: All right.

MS. DeBRIERE: Plaintiffs' Trial Exhibit 24 is AHCA's automated prior authorization and bypass list. My understanding, Your Honor, is that defendants object to this exhibit on the basis of the lack of foundation, which speaks to my co-counsel's earlier reference to the authenticity and potential need for a records custodian as well as relevance.

I'm happy, Your Honor, to argue relevance, and then we can address the need for the records custodian.

So relevance, Your Honor, is related to AHCA's automated prior authorization and bypass list, speaks to those

drugs that AHCA covers without any demonstration of the need for medical necessity, and this is going to speak to our comparability argument, showing that certain drugs, they don't require any criteria in order to authorize.

THE COURT: What's wrong with that?

MR. JAZIL: Nothing, Your Honor. I just wanted someone to explain the relevance to me.

THE COURT: All right. Plaintiffs' Exhibit 24 is admitted.

(PLAINTIFFS' EXHIBIT NO. 24: Received in evidence.)

MS. DeBRIERE: The next exhibit is Plaintiffs' Trial Exhibit 21, which is Florida Administrative Code Rule 59G-1.010.

THE COURT: You can admit that, but you don't need to. It's like putting a statute or a rule in evidence. I would -- that's something I look at every day, so if you want to put it in evidence, that's fine. Plaintiffs' 21.

(PLAINTIFFS' EXHIBIT NO. 21: Received in evidence.)

MS. DeBRIERE: Thank you, Your Honor. Related to that is Florida Medicaid definitions policy at Plaintiffs' Trial Exhibit 22. That is incorporated by reference by 59G-1.010.

THE COURT: Same thing, I think, it doesn't hurt to have it handy. If it's incorporated by reference, I'm sure I could find it, but sometimes those things are better admitted

into evidence so that I don't have to search for it and make sure I have the right one. The problem with Googling things is, of course, you can sometimes 15-year old documents that aren't what you were looking for.

Is there a problem with Plaintiffs' Exhibit 22?

MR. JAZIL: No, Your Honor.

THE COURT: Plaintiffs' Exhibit 22 is admitted.

(PLAINTIFFS' EXHIBIT NO. 22: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 74. Objections include lack of foundation, relevance, and hearsay.

And, Your Honor, this is a public record produced by the Office of Substance Abuse and Mental Health, which is a division of the Health and Human Services; and, of course, that division regularly engages in the activity of releasing publications related to advancing behavioral health in the U.S., which would include this document.

Relevance speaks, of course, Your Honor, to the title of the document, and that's HHS's position on the actions to support LGBTQ, plus youth, including of course supporting individuals who are transgender.

THE COURT: Give me just a minute.

Mr. Jazil, do you object?

MR. JAZIL: Yes, I do. It's a 111-page report. I don't know what sections of are or aren't relevant to this

case. The report includes a section on the state of the evidence, et cetera. So, first, Your Honor, I'm not entirely clear what it is we are admitting this for, what sections of it we believe are relevant, and whether or not the materials in it would be --

THE COURT: Well, how about this -- it's a question. If I understand it correctly, there is evidence that the way the State got involved in this at all is something like this:

The State paid for this care under its Medicaid plan for years. There is a GAPMS report back when the State started doing this that approved it. Then the federal government issued some guidance that apparently -- I guess the plaintiffs would say raised the hackles of the people in the state, and in reaction to that, they triggered a new GAPMS report and we came up with a new rule.

I don't know the timing. So the answer may be this wasn't it. Why isn't this admissible at least to show the activities of the federal government to which the State reacted?

MR. JAZIL: Your Honor, I don't know if that's the reason why it's going to be introduced into evidence. I believe this report is from 2023. I also don't know whether or not the state of the evidence cited in it is being offered for the truth of the matter asserted.

THE COURT: Well, that's a different question. Then

my next question about it is:

You have made a big deal out of the alleged position of European countries. In fact, I just got in your memo in the related case where you continue to say that Florida is just like the European countries.

And just parenthetically I'll tell you, I scratch my head every time because I think it's just not. So you seem to adopt the theory that anything you say three times or 300 times is true, and it's not.

But part of what you have hammered again and again and again is the position taken by European countries.

This is the position taken by the United States. If you can continue to push what the European countries say, why can't they show what the United States said?

MR. JAZIL: Understood, Your Honor. If this is being admitted to show the United States' position, that is one thing. If it's being used to show the state of the evidence, that's another thing. So perhaps the caveat that your Your Honor has the GAPMS report.

THE COURT: I think that's exactly right. Part of the discussion here is what's the standard in the profession, and so we have had witnesses talking about all of the literature and dealing with things. So the peer-reviewed literature is certainly, to me, a lot more reliable than the position that some government has taken.

But the positions that governments have taken are part of assessing the overall lay of the land and what's going on out there. And so we had a witness -- and you may have witnesses, I take it, there have been changes not only in Europe, there have been changes in the United States among various states, and I think this admissible to show the activities of the federal government. I'll admit it for that purpose.

I'm certainly not going to make a finding on a medical issue, for example, based on some statement that is made in a government publication without backup that is not supported by experts or other testimony in the record. I do think for that purpose this is hearsay.

If it was actually a finding, that would be different. I take it, just having looked briefly at this, these are not findings you are admitting for that purpose, but just to show the activity of the office. You are nodding "yes."

MS. DeBRIERE: That's correct, Your Honor.

THE COURT: So it's admitted for that purpose.

What's next?

(PLAINTIFFS' EXHIBIT NO. 74: Received in evidence.)

MS. DeBRIERE: The next exhibit is Plaintiffs' Trial Exhibit 27, which is AHCA's prior authorization criteria for coverage of testosterone. The objections are authentication,

lack of foundation, and relevance. So, Your Honor, I can argue relevance which is --

THE COURT: Mr. Jazil, isn't that admissible? Agencies can change positions. That's certainly okay. There has been development through the decades on what has to be shown to support an agency's change of position. But at least they should be able to show that the agency has changed position.

MR. JAZIL: Your Honor, this isn't a document that we produced. It has a plaintiffs' Bates label.

MS. DeBRIERE: I can help clarify, Mr. Jazil. So on our stipulated exhibits list, we provided two online links, one to AHCA's preferred drug -- PDL, preferred drug list, as well as AHCA's drug criteria. AHCA's drug criteria has a list of drugs. This testosterone document is one of those criteria. It is the documents that live on your website, and since you've stipulated to the admissibility of any documents that are on that website, you know --

THE COURT: All right. This goes back to something I said a minute ago. Not everything you find on the internet is actually authentic. But if it's on your website, it probably is. You just -- if you need to check out and find out if it really is; although, I would have hoped that got done during the pretrial process, but --

MR. JAZIL: Your Honor, I will take my friend's word

at face value. If she says it's off our website, it's off our website, I'll withdraw the authentication objection.

THE COURT: All right. Look, you have folks there that are really good at checking on this kind of thing. So if you go back and find out this isn't really it, then you bring it back up and we'll straighten it out.

MR. JAZIL: Yes, Your Honor. As I understand it before, my friend is objecting that the relevant issues are overcome because they go to the comparability claims, and so --

THE COURT: Relevance is the low standard. Plaintiffs' 27 is admitted.

(PLAINTIFFS' EXHIBIT NO. 27: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 28. These are the agency's responses to plaintiffs' questions dated March 1, 2023. These -- the objection, Your Honor, is relevance. These were responses provided to us after the first round of the 30(b)(6) deposition in which the designee could not answer all of the questions for the topics which we noticed him for.

MR. JAZIL: Your Honor, I had the relevance objection based off of my perspective that under *Rush*, the process doesn't matter, but --

THE COURT: That's overruled. And what makes bench trials easier than jury trials is, if it's irrelevant, it

won't matter. Plaintiff's 28 is admitted.

(PLAINTIFFS' EXHIBIT NO. 28: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 67. This is a document from the Food and Drug Administration entitled "Understanding unapproved use of approved drugs off label."

Your Honor, the objections are lack of foundation, relevance, and hearsay. I can speak to hearsay inasmuch as this is a public document taken off of the FDA's website. I'm happy to provide the Court the URL.

As to relevance, there has been a lot of reliance in the GAPMS memo on the drugs not being FDA approved for indications, which is off-label a short form for not having a FDA-approved use for a particular indication of a drug. So this is just further description of what and when it's appropriate to authorize drugs for an off-label use.

MR. JAZIL: Your Honor, this is, as I understand, a Q&A off an FDA website. It's not the same as an FDA rule. It is not the same as an FDA guidance document. To the extent it's being used to establish that off-label use is appropriate under certain circumstances, I don't think that is an appropriate use of this.

THE COURT: I will admit this under 803(8). This is another one of those. I mean, no matter how many times you and your experts say it, the fact that a use is not the use

that was approved by the FDA at the outset when the drug came to market does not indicate that use of the drug is unsafe. It just doesn't. It's the kind of thing that advocates take to a legislative hearing I think in hoping that the legislators just won't understand, or that you take to a rule hearing in the hope that, well, it's just something you can put on the scale so that you can explain some decision made on some other basis.

However that might be -- and from that comment, you can tell that when you put your experts on to hammer on this not approved by the FDA, they are going to have some explaining to do, and I'll listen carefully to the explanation.

But aside from that, I do think that this is at least what the FDA says about this, and it's admissible.

Plaintiffs' 67 is admitted.

(PLAINTIFFS' EXHIBIT NO. 67: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 62. This is the CMS EPSDT, a guide for states regarding the coverage of the EPSDT Medicaid benefit. It's a public document. I would -- also add from the Centers for Medicaid and Medicare Services. I would also point out that this document has been previously cited in other courts within the Eleventh Circuit, including *CR v. Noggle*, which is at 559 F.Supp.3d 1323.

THE COURT: Mr. Jazil, anything different about this? This is the government's activities and what CMS says about how this works?

MR. JAZIL: No, Your Honor. Your previous rulings are clear to me.

THE COURT: This is admitted under 803(8).

(PLAINTIFFS' EXHIBIT NO. 62: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 63. This is a CMS informational bulletin regarding beneficiary protections and Medicaid drug coverage. This again is a public document, and as to relevance --

THE COURT: Same thing. Plaintiffs' 63 is admitted.

(PLAINTIFFS' EXHIBIT NO. 63: Received in evidence.)

MS. DeBRIERE: Thank you, Your Honor.

Plaintiffs' Trial Exhibit 295, the objection here, Your Honor, is lack of foundation. This was a document produced to plaintiffs in response to a subpoena to the Executive Office of the Governor. And so there is no relevance objection, so I will just speak to the lack of foundation.

THE COURT: Is there a foundation problem?

MR. JAZIL: Your Honor, I'll confess this does come from the Executive Office of the Governor, but to me foundation is more than just authenticity. And I don't know

what we are doing with this document. Is it just going to be introduced into evidence and --

THE COURT: Well, look, here's an important issue in the case: motivation, animus. I think it matters whether this rule started and was adopted by medical professionals exercising their medical judgment, or whether it started in the governor's office with nonmedical personnel who basically sent word down to the doctors, here's what you're to decide.

Now, I don't know what the answer to that is. And, of course, it could start with the governor's office and get pushed down to doctors who then make a good medical decision. So where it started doesn't tell you how the decision was made, but it's certainly relevant how this works. And I have seen this before, although I can't read it on the screen.

The chance that this document is going to affect the decision is pretty remote. It doesn't concern me that somebody in the governor's office is keeping up with how this process works. I probably would be surprised if they weren't. They probably ought to be keeping up with everything that goes on in the state, and I think they probably do. So I don't think this is going to make much difference. But the fact that it's there and they are keeping up with it is at least relevant.

As I said before, relevance is a very low standard. Is the chance that the governor initiated this greater than it

would be without this evidence, that's the 401 test, yeah, it does show that at least somebody in his office was paying attention.

MR. JAZIL: Your Honor, my objections are borne in part from, are we going to have a witness talk about these things or am I going to be, you know, confronted with these in summation, where there is a story told with some of this?

THE COURT: Well, you may be confronted with it in summation, but if they don't know who did it or what they did with it or when it came up, they are going to better spend their time on something else.

MR. JAZIL: Understood, Your Honor.

THE COURT: Because this isn't going to tell me much. On the other hand, you're probably going to have a witness from AHCA.

MR. JAZIL: Yes, Your Honor.

THE COURT: They might even ask that witness questions about it or maybe you will. This is admissible.

MR. JAZIL: Understood, Your Honor.

THE COURT: Plaintiffs' 295 is admitted.

(PLAINTIFFS' EXHIBIT NO. 295: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 296. This is similar, Your Honor, to 295. The objection is lack of foundation.

THE COURT: Same thing, same ruling. 296 is

admitted.

(PLAINTIFFS' EXHIBIT NO. 296: Received in evidence.)

MS. DeBRIERE: The next exhibit is Plaintiffs' Trial Exhibit 330. The objections are lack of foundation, relevance, and hearsay.

Your Honor, this is a draft memo of a GAPMS for specially-modified foods. This came from AHCA. It was produced to us in discovery. The relevance, Your Honor, is showing what information was previously relied on in the GAPMS process to determine whether the service was experimental.

MR. JAZIL: Your Honor, there is also a hearsay objection. I don't know if this was ever finalized or not. As I understood the exception for public records, it's an agency position. This is a draft that's unsigned.

THE COURT: Is this just a draft?

MS. DeBRIERE: It is just a draft, Your Honor, and it is unsigned.

THE COURT: How does it show what they relied on if we don't know they relied on it?

MS. DeBRIERE: As much as it's not finalized, I think the collection and organization of the information in the GAPMS memo shows that the agency uses that type of information to eventually reach a conclusion.

THE COURT: Only if they used it. I mean, if this is somebody internally there that wrote some memo and it got

tossed to the curb, it doesn't show that that's the kind of thing they used. It may indicate the kind of thing that they don't use, right?

MS. DeBRIERE: Yes, Your Honor.

THE COURT: That one is excluded, unless you can show that this actually corresponds with something that was done or --

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 331. This is a final signed version of a GAPMS related to scleral contact lenses. Same argument, Your Honor. This is the type of information that the agency relies on in determining whether a service is experimental.

MR. JAZIL: Your Honor, my only objection was relevance.

THE COURT: Overruled. Plaintiffs' 331 is admitted.

(PLAINTIFFS' EXHIBIT NO. 331: Received in evidence.)

MS. DeBRIERE: Your Honor, Plaintiffs' Trial Exhibit 332. This is another GAPMS memo.

THE COURT: Same thing?

MS. DeBRIERE: Signed and finalized.

MR. JAZIL: Yes, Your Honor, same objection, relevance.

THE COURT: 332 is admitted.

(PLAINTIFFS' EXHIBIT NO. 332: Received in evidence.)

MS. DeBRIERE: And Plaintiffs' Trial Exhibit 333.

Same arguments, Your Honor.

MR. JAZIL: Yes, Your Honor.

THE COURT: Same ruling, Plaintiffs' 333 is admitted.

(PLAINTIFFS' EXHIBIT NO. 333: Received in evidence.)

MS. DeBRIERE: Next exhibit, Your Honor is Plaintiffs' Trial Exhibit 291. Your Honor, the objection to this is relevance. This is an email from Jason Weida, Secretary Weida, to Devona Pickle and Andre Van Mol regarding the payment to Dr. Van Mol by AHCA for participating in the GAPMS process. And so it goes to show, Your Honor, the process that was used in drafting the GAPMS and adopting the final Challenged Exclusion.

THE COURT: I don't see the attachment. Was there an attached itemized charge?

MS. DeBRIERE: It should be there now, Your Honor.

THE COURT: Why isn't this admissible to show who drafted the document?

MR. JAZIL: Your Honor, I just had a relevance objection to it, but --

THE COURT: Isn't that -- Dr. Van Mol wrote the document. Isn't that relevant? Is that what the background document is, master background document? Do we know what that is?

MR. JAZIL: Your Honor, I believe this is referring to just the invoices.

THE COURT: Well, the hours he's charging for, the first item on the list is *Research and drafting of master background document*.

MR. JAZIL: I believe that's a bibliography he provided. I had a relevance objection to this, Your Honor. As I understand my friend's point, this goes to the process, and we've just been consistently making objections to the process.

THE COURT: All right. So that objection is overruled in any event. So Plaintiffs' 291 is admitted.

(PLAINTIFFS' EXHIBIT NO. 291: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 292. This is a very similar document to the one we just reviewed. It's regarding invoices from Romina Brignardello-Petersen to AHCA regarding payment for her participation and adoption --

THE COURT: Scroll that down. What does the list say? Nothing. Look, here's what happens with these kind of invoices, you are welcome to ask any expert how much they have been paid.

MR. JAZIL: Your Honor, 292(a) is the accompanying document which is the attachment.

THE COURT: Is this the same thing?

MR. JAZIL: We have a relevance objection.

MS. DeBRIERE: I'm sorry. It did not make it on my

list. I apologize.

MR. JAZIL: 292 and 292(a), we have the relevance objections.

THE COURT: But same, based on process?

MR. JAZIL: Yes, Your Honor.

THE COURT: Overruled. So 292 and 292(a) are admitted.

(PLAINTIFFS' EXHIBIT NOS. 292 and 292(a): Received in evidence.)

MS. DeBRIERE: Plaintiffs' Trial Exhibit 313 is our next one. The objection here is relevance. This is a discussion, Your Honor, between AHCA employees regarding a policy transmittal and later a provider alert, speaking to continuity of coverage once the Challenged Exclusion was put into place as to whether they should notify individuals that they would be entitled to a continuity of care protections until the final implementation of the exclusion. And that, Your Honor, demonstrates that they were previously providing care.

MR. JAZIL: Your Honor, I had a relevance objection. I didn't understand what it was being used for.

THE COURT: Plaintiffs' 313 is admitted.

(PLAINTIFFS' EXHIBIT NO. 313: Received in evidence.)

MS. DeBRIERE: Next exhibit is Plaintiffs' Trial Exhibit 313(a). I probably should have spoken to these

together.

THE COURT: Same ruling, 313(a) is admitted.

(PLAINTIFFS' EXHIBIT NO. 313(a): Received in evidence.)

MS. DeBRIERE: Plaintiffs' Trial Exhibit 314, which is -- the objection is based on relevance, and, again, is just further email conversation between AHCA employees about the provider alert.

THE COURT: Same issue?

MR. JAZIL: Yes, Your Honor.

THE COURT: Same ruling, 314 is admitted.

(PLAINTIFFS' EXHIBIT NO. 314: Received in evidence.)

MS. DeBRIERE: Plaintiffs' Trial Exhibit 315, this is the draft policy transmittal, Your Honor, that the emails are discussing, and the objection is relevance.

THE COURT: 315 is admitted.

(PLAINTIFFS' EXHIBIT NO. 315: Received in evidence.)

MS. DeBRIERE: And then Plaintiffs' Trial Exhibit 316, objection is relevance. It's a sign-off form regarding the provider alert.

THE COURT: Same issue, same ruling, 316 is admitted.

(PLAINTIFFS' EXHIBIT NO. 316: Received in evidence.)

MS. DeBRIERE: Next exhibit is Plaintiffs' Trial Exhibit 254. The objections are foundation and hearsay. Your Honor, because these are statements made by employees of defendant, they are party admissions and not hearsay under

801(d)(2). We do have the foundation issue which is why we raised the records custodian.

THE COURT: This is 254?

MS. DeBRIERE: Yes, Your Honor.

THE COURT: And what's the objection?

MR. JAZIL: I don't know what the role these people play to the agency and whether or not they had authority to talk about these issues in the manner they are talking about.

THE COURT: So when somebody sends a memo and says, "Please work on creating criteria for approval of agents used to suppress puberty and transgender children," you think that's not within the scope of their work?

MR. JAZIL: Your Honor, I can't tell from the emails. I apologize, Your Honor. I read these a while ago, but I can't tell readily whether that is, in fact, the case.

MS. DeBRIERE: Your Honor, I will note that we have deposition testimony identifying Arlene Elliott as a program administrator in the pharmacy section for AHCA.

THE COURT: Well, is it in evidence? Maybe you don't need it. Just authenticate the document. But the hearsay objection is overruled. If that's all we are dealing with, 254 is admitted.

(PLAINTIFFS' EXHIBIT NO. 254: Received in evidence.)

MS. DeBRIERE: Your Honor, there are going to be similar arguments for the remaining exhibits, beginning with

Plaintiffs' Trial Exhibit 255.

THE COURT: You have a series that are all internal memos?

MS. DeBRIERE: Emails, yes, Your Honor. And the objections are the same for all of them, foundation and hearsay. So we would state that it's not hearsay because it's a party admission.

THE COURT: Read the numbers out.

MS. DeBRIERE: 255, 263, 276, and 346.

THE COURT: The ruling is going to follow the same pattern. If you get to those and one of those, you have reason to assert that it's not within the course and scope and that I can't find it within the course and scope based on the document itself, if there is a specific issue, you can bring it back.

MR. JAZIL: Yes, Your Honor.

THE COURT: But those are the admitted --

(PLAINTIFFS' EXHIBIT NOS. 255, 263, 276, 346: Received in evidence.)

THE COURT: -- subject to any reconsideration you bring back to me based on the specific document.

MR. JAZIL: Yes, Your Honor.

THE COURT: If we don't speak to it further, they are part of the record, they are admitted.

MS. DeBRIERE: Your Honor, that concludes my portion.

THE COURT: All right. Are there some with no objection?

MS. DUNN: There's one other outstanding issue with regard to the exhibits. During the testimony of Jeff English, Plaintiffs' Exhibit 302 was discussed extensively, and I believe that the Court indicated that it would be admitted as a party admission, but the transcript for that day does not reflect that it was, in fact, admitted into evidence.

THE COURT: Long experience teaches me to believe that, when I remember what happened and the transcript says something different, the transcript is always right.

MS. DUNN: It was probably an oversight on our part.

THE COURT: That's the email chain.

MS. DUNN: Yes.

THE COURT: 302 is admitted.

(PLAINTIFFS' EXHIBIT NO. 302: Received in evidence.)

THE COURT: Other exhibits? What else?

MS. DUNN: Yes, Your Honor, in our pretrial disclosures that were filed we indicated a number of a deposition disclosures that we would be moving into evidence. I have those copies of the depositions with those designations highlighted. I have a copy for defendants as well. If I can approach --

THE COURT: Yes.

MS. DUNN: -- the Court?

THE COURT: I look forward to reading them.

MS. DUNN: I'd ask the Court to move those into evidence as well.

MR. JAZIL: Your Honor, I believe there is a caveat with Mr. Brackett and Ms. Dalton that these designations would come in if they did not testify live. They will be testifying.

THE COURT: They both work for the department?

MR. JAZIL: Yes, Your Honor.

MS. DUNN: Ms. Dalton is the bureau chief for the Bureau of Medicaid Policy, and Mr. Brackett was the agency's 30(b)(6) representative.

THE COURT: Well, you can admit the 30(b)(6) and probably Ms. Dalton's deposition. Let me tell you my experience, frankly, I learned the hard way as a young lawyer. When there is a witness testifying live, the chance that the deposition testimony is going to make any difference or be credited differently from the live testimony is pretty slim.

Probably when the witness testifies live and you cross-examine, including with anything inconsistent in the deposition, I'll have what I need. If you nonetheless want to admit these, I think you are entitled to it. Under the deposition rule, a deposition of an opposing party, you can always put in the substantive evidence.

So I will expect to admit these and treat them as

part of the record. These are people who are equivalent of the defendant within the meaning of that rule, are they not, Mr. Jazil?

MR. JAZIL: They are. I never made a cross-designations because of the caveat that they were being --

THE COURT: And as long as what you want to say gets said from the witness stand, it won't matter whether it was cross-designated in the deposition as well, and this -- what's said in here, I'll admit it. These are parts of the depositions of Mr. Brackett, Ms. Dalton, and Mr. Donovan. And the actual notebooks, I'll keep with the record.

MS. DUNN: We can also file those transcripts on the electronic case record.

THE COURT: That would be good. Do that as well, and then I will --

MS. DUNN: Those are full copies of the transcripts. Just the designated portions are highlighted.

THE COURT: Figure out whether you can file those electronically and the highlighting works. Figure out how to do that. It makes it much easier if we don't have to mail the -- or ship the hard-copy transcripts to the Circuit. It's harder for them to find it.

Frankly, when it gets to the Circuit, there will be three judges and three sets of law clerks, and if all of them

can get to this electronically, it's much better than trying to find the one set of pretty white notebooks that are somewhere in Atlanta.

MS. DUNN: Absolutely, Your Honor.

THE COURT: What else?

MR. GONZALEZ-PAGAN: Thank you, Your Honor. That would conclude the presentation of evidence from the plaintiffs.

THE COURT: The plaintiffs rest?

MR. GONZALEZ-PAGAN: Yes, Your Honor, with the caveat that -- I believe, it is my understanding that 254 has been signed this morning. So there will be a motion to amend that will be filed in short order to include Section 3 of --

THE COURT: 254 is the bill that we talked about last week.

MR. GONZALEZ-PAGAN: Correct, Your Honor.

THE COURT: It has been signed this morning?

MR. GONZALEZ-PAGAN: That is my understanding, Your Honor.

THE COURT: All right. I'll give thought to it over lunch to what that means or doesn't mean. I don't think it affects the substance. At least the core substance of the case is the not affected, right?

MR. JAZIL: My perspective, I still need to get some guidance from my client. I heard it being signed by

Ms. Chriss during the break. From my perspective, if my friends for the plaintiffs in this case are challenging Section 3 that deals with the Medicaid provision, it should not affect the core issue as framed by *Rush*. Section 3 would still have to pass the, as I understand it, the *Rush* test as the Court laid out.

There are separate claims on the equal protection, et cetera. And, again, I understood my friend's colloquy with the Court earlier, they will be moving to amend to include a challenge to the Section 3, they rested their case, there is no new discovery, and that would be the motion.

Your Honor, I'm asking the Court and my friends for some guidance, because during the break I will go out and try to figure things out.

THE COURT: You want to amend the challenge of the statute.

MR. GONZALEZ-PAGAN: That is correct.

THE COURT: It does seem to me that that -- before I finish that sentence, I should say this:

Sometimes when I reach a conclusion in 10 or 15 seconds, it turns out not to be correct. Sometimes when I reach a conclusion after 15 months, it turns out not to be correct, but it's better than in 10 or 15 seconds.

Just having heard it, it does seem to me that this renders moot the challenge to the rule. The adoption of the

rule may still be relevant on the question of animus, motivation, and whatever in an attenuated way, a different decision-maker, different process. So it could be relevant. But a challenge to the rule itself now is probably moot; is it not?

MR. GONZALEZ-PAGAN: Your Honor, if I may. We would argue that the Affordable Care Act claim for which we have asserted nominal damages, and there have been instances that have come out in testimony about past discrimination, including the rejection of prior authorization to Plaintiff Brit Rothstein. The passage and enactment of 254 would not render that part of the case moot in any way.

Out of an abundance of caution either way, I think our intent is to proceed to amend to include only Section 3 of 254. It is my understanding that my colleagues and friends working on the *Doe v. Ladapo* case are asserting claims as to the rest of the aspects of 254.

THE COURT: And Section 3 is just the --

MR. GONZALEZ-PAGAN: State funding and specifically as to Medicaid, Your Honor.

THE COURT: Well, it may be right. If there is a nominal damages claim, the defendant is just the --

MR. GONZALEZ-PAGAN: In this case, it would be the same parties. And we would argue, I believe which is what my friend was asking about, that the presentation of the evidence

in terms of substance is truly the same, and so that would be how we would be proceeding to the Court.

THE COURT: You don't plan to have any evidence about the legislative process?

MR. GONZALEZ-PAGAN: Your Honor, from our position, we -- I think we can discuss that. But many of the aspects that have to do with the legislative process, we would argue the Court is empowered to make findings as to those aspects without the need for trial testimony, they're judicial legislative fact-finding.

I would just argue that we need -- our case is not completely moot. It just means we need to challenge both 254 and the rule. The judgment needs to apply to both.

THE COURT: You think you can get nominal damages against a state official in his official capacity?

MR. GONZALEZ-PAGAN: Yes, Your Honor. In fact, I argued that before the Fourth Circuit, and I can confirm that sovereign immunity has been waived at least as to the Fourth Circuit and cert was denied.

THE COURT: If you were in the Eighth Circuit, you would have an easier case. But you are in the Eleventh Circuit, so I get it. If I have dealt with a nominal damages claim against a state official, I have forgotten it, so I will go back and give it some thought.

But, in any event, do you have a written amended

complaint?

MR. GONZALEZ-PAGAN: We will be filing it probably later this evening, Your Honor. We are working on it.

THE COURT: But it's not going to surprise Mr. Jazil?

MR. GONZALEZ-PAGAN: I do not intend it to do so, and we are happy to share it with our friends before filing it as well.

MR. JAZIL: Your Honor, just a couple of other points of clarification. Because the state statute is being challenged, perhaps my friends can also notify the Attorney General's Office.

Second, Your Honor, again, as I understand it, the Section 3 deals with public post-secondary institutions, group healthcare plans and the managed care plans, and it's under Chapter 49. My understanding is this is still challenged, the managed care plans, AHCA. My friend is nodding in the affirmative.

MR. GONZALEZ-PAGAN: That is correct.

THE COURT: And notice to the Attorney General, at least in the local rule -- and I looked back -- isn't that required when there is not an official capacity state official as a defendant?

MR. JAZIL: Your Honor, I think as I'm coming up to speed with the signing of the legislation, I can't remember whether it's in the local rule or whether it's a Florida

statute that requires the Attorney General to be notified. I apologize, Your Honor.

THE COURT: All right. We can deal with those.

You are ready to go ahead with the presentation of evidence?

MR. JAZIL: Yes, Your Honor.

THE COURT: All right. Let's take an hour for lunch. That makes it 1:45 we'll start back. Good luck with the weather and the lunch break. I will see you back here in an hour and two minutes.

(*A luncheon recess was taken at 12:44 p.m.*)

AFTERNOON SESSION
(1:45 P.M.)

THE COURT: Please be seated. Mr. Perko, please call your first witness.

MR. PERKO: Your Honor, the defendants call Dr. Paul Hruz.

DEPUTY CLERK: Please raise your right hand.

PAUL WILLIAM HRUZ, DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: Paul William Hruz, H-r-u-z.

DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Hruz, what positions do you currently hold?
A. I am currently an associate professor of pediatrics and associate professor of cellular biology and physiology at Washington University in St. Louis.
Q. Do you also hold any clinical positions?
A. I am also serving as the associate fellowship program director, a position that I previously held as the director.
Q. Could you please summarize your educational background?
A. I received a Bachelor of Science degree in chemistry at Marquette University. I then received my Ph.D. in biochemistry and my M.D. at the Medical College of Wisconsin. I completed my residency training in general pediatrics at the University of Washington in Seattle, and my fellowship training in pediatric endocrinology at Washington University.
Q. Are you a member of any medical organizations?
A. Yes. I am currently a member of the American Diabetes Association, the Pediatric Endocrine Society, and the Endocrine Society.
Q. Do you hold any professional certifications?
A. I am board certified in pediatrics and pediatric endocrinology, and I also have a certification in healthcare ethics.
Q. Have you ever served as a peer reviewer for any journal or grant-funding agency?
A. Throughout my 25-year career, I have routinely served as

a peer reviewer for a variety of journals, the same top-tier journals that I submit my own papers for publication, and I have also served as a reviewer on several grant review study sections including for the American Diabetes Association and for the National Institute of Health.

Q. Can you please summarize your professional experience since obtaining your degrees?

A. In my role as a pediatric endocrinologist and physician scientist, I devote my time to several different areas. This includes direct patient care, research, and the education of residents, medical students and clinical fellows.

Throughout my career, I have also taken on roles in leadership as I served as the chief of our division of pediatric endocrinology and diabetes at Washington University.

Q. Could you please explain what role research plays in your work?

A. In my research roles, for two decades, I have run a basic science research laboratory that for over a decade focused on questions related to adverse metabolic effects of various drug exposures and have transitioned into investigation of new drug discovery.

Within that context, I became very much involved in understanding the regulatory process, what is necessitated in evaluating the safety and efficacy of various medications

that are used in the treatment of various diseases.
Q. And is gender dysphoria one of those disorders?
A. I began investigating gender dysphoria about a decade ago, as the proposition was made at my institution to begin a gender center there. That necessitated me in my role as chief of our division to systematically look at the quality and nature of the evidence that was being put forward to justify the creation of that center.
Q. Dr. Hruz, what are some of the pediatric endocrine disorders that you treat?
A. As a pediatric endocrinologist, I treat a variety of hormone diseases, diseases that are caused either by a deficiency in the production or action of hormones. And by that, I mean substances that are made and secreted from one part of the body that act in a different part of the body. This includes treatment of disorders of metabolism, like diabetes mellitus, pituitary abnormalities, disorders of thyroid function, disorders of growth and development, disorders of sexual development, and puberty disorders, also includes diseases relating to abnormal menstrual function.
Q. And what's your understanding of gender dysphoria?
A. Gender dysphoria is a diagnostic term that refers to a condition in which one experiences a sense of their gender identity that is discordant with their biological sex. This diagnostic category became in use with the publication of the

Fifth Edition of the Diagnostic and Statistical Manual that is used in the field of psychiatry superseding the previous diagnosis of gender identity disorder.

Q. How does the diagnosis of gender dysphoria differ from the diagnoses for the other pediatric endocrine disorders that you treat?

A. In all of the endocrine disorders that I encounter in my practice, with the exception of gender dysphoria, there are objective, biological, radiologic or clinical features that allow for an objective diagnosis assessment of a response to treatment. This is in contrast with gender dysphoria where, to my knowledge, there is not a single biological or radiologic or objective test that can be used in the way that endocrinologists use to treat other diseases.

Q. Thank you, Doctor. I need to back up. I forgot one question.

Did you submit a curriculum vitae attached to your expert report in this case?

A. Yes, I did.

Q. And does it accurately summarize your professional experience and education?

A. Yes, it does.

Q. Does it contain a list of your publications?

A. It does.

MR. PERKO: Your Honor, I believe it's on the

stipulated exhibit list as Exhibit DX29. Ask it to be admitted.

THE COURT: DX29 is admitted.

(DEFENDANTS' EXHIBIT NO. 29: Received in evidence.)

BY MR. PERKO:

Q. Now, Dr. Hruz, I would like to talk to you a little bit now about treatments for gender dysphoria.

What are the various treatment approaches for gender dysphoria?

A. Well, there have been various terms that have been used, but they can generally be categorized into three different approaches to alleviate the suffering that people experience from this sex-discordant gender identity.

MS. RIVAUX: I'd like to object. I don't know if he is being qualified on all of these topics.

THE COURT: What are you tendering him as an expert in?

MR. PERKO: I will tender him as an expert in endocrinology, pediatric endocrinology.

THE COURT: Do you have questions at this tome?

MS. RIVAUX: If the topic is solely pediatric endocrinology, I don't have any questions. If it goes beyond the scope of that qualification, then, yes, I would have some questions.

THE COURT: This is your time to voir dire if you

wish to voir dire on credentials. Otherwise, you can object to questions as they come up and you can cross-examine.

Do you wish to ask questions now?

MS. RIVAUX: I'll object as they come along.

THE COURT: All right.

BY MR. PERKO:

Q. Let me ask that question again, Doctor.

What are the various treatment approaches for gender dysphoria?

A. As I had begun to explain, there are three categories of intervention to alleviate the suffering that individuals experience because of sex-discordant gender identity. They can be grouped into a reparative approach, a watch-and-wait or expectant approach, or the affirmative approach.

Q. What is the reparative approach?

A. All of the three approaches all differ with respect to the scientific premise and the goal of the intervention. The reparative approach is based upon the premise --

THE COURT: Wait just a minute.

MS. RIVAUX: I'm going to object, Your Honor. This is outside the scope of pediatric endocrinology.

MR. PERKO: I don't believe it is, Your Honor. It talks about hormonal treatments.

THE COURT: Doctor, how many patients have you treated for gender dysphoria?

THE WITNESS: As will be stated in my testimony, in my review of the literature, I have concluded that the risk versus relative benefit --

THE COURT: Let me stop you. If you can just answer my question: How many patients have you treated for gender dysphoria?

THE WITNESS: I have not because of ethical concerns about the safety and efficacy of that treatment.

THE COURT: How is he going to testify about treating patients when he's never treated one?

MR. PERKO: He's familiar with the literature, Your Honor.

THE COURT: If he read about cardiology, could he come and testify about cardiology?

MR. PERKO: Well, Your Honor, this is specifically related to the subject of endocrinology.

THE COURT: If you want to ask him questions about his expertise on pediatric endocrinology, you may certainly do it. But if all he's going to testify about is something unrelated to endocrinology, that he's never done, I'm not sure I understand the basis on which you think he can testify.

MR. PERKO: He's going to be testifying about puberty blockers and cross-sex hormones, Your Honor. It's established, he has got experience in prescribing those treatments. He has kept up with literature to determine

whether it's appropriate to prescribe those treatments for gender dysphoria.

THE COURT: I'm going to hear the testimony, because, frankly, it would be appropriate to have a proffer, in any event. It's probably more useful to have the proffer in question-and-answer form and to hear the cross-examination. And we can discuss ultimately whether the testimony is inadmissible, admissible, and entitled to very little weight, or admissible and entitled to great deal of weight and persuasive.

So at this point I will overrule the objection, and we can address those subjects later as part of argument.

MS. RIVAUX: Your Honor, if I can ask for one clarification. Some of the topics that he started testifying about are outside even the scope of pediatric endocrinology. For example, he was just mentioning the reparative model of treatment. That is outside the scope of pediatric endocrinology.

So while I understand -- I just want to make sure and whether you want me to object as the questions come up or how to handle it.

THE COURT: I don't need objections as it comes up. You can have a standing objection to his testimony about treatment of patients of the kind he has never provided.

MS. RIVAUX: Thank you, Your Honor.

BY MR. PERKO:

Q. Dr. Hruz, you mentioned the affirmative approach. Can you explain what that is?

A. The affirmative approach is the approach that actually involves the participation of the pediatric endocrinologist. That is based on a vastly different scientific premise than the other two approaches and necessitates or involves the use of puberty blockers and cross-sex hormones, which are medications that are used to treat pediatric endocrine disorders.

Q. Let's talk about the type of hormonal treatment you provide in your practice.

Have you ever prescribed puberty blockers in your practice?

A. Yes, I do.

Q. What conditions do you prescribe them for?

A. As a pediatric endocrinologist, this class of medication is routinely used in the treatment of central precocious puberty.

Q. Any other conditions that you've prescribed it for?

A. Other than its new use now in gender dysphoria, not in the setting of pediatric endocrinology, no.

Q. One of the medical treatments or interventions for gender dysphoria is cross-sex hormones.

Could you explain what cross-sex hormones are?

A. The term "cross-sex hormones" refers to the administration of androgens, namely testosterone, to biological females to allow them to appear masculinized, or estrogen to a biological male to lead to feminization, so the appearance of secondary sexual characteristics corresponding to the desired sexual identity.

Q. Backing up to puberty blockers. What are the risks associated with using puberty blockers to treat gender dysphoria?

A. There are significant risks that are unique to the application of the use of puberty blockers, the GnRH agonists, in somebody that is going through normally-timed puberty.

As opposed to the use in central precocious puberty, where one is intending to suppress the signals from the pituitary gland to the gonad at a time where it's occurring abnormally, the intention of using this in the treatment of gender dysphoria is to disrupt that signaling at a time when it would normally be occurring.

The consequences of this are severalfold. The well-documented concern is the effect of preventing somebody going through puberty at a time when maximal bone density is being accrued. This occurs during the teenage years in response to the sex steroid hormones that are produced by puberty; that the maximal bone density that one achieves by

the early 20s is going to be all that one has to carry them out through the rest of their life. So one of the concerns of giving this class of drugs to block normally-timed puberty is to prevent one from accruing maximal bone density.

There are unknowns about the -- it is very well established in the endocrinologic literature that sex steroid hormones are important in brain maturation. There are both organizational and activational effects of sex steroid hormones. By that I mean, differences in structure and neuronal signaling within the brain.

It is an unexplored -- virtually unexplored area as what the consequences are of disrupting that process. Only some of the questions related to that have even been asked in a formal way in scientific investigation.

And lastly -- not lastly, but in addition to that, there are other concerns as well. But the most important is the question as to whether this intervention itself influences the trajectory for the individual; meaning, that it's often presented by the endocrinologist that this is merely a pause button that allows one time to more explore their gender identity.

There are many who question that premise based upon the observation that nearly 100 percent -- the published studies show anywhere from 97 to 100 percent of the individuals who receive puberty blockers will proceed on to get cross-sex

hormones. So, objectively looking at that, one can question whether that really is serving that purpose as a pause button.

Another concern I will add is that, when it is stated that it is safe and fully reversible, the reversibility refers specifically to the reengagement of the signals from the pituitary gland to the gonad when you remove the drug, and that does occur.

What is very frequently missed is that in the process of interrupting normally-timed puberty, which is a temporally dependant process that occurs at the same time as the cycle social component known at adolescence, is disassociated; meaning that, when one allows -- if one were to withdrawal the puberty blocker and allow that gonadal access to reactivate, one cannot buy back the time that -- where that puberty was blocked.

And there are many questions that are not answered as to whether that disruption has any lasting effects on that individual that went through that intervention.

Q. We talked a little bit about cross-sex hormones.

Do you prescribe -- first of all, is testosterone an estrogen?

A. Testosterone is an androgen.

Q. But that is considered a cross-sex hormone?

A. If testosterone is given to a biological female, that

would be a cross-sex hormone use.
Q. Do you ever prescribe testosterone to adolescents in your clinical practice?
A. Yes, I do prescribe testosterone to males that have disorders in pubertal maturation, that have hypogonadism, which means inability for the testes to function normally, either by a primary defect in the development or functioning of the testes or by having an abnormality at the level of the pituitary gland signaling to that testicle.
Q. And do you monitor the testosterone levels of patients that you treat?
A. It is essential in the treatment of testosterone for gonadal disorders to be very vigilant in assessing hormone levels, recognizing that, one, that you have the response that is expected in producing the levels of that androgen, and also to make sure that you're not achieving toxic levels because of the significant risks of adverse effects related to that.
Q. What are the risks associated with using testosterone to treat gender dysphoria?
A. Well, in addition to the general risks of using testosterone where it could be administered to in excess even to male, which can lead to elevations in blood pressure, changes in lipid levels, causing -- inducing abnormal metabolism that increases the risk of cardiovascular disease.

It can also lead to elevations in red blood cell counts, a condition known as polycythemia.

But giving testosterone to a female is not equivalent to giving that same hormone to a male. And the reason for that is that there are clear biological differences in every nuclear cell of the body between males and females.

These are due to programmed epigenetic effects, modifications to the DNA that lead to differential expression of various genes. In fact, it is known that there are over 6,500 sex differentially expressed genes throughout the body. This is recognized by our National Institute of Health and requiring that when one is developing a new drug, that one studies both males and females, recognizing that the response to treatment and adverse effects may be different depending on the sex of that individual.

So also it's recognized by the Endocrine Society in a position statement that they published several years ago, where talking about sex as a biological variable, acknowledging the essential importance of recognizing that there are program differences between males and females.

So, therefore, there are greater attendant risks when you give testosterone to a female above and beyond that which you would see in giving that same hormone to a male.

Q. And, Dr. Hruz, we've heard some testimony about use of estrogen for treatment for gender dysphoria.

What are the potential risks of using estrogen for the treatment of gender dysphoria?

A. So, again, the same point that applies to the treatment of estrogen when given to a biological male; meaning, that you are giving a hormone at levels that are not native to the biological sex of that individual. The risk factors associated with giving estrogen, even to a female, include increased risk of clotting, changes in blood pressure.

The effects that actually have been shown to occur in males that are given estrogen as part of a gender affirmation can increase risk of a thromboembolic stroke three to fivefold.

And just to be clear about that, meaning a stroke that can lead to permanent neurologic damage or even death.

Q. Dr. Hruz, you said you are a member of the Endocrine Society. Did I get that right?

A. That's correct.

Q. And are you familiar with the Endocrine Society's clinical guidelines?

A. I am very familiar with a series of guidelines that have been produced by the Endocrine Society, yes.

Q. Do you utilize any of those guidelines?

A. Clinical practice guidelines like those that are published by the Endocrine Society are quite valuable to clinicians that are involved in the care of patients. And as

I teach all of my residents and fellows, clinical practice guidelines are only as good as the evidence by which they are based upon.

They cannot be interpreted as definitive. There is a very longstanding history of clinical practice guidelines not only for the Endocrine Society but in other fields as well, that I'm required to be up to date on, where the guidelines themselves change.

So they need to be utilized as they are intended to be able to synthesize a relatively large amount of data to be able to make tentative recommendations about the approach to care in the context of -- by which a patient is being encountered in the clinic with all of the variables associated with that, with recognition of the quality of evidence that is present in the production of those guidelines.

Q. Are you familiar with the Endocrine Society's guidelines for the treatment of gender dysphoria?

A. I am very familiar with the Endocrine Society guidelines for the treatment of gender dysphoria, the first guidelines that came out in 2009 and the revision that came out in 2017.

Q. Are you familiar with the grading or recommendations assessment development and evaluation or GRADE?

A. Yes, I'm very familiar with that.

Q. Could you briefly describe that?

A. The GRADE system is a systematic way of rating the quality of evidence that is present within clinical practice guidelines. They rate the quality of evidence from very low, low, moderate, or high levels of evidence. And the weight that one puts upon those recommendations and the predictive value by which those recommendations may or may not change over time, depending on the production of new evidence, is reflected in that grading system. By definition, studies that are of very low quality mean that it is very likely that the recommendations will change as new information becomes available.

Q. Does the Endocrine Society use the GRADE system in developing its clinic guidelines?

A. Yes. The Endocrine Society does make use of the GRADE system, yes.

Q. What is the quality of evidence supporting the Endocrine Society's guidelines for the treatment of gender dysphoria?

A. It's important to recognize that nearly all of the recommendations that are made in the Endocrine Society guidelines for the treatment of gender dysphoria are based upon low and very low quality evidence.

Q. Are you familiar with the World Professional Association for Transgender Health, or WPATH?

A. Yes, I am.

Q. What is it?

A. It is an organization that began as a scientific organization to help establish effective interventions for those that have this experience of sex-discordant gender identity. This organization has put forward their own set of clinical practice recommendations or guidelines that they currently have referred to as, quote, Standards of Care unquote. They are currently in the eighth iteration of those practice guidelines.

Q. And are you familiar with the WPATH Standards of Care, Version 8?

A. Yes, I am very familiar.

Q. What the evidence base for those standards?

A. So new to the SOC 8 document was an attempt to be able to incorporate a review of the literature that was present in making their recommendations for the care, which had been notably absent in prior iterations of that document.

With respect to my area of endocrinology and where it's very important in the treatment using the affirmative approach, in that document they acknowledge that there's very little evidence that helps guide the decisions that are being made. In fact, they claimed they were not able to do a systematic review based upon the level of evidence.

Q. Let's turn to treatment of gender dysphoria internationally.

Do clinicians and academics like yourself keep up with

developments in other countries?

A. It's very important for us as clinicians to be aware of what is going on around in other countries. Many times the introduction of new medications or new treatment approaches come from other countries, and changes in care, we need to be aware of that as we continue to evolve our practice.

THE COURT: Why would you keep up with the treatment of gender dysphoria in other countries if you don't treat anybody for gender dysphoria?

THE WITNESS: Because I'm a physician scientist, and I approach this with the goal of being able to achieve the best benefit for the patients. When I began and I made my decision, my conclusion that the available scientific evidence regarding risk and purported benefit did not justify engagement of myself as a pediatric endocrinologist in that condition, it did not mean that I was not willing to continue to look for the emergence of new evidence that would change that opinion.

Therefore, it's essential for me to maintain that perspective of being aware of what new research is being produced and the discussion that is going on nationally and internationally to be able to maintain that goal of providing -- or assessing whether there is a role for a pediatric endocrinologist in this condition.

THE COURT: So you're open to being persuaded and to

beginning to treat gender dysphoria with medicines.

THE WITNESS: In fact, I'm not only willing, I have actually openly had conversations with many of my colleagues about the need for conducting high-quality research trials and am very much in support of that being done.

THE COURT: I understand that you personally would treat gender dysphoria patients including with medications to affirm their gender identity if you were satisfied that the evidence was sufficient?

THE WITNESS: That's my role as a physician.

THE COURT: So that's yes or no.

THE WITNESS: Yes.

THE COURT: That answer is yes?

THE WITNESS: Yes.

THE COURT: You may continue.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. Have there been any developments with regard to gender dysphoria care in Sweden?

A. So, yes, there have been significant developments. I'm aware of dating back to about May of 2021 when the Karolinska Hospital reversed course and decided that they would not offer puberty blockers and cross-sex hormone therapy to gender dysphoric youth outside of a clinical trial. This was followed up by a more formal policy statement in December of

2022, acknowledging the basis by which that decision was made. And that was essentially the same conclusion that I had made in my review of the literature, that there was not sufficient evidence that was present to justify the use of those medications for that condition, but acknowledged that there was a need to obtain more information.

Q. Was that analysis performed by the Swedish National Board of Health and Welfare for the care of --

A. Yes.

Q. And did the Swedish National Board of Health and Welfare prepare a summary of its conclusions?

A. Yes. I'm aware I think it was in December of 2022.

MR. PERKO: If I can pull up Exhibit DX8, please.

BY MR. PERKO:

Q. And you have a copy with you, Doctor. Ask if you recognize this document?

A. Yes, I do.

Q. Is this a fair and accurate copy of the summary issued by the Swedish National Board of Health?

A. Yes. This is the summary that I referred to that I've previously read, yes.

MS. RIVAUX: I object, Your Honor, on hearsay grounds.

THE COURT: The ruling here would be the same as what we talked about before lunch when you were objecting to their

documents, would it not, Mr. Perko?

MR. PERKO: Yes, Your Honor.

THE COURT: Same ruling. You can put this in to show the activity but not to show the truth of the assertions in it.

MS. RIVAUX: Your Honor, two more points. I believe this is document is a translation, and there is no certification of translation as well as proper authentication of where this document came from.

THE COURT: Well, he can --

MS. RIVAUX: And it's incomplete.

THE COURT: That's three things.

First, I much prefer English to Swedish, or whatever the original is in, but somebody needs to tell us where it came from and that it's accurate.

Then what was your last point?

MS. RIVAUX: That it was incomplete.

THE COURT: That's another problem, I guess. If it's not complete, you can certainly put in the rest of it under Rule 106.

MS. RIVAUX: The exhibit itself doesn't even have the attachments to it.

MR. PERKO: Excuse me, Your Honor. Your Honor, I don't believe there are any attachments to this document that I'm aware of.

THE COURT: Well, let's do this:

First, let's find out if Dr. Hruz knows where this came from and what the translation is and so forth. I don't know if he gave this to you or you got it somewhere else. It's like the one we had in the plaintiffs' case where the witness first said, oh, yes, I know what this is, and then started looking at it and said, no, that's not what I thought it was. Let's find out.

BY MR. PERKO:

Q. Dr. Hruz, where did you get this document?

A. This is searchable on the internet. You are able to find it from the --

THE COURT: That won't do it.

THE WITNESS: -- government website.

THE COURT: Do you know where this one came from?

THE WITNESS: Yes. This is the published policy statement that is available that, at least in my effort to stay abreast of the developments that are happening internationally, this is what I was able to find.

BY MR. PERKO:

Q. And was it on the website for the Swedish National Board of Health and Welfare?

A. I'm pretty sure it was.

Q. Has this been translated or was this originally released in English?

A. I did not translate this. This is the document as I read it.

MR. PERKO: Your Honor, I move the exhibit into evidence.

THE COURT: So he's pretty sure he got it off the internet.

MR. PERKO: I believe he said --

THE COURT: He's pretty sure it's their website.

Let me ask this to the plaintiffs:

Do you have any reason to believe this is not what it purports to be?

MS. RIVAUX: I just don't know, Your Honor, what website it came from or where it came from, so it's hard to tell.

THE COURT: This is going to be a ruling similar to one I mentioned before the lunch break when you were introducing documents.

I'm going to admit this. The standard to authenticate a document in the circuit is pretty low. The case I always cite is the *Siddiqui* case, S-i-d-d-i-q-u-i. There are others. It just needs to be evidence sufficient to support a finding that it is what it purports to be. It's probably not a precise articulation of the rule, but that's the gist of it.

When all you have so far is a witness saying he's

pretty sure this is where this came from, that is about as thin a showing as you could make. On the other hand, this is the kind of thing that shouldn't generate a lot of controversy, especially with lawyers this good on both sides with information that's publicly available.

I'm going to admit this, but just like I told Mr. Jazil about the other documents, you look into it. You've got a dozen or so people sitting there at your counsel table on that side. If this isn't what they say it is, then I'll change the ruling.

MR. PERKO: Thank you, Your Honor.

MS. RIVAUX: Your Honor, if I can just clarify if your ruling is also only to admit it for the position of the government as opposed to any of the hearsay statements?

THE COURT: Yes. This is to show the activity of that organization and the activity -- and what gets done is itself relevant just because, in part, the analysis of whether to pay for this kind of care deals with the consensus in the community or the standard in the community. And so what different folks are doing, how this is being treated in different places, is itself relevant.

So right or wrong, if, for example, it turned out that a hundred percent of the cardiologists in the United States were treating blockages with stints, it would be relevant that a hundred percent were treating blockages with

stints even if it was a bad decision. And so that wouldn't be proof that stints are the best way to treat it, but it would be some proof of the standard of care. So exactly the same ruling as I made on the plaintiffs' documents before the break.

MS. RIVAUX: Thank you, Your Honor.

MR. PERKO: Thank you, Your Honor.

(DEFENDANTS' EXHIBIT NO. 8: Received in evidence.)

BY MR. PERKO:

Q. Dr. Hruz, are you familiar with a recent article published out of Sweden by Ludvigsson, et al., entitled, "A systematic review of hormone treatment for children with gender dysphoria and recommendations for research"?

A. Yes. That was the systematic review that was published in the journal "Acta Paediatrica," a peer-reviewed journal which essentially has the same -- it was a systematic review that came to identical conclusions as presented in this government document that the relative risk versus benefit does not currently justify the use of hormones and puberty blockers in these children, and documents generally the low quality of evidence that is present in this field.

Q. Can you explain what a systematic review is?

A. A systematic review is a formal way of looking at the literature using very strict criteria to be able to include studies that fit the goals of that assessment.

It is considered one of the highest levels of information that can be used as we try to synthesize the available literature on a particular question or topic, and it is very important to be able to consider when a systematic review has been done, the conclusions that have been reached from that.

Q. Dr. Hruz, have there been any developments with regard to gender dysphoria treatment in Finland?

A. Similar to what has happened in Sweden, Finland also did their own review of the literature and they published the PALKO/COHERE report, and essentially came to the same conclusion about the low quality of evidence and led to policy changes in that country, prioritizing psychological interventions in the treatment of gender dysphoria and recognizing that, when affirmative interventions, including puberty blockers and cross-sex hormones are offered, that it needed to be done within the setting of a research trial.

Q. I would like to pull up Exhibit DX9 and have you take a look at it, Doctor.

MS. RIVAUX: Your Honor, I have the same objection to this document as I did to the prior document.

THE COURT: What is DX9, Mr. Perko?

MR. PERKO: DX9.

THE COURT: What is it? It's the same thing out of Finland, comparable --

MR. PERKO: I'll have the witness clarify if you

want.

THE COURT: Well, you can tell me. If it's the same objection and the same kind of document, it's going to be the same ruling.

MR. PERKO: It's the same type of document.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 9: Received in evidence.)

MS. RIVAUX: Thank you, Your Honor.

BY MR. PERKO:

Q. Can I get you to identify what this document is?

A. These are the specific recommendations of the council for choices in healthcare that was put forward by Finland.

Q. Is that a complete and accurate copy of those recommendations?

A. It appears to be a complete document, yes.

Q. Have there been any developments in the United Kingdom with respect to treatment of gender dysphoria?

A. Yes. There have been several developments within the United Kingdom and specifically related to my area of pediatric endocrinology in the United Kingdom.

They did systematic reviews of the literature. As I mentioned for the other countries, these were contained relative to puberty blockers and cross-sex hormones in two separate reviews by the National Institute of Clinical Excellence, NICE, trials that formed the basis for the

National Health Service to appoint an individual by the name of Hilary Cass to perform an independent review of the services that were provided in that country at the Tavistock Center, which until recently was the only place in that country where gender-affirming services were offered to youth that had sex discordant gender identity.

On the basis of the interim report from the Cass review, major changes had been made to delivery of healthcare within that country. Within that Cass review, they acknowledged the same concerns about the low quality of evidence and many other concerns related to the presentation of children and the care that is being -- that had been delivered in their previous model.

Q. Let me show you what has been marked as Exhibit DX10.

Can you identify that document?

A. This is a the copy of the Cass review that I was referring to.

MS. RIVAUX: Your Honor, I have the same objection to this one, but in addition this one is an interim report. It's not a final report.

MR. PERKO: It is an interim report, Your Honor, but it's what Hilary Cass put out.

THE COURT: Doctor, I'm not sure I fully understood. Who is Dr. Cass?

THE WITNESS: She is a pediatrician who was appointed

by the National Health Service to conduct this review of gender services in the United Kingdom.

THE COURT: So she was working for the government?

THE WITNESS: National Health Center, yes.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 10: Received in evidence.)

MS. RIVAUX: Thank you, Your Honor.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. If I can show you Exhibit DX11 and ask what that document is.

A. This is a copy of that NICE review, and the one specifically relating to use of puberty blockers.

Q. And is this a complete and accurate copy of the NICE review?

A. Yes, it appears to be.

MS. RIVAUX: Your Honor, the same objection. I hate to stand up, I'm just preserving the record.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 11: Received in evidence.)

BY MR. PERKO:

Q. And if you can look at DX12, and what is that?

A. This is the second systematic review by NICE, and this is the one specifically referring to cross-sex hormones.

MS. RIVAUX: Again, same objection.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 12: Received in evidence.)

BY MR. PERKO:

Q. This is a complete and accurate copy of the NICE review, second NICE review?

A. Yes.

Q. Have there been any developments in France with respect to the treatment for gender dysphoria?

A. So France has come out with a -- their academy -- the French Academy of Sciences came out with a statement that was somewhat more nuanced than the other three countries that we've already discussed.

Yet, in their assessment of the current state of knowledge related to the care of individuals with sex discordant gender identity with affirming hormones, they specifically acknowledged the conclusions made by Sweden. They recognize that the utmost of caution needs to be made in the care of these individuals. And like these other countries have concluded, that there needs to be a prioritization of psychological care as we recognize the low quality of evidence present.

Q. Let me show you what has been marked as Exhibit DX13, and ask if you recognize it.

MS. RIVAUX: Your Honor, this one I have a bit of a different objection. This one is a press release. It's not a

government report of any kind.

MR. PERKO: It's reflective of what the government did, Your Honor. It's a statement of the government.

MS. RIVAUX: Your Honor, this is not the government.

THE COURT: Dr. Hruz, what is the French National Academy of Medicine?

THE WITNESS: It's a medical organization that makes decisions about the healthcare that is delivered in that country or makes guidelines and recommendations for them.

THE COURT: That's two different things. Is it --

THE WITNESS: So it's -- -

THE COURT: Wait until I through talking. The court reporter has to take us down, and it's much easier if we speak one at a time.

Does this organization make rulings that have the force of law, or is it an organization that does analysis and makes recommendations?

THE WITNESS: It would be equivalent to the American Academy of Pediatrics here in the United States.

THE COURT: So we put in the WPATH statement. What's wrong with this one?

MS. RIVAUX: Well, if they'll agree to all of the position statements that we've submitted, then we would agree to this one.

THE COURT: I'll admit it for the same purpose as the

other statements. This is a position taken by a medical organization. It's a little further removed because it's in France, and it's not the United States, but it's part of the body of evidence that could inform analysis of the Standard of Care.

MR. PERKO: Thank you, Your Honor.

(DEFENDANTS' EXHIBIT NO. 13: Received in evidence.)

BY MR. PERKO:

Q. Is this a complete and accurate copy of the document that it purports to be?

A. This is the same document that I read, yes.

Q. Have there been any developments in New Zealand and Austria with respect to the treatment of gender dysphoria?

A. Yes. The Royal Australian and New Zealand College of Psychiatry did come out with a statement very similar to these other documents that we've already discussed.

What's notable in this document is that the statement by that College of Psychiatry deviated sharply with their earlier recommendations that were made in 2015, acknowledging in this document that there are conflicting viewpoints on the best way to treat gender dysphoria, and when I first read this document, it reinforced my conclusion that what the WPATH claims as Standards of Care, which means that there are a universal consensus about treatment, does not exist.

This clearly highlights the fact that this is an area

that remains highly contentious and with differing viewpoints and recognition of the low quality of evidence that currently exist with respect to using the affirmative model.

Q. If I can show you Exhibit DX14 and ask if you recognize this document?

A. This is indeed the document that I read.

Q. What is it?

A. This is the statement by the Royal Australian and New Zealand College of Psychiatrists.

MS. RIVAUX: Same objections, Your Honor.

THE COURT: Same ruling.

BY MR. PERKO:

Q. And is it a fair and accurate copy of that statement?

A. Yes.

Q. Switching gears a little bit, Doctor, I would like to talk a little bit about the scientific literature in the area of gender dysphoria.

First, can you please explain the types of studies that are used in medical research?

A. Well, it's very important to this question of quality of evidence to recognize why there is a gradation of quality of evidence.

The lowest tier is generally anecdotal in case reports. And then moving on to observational types of studies and with higher quality of evidence, the standard of randomized

controlled trials, and then the metaanalysis or the symptomatic synthesizing of various randomized controlled trials.

Each of those levels differ with the confidence with which one can have in making conclusions based upon the evidence. In relevance to the assessment of the affirmative model using cross-sex hormones and puberty blockers for gender dysphoria, it's very important to recognize that observational cross-sectional retrospective studies that do not include a controlled groups are not capable of establishing a causal relationship between intervention and response.

At best, these types of studies, the case reports at best can usually lead to hypotheses generation, the recognition that further research needs to be done, and the design and conduct of subsequent research studies. An observational study, a cross-sectional study can establish an association, but it cannot establish the causal relationship between the intervention and response.

Q. Now, the plaintiffs' experts so far in this trial have quoted a few papers from the literature. I would like to go through them with you.

First of all, what is a "longitudinal study"?

A. A longitudinal study is where you follow patients over time. So you have a period of time, and then you look at a

follow up. And that is in contrast to a cross-sectional study where you gather data at one particular point in time.

Q. Are you familiar with the 2011 longitudinal study that was conducted by de Vries et al., that measured mental health outcomes after receiving puberty blockers?

A. Yes, I'm very familiar with that. This is really the basis for what is referred to as "the Dutch protocol."

Q. What is your assessment of that study?

A. So this study recruited 70 patients consecutively that entered into the gender clinic in that country and followed them at two time points: one at the beginning of receiving puberty blockers, and the second follow point was just before receiving cross-sex hormones.

The study itself did not have a control group. Again, very, very important in trying to assess whether any study outcomes are due to the intervention itself or another factor.

It stated very clearly in that report that all of the patients in that study received psychological support. Therefore, it's not possible to conclude that any differences were not due to that psychological support that was received.

The patients were patients that are vastly different to the ones being referred in large numbers to clinics here in the United States; meaning, that they were predominantly males identifying as females, and nearly -- I believe all of

them with the prepubertal onset of their sex discordant gender identity.

In that 2011 study they found at the intervention time point, the follow-up time point, their gender dysphoria did not change. They had persistent elevated rates of anxiety. They showed some differences in some of their psychological outcomes. Again, because of the nature of the trial design, it is not possible to conclude whether that was due to them receiving puberty blockers.

Q. Are you familiar with the follow-up 2014 study published by de Vries, et al., entitled "Young adult psychological outcome after puberty suppression and gender reassignment"?

A. Yes, I'm very familiar with that study.

Q. What's your assessment of that study?

A. That was a follow-up study of that same initial cohort of 70 individuals; however, only 55 of them were entered into the follow-up study. There were several patients that were lost to follow up. It's important to note that one of the patients died as a result of the surgical intervention that was performed on that individual.

There are many -- the similar questions and concerns about the limitations of the 2011 study apply also to the 2014 follow-up study in that it did not include a control group. All of the patients received psychological care; and, in fact, those that had severe psychiatric conditions would

not have been eligible to enter into the study.

Another major concern about that study is that their very assessment of gender dysphoria, which was a primary outcome, involved the use of a scale that was given -- a different scale that was given whether one was a biological male or female. And then at the follow-up time point after the cross -- after the gender-affirming surgery, those same subjects were given the other scale; meaning, that they changed the outcome tool and made the claim that their gender dysphoria was reduced.

But by the very way that they conducted the study, it actually proves the opposite of what they intended to show in that questions were asked that were not appropriate for somebody, depending on the sex that they had, which really was not able to capture that outcome.

Q. Can you explain why the questions were not appropriate?

A. So, for example, to ask a male subject that identifies as female whether they are bothered by menstruating would have no utility. Yet, that was the -- it also changes midstream the assessment tool. So essentially you are asking questions that are going to influence the outcome just by the basis of the questions that are being asked.

Q. So, if I understand it correctly, the question was asked before you started the treatment, if you were satisfied with your gender identity or what have you, and then when the

patient was transitioned, then the question was the opposite?
A. So in the study, in the 2011 study, they used the same scale at the start of pubertal blockade and just before cross-sex hormones, and then they switched after the surgical gender-affirming surgery to the other scale, making the decision that, for whatever reason that they used, that is what the studies showed.
Q. Okay. I just have a few more -- three more studies, Dr. Hruz.
Are you familiar with the 2018 paper by Dr. Olson-Kennedy entitled, "Chest reconstruction and chest dysphoria in trans masculine minors and young adults: Comparisons of nonsurgical and post surgical cohorts"?
A. Yes, I'm aware of that study.
Q. And what is your assessment of that study?
A. I think it's important to acknowledge this as another example of the serious limitations of the studies that are being presented to establish the efficacy of this particular affirmation approach.
There are many limitations in that study. As far as the control group itself was a convenient sample, and the study tool that they used in that study was not validated at the time they conducted the study. The author of the study devised on her own this novel scale for assessing what they refer to as "chest dysphoria."

Another concern is that the follow-up period was far too short to be able to assess that outcome. On average, it was about two or two and a half years of follow-up after the surgery intervention. When, in other studies like the Dutch cohort study published in 2018 by Wiepjes, the data shows that much of the regret from surgery can occur as much as ten years after the intervention.

Q. Are you familiar with the 2022 study by Kristina Olson, et al., entitled, "Gender Identity Five Years After Social Transition"?

A. Yes, I'm familiar with that study.

Q. What's your assessment of that study?

A. So that study actually borrows data from what's called the "Trevor Project." They are trying to look long-term about the trajectory of individuals that are with sex-discordant identity over time. The conclusion of that study, looking five years after social affirmation, was that there was, I believe, 7 percent that had undergone transition that ended up -- they call it retransition, I would say detransitioned -- over that interval.

There are -- the data themselves, which are in stark contrast to other data that show that the experience in that population in the time interval, that the desistance rate is much higher. They concluded that they had diagnostic accuracy to assert that there was an alleviation of the

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023 /s/ Mohammad O. Jazil

No. 23-12159

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME VIII OF XIII

Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
(850) 274-1690

Counsel for Defendants-Appellants Florida Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

Ashley Moody
Attorney General of Florida

Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
(850) 414-3300

Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

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/s/ Mohammad O. Jazil
Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
Phone: (850) 391-0503
Facsimile: (850) 741-1023
mjazil@holtzmanvogel.com
mbeato@holtzmanvogel.com
Counsel for Defendants-Appellants Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

/s/Joseph E. Hart
Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
Phone: (850) 414-3300
henry.whitaker@myfloridalegal.com
joseph.hart@myfloridalegal.com
Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

concern that patients would be put on a path that was not correct for them.

An alternate way to look at the data that seems much more plausible as a hypothesis is that the intervention itself, social affirmation is not a neutral intervention, and that the process of socially-affirming somebody can change the trajectory for which one goes forward with that. Because it did not contain a control group, one cannot assess which of those hypotheses is correct.

Q. One final study, Dr. Hruz. Are you familiar with the 2022 paper by Chen, et al., entitled, "Psychosocial functioning in transgender youth after two years of hormones"?

A. Yes, I am familiar with that study.

Q. What's your assessment of that study?

A. This was a longitudinal study done at four different centers where they recruited approximately 300 patients to follow them over time. The two-year, follow-up data is contained within that Chen study, and many, many questions about that.

First off, this, as a longitudinal study, there is no control group so similar to the other studies that I mentioned. Because of that, there is no way to establish whether there is a causal relationship between intervention and outcome.

They claim it's a two-year follow-up, but a very large number of subjects in that study did not have a full set of two-year data, so the follow-up period was even shorter than that.

They did not use robust measures of psychological well-being. The ones that they do report where they have -- many of them where they have claimed that there is significance, they maybe statistically significant but clinically insignificant. There is no way to be able to follow up individual patients longitudinally from the data that they showed.

And probably most concerning in this two-year, follow-up study, that out of those patients that were enrolled in that study, two of the patients died by a completed suicide. In any other clinical study that I'm aware of, if you had two deaths during a longitudinal study, it would lead to a halting of the study and critical assessment as far as the nature of what was going on before proceeding onward.

So there are many features of that study that limit what one can conclude and raise serious questions about the outcome that has been reported by that study.

Q. Dr. Hruz, how would you characterize the evidence used to support the use of puberty blockers and cross-sex hormones to treat gender dysphoria?

A. I would say, in general, the evidence that does exist is

sparse, of very low or very low quality, and there are many questions that remain to allow one to assess both the safety and the efficacy of these interventions.

MR. PERKO: Thank you, Your Honor.

Oh, one more line of questions.

BY MR. PERKO:

Q. Dr. Hruz, were you here for the testimony of Ms. Hutton earlier today?

A. Yes, I was.

Q. And she mentioned a meeting that you had ten or so years ago. In your mind what was the purpose of that meeting?

A. I specifically called or contacted Ms. Hutton as I was in the phase of investigating the evidence related to this new affirmative model for the treatment of gender dysphoria, as I noted in my role as division chief.

I called the meeting to specifically gain better understanding of the experience that Ms. Hutton had in encountering her child that had sex-discordant gender identity. I'm very grateful for that. Much of what she shared with me during that meeting helped me to understand again the context of her experience.

That was the reason -- when I invited her for that meeting, I made it very clear that I was not convinced at that point in time by the scientific evidence, and that I had several questions related to the scientific premises that

were being put forward, and I had intended to be able to use the information from her story to help me assess some of those questions that I had.

I did recognize at that time that she was an advocate parent and not a physician scientist, and I made it very clear to her that I was not intending to debate. I was merely intending to listen to her story.

Q. Dr. Hruz, at any time did you tell Ms. Hutton that sometimes children were just born to suffer?

A. I heard that comment this morning, and I'm lost to understand how she could make that statement. I do not hold and have never held to that belief.

MR. PERKO: Thank you, Your Honor. I have nothing further.

THE COURT: Well, while he's asking that, they may want to cross.

Did you tell her any of the treatment of transgendered individuals was against God's plan?

THE WITNESS: I would not have said that, no.

THE COURT: Did you say anything about reading Pope John?

THE WITNESS: In that course of that conversation, we asked Ms. Hutton -- my intention was to learn about her experience. Her goal, as I surmised from her questioning me, was to convince me to open up the gender center at my

institution. And as she continued to become more agitated by the fact that what she was asking me was not something I could accept based upon what I had learned up to that point in time, the conversation entered into many areas of her personal life journey with details that I'm sure she would not want to make public, and really that was tangential to the purpose of that conversation.

THE COURT: Do you recall my question?

THE WITNESS: Yes, I do.

THE COURT: What's the answer to my question?

THE WITNESS: We got into questions related to anthropology, the understanding of the human individual, addressing the question of whether one could possibly be born in the wrong body. And to illustrate the understanding of that, I did include a reference to that document.

THE COURT: Cross-examine?

CROSS-EXAMINATION

BY MS. RIVAUX:

Q. Good afternoon, Dr. Hruz.

A. Good afternoon.

Q. So I understand you told the Court here that you have never treated a patient for gender dysphoria, correct?

A. It would be unethical for me to engage in a form of treatment that I have deemed not justified by an assessment of the relative risk and benefit.

Q. I understand your explanation, but the question was: Have you ever treated anybody for gender dysphoria?
A. Because of my ethical concerns, no.
Q. And you have no training in diagnosing anyone in gender dysphoria?
A. I have the same type of training of reading the DSM-5 that my colleagues that do make that diagnosis as endocrinologists.
Q. Now, but you have never had any specific training for diagnosing gender dysphoria, correct?
A. Neither I nor my colleagues that are in the pediatric endocrine division at St. Louis Children's Hospital have done anything different other than read the DSM criteria for that diagnosis.
Q. You are not a mental health professional?
A. Correct.
Q. And you haven't relied on the DSM to diagnose a patient?
A. That's correct.
Q. And you don't determine patient treatment in reliance on the DSM ever, correct?
A. That is not correct. In my practice of pediatric endocrinology, many of the conditions that I treat are heavily influenced by comorbidities that include psychiatric disease, and it is my duty as a physician to recognize that and be able to tailor my care in light of those diagnoses.

Q. You have no experience treating gender dysphoria?
A. As I said, the role of an endocrinologist is in the administration of puberty blockers and cross-sex hormones, and I have deemed that not justified by the available evidence.
Q. And you mentioned different approaches like the reparative model; is that correct?
A. That is correct.
Q. You've never used that model as a treatment with any patient for gender dysphoria, correct?
A. The only -- of those three models that I presented, the only one that involves the pediatric endocrinologist is the affirmative model.
Q. But my question was: Have you ever used that methodology for the treatment of gender dysphoria?
A. I don't know of any endocrinologist, myself or any other endocrinologist that has used that model, no.
Q. So fair to say then, you've never used the watchful-waiting methodology for the treatment of care for gender dysphoria, correct?
A. To the extent that I cared for patients for other conditions that express sex-discordant gender identity, I accompany them in the care of their other conditions. That's not fully in line with the expectant model, but it certainly does align with that.

Q. That's not gender dysphoria, right?
A. I don't know that I understand your question.
Q. I'll move on.
You've never conducted any formal research relating to gender dysphoria, correct?
A. I have not personally been able to conduct the studies that I think need to be done, though I have proposed them to my colleagues at Washington University. I am involved in the supervision of our clinical fellows, two of whom are currently conducting research studies in the area of gender dysphoria. Both of them are doing studies related to adverse drug effects related to that.
My role is as an advisor, not as a primary mentor, in helping them to generate their hypotheses, to critically evaluate their data, to make appropriate preparations for presentation at national conferences.
Q. And prior to this -- would you say that you're directly participating in a clinical trial?
A. No, I'm not directly participating.
Q. Okay. And you've never published any peer-reviewed literature on the cause of gender dysphoria in a scientific journal, correct?
A. I have published a peer-reviewed article in an ethics journal related to that question.
Q. But my question was in a scientific journal.

A. I think ethics is a field of science.
Q. Well, you published an article in the Linacre Quarterly, correct?
A. That's correct.
Q. And that is not a scientific publication, correct?
A. Well, as I just said, it was published in an ethics journal. In fact, the Linacre is the longest standing peer-reviewed ethics journal in the United States.
Q. But not a scientific journal, right? You've made that distinction.
A. I made my distinction there.
Q. And who is the publisher of Linacre Quarterly?
A. The Catholic Medical Association.
Q. Do you have any association with the Catholic Medical Association?
A. Yes.
Q. And what's your involvement with the Catholic Medical Association?
A. I have participated -- I'm a member of the Catholic Medical Association.
Q. You are member of the Catholic Medical Association; is that right?
A. Yes.
Q. Are you aware of their position on gender-affirming care?
A. Where would you be referring to where that is published?

Q. Well, I'm asking if you are aware -- let me ask it this way:

Are you aware of whether the Catholic Medical Association opposes gender-affirming care?

A. I'm aware of, amongst my colleagues, the same questions that I have related to the safety and efficacy of gender-affirming care.

THE COURT: Does the association oppose gender-affirming care?

THE WITNESS: I would say "oppose" is not the word that I would use. They have ethical objections and concerns to many of the arguments for the gender-affirming model.

BY MS. RIVAUX:

Q. Did the Catholic Medical Association issue a position statement on gender-affirming care?

A. I'm not certain.

Q. Okay. You haven't gotten any grants to study gender dysphoria, correct?

A. That is correct.

Q. And you have applied for grants for other areas of study, correct?

A. Throughout my career, I've not only applied but also received a number of grants, yes.

Q. And the reparative mode or methodology that you mentioned earlier, are you aware of what the American Psychiatric

Association says regarding the reparative model?
A. It depends on how you refer to that and how it is conceived. But I am aware of many that use the term "conversion therapy," and in general argue that it is harmful and ethical -- unethical is the statement that they have made repeatedly in relation to that approach.
Q. And you stated the reparative therapy is the explicit goal of realigning one's gender with one's biological sex; is that correct?
A. That is correct.
MS. RIVAUX: Can we pull up Exhibit 46, please?
BY MS. RIVAUX:
Q. Are you aware of the American Psychological Association's position on reparative therapy?
A. Only to the extent that I have heard repeatedly from nonscientific domains. So, again, I'm a pediatric endocrinologist. But, yes, I am aware that they have made that same conclusion.
Q. And do you recognize this document?
A. Either this or a similar type of document, correct.
Q. And this is the American Psychological Association resolution on gender identity change efforts, correct?
A. Correct.
Q. And if we go to page 2, at the bottom, are you able to read that, or no? It's kind of hard to read. We may have to

use the ELMO. You can zoom in. Page 2, bottom, third paragraph from the bottom, there we go.

Do you see where it says: *Whereas, GICE* --

What does "GICE" stands for?

A. I believe it's "Gender Identity Conversion Efforts."

Q. -- *have not been shown to alleviate or resolve gender dysphoria.*

Did I read that correctly?

A. Correct.

Q. Then going on to page 3 at the bottom, please, where it says:

Be it therefore resolved that consistent with the APA definition of evidence-based practice, APA 2005, the APA affirms the scientific evidence and clinical experience indicate that GICE put individuals at significant risk of harm.

A. Yes, you read that correctly.

Q. And after that it says:

Be it further resolved that the APA opposes GICE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals and organizations to avoid GICE.

Did I read that correctly?

A. Yes, you did.

MS. RIVAUX: I would like to move this exhibit into

evidence, Your Honor.

MR. PERKO: Hearsay, Your Honor.

THE COURT: Same treatment as the other documents, should it not be?

MR. PERKO: Yes, Your Honor.

THE COURT: Plaintiffs' 46 is admitted with the same limitations.

(PLAINTIFFS' EXHIBIT NO. 46: Received in evidence.)

MS. RIVAUX: Thank you, Your Honor.

BY MS. RIVAUX:

Q. I was looking at your CV and looking at some of your publications. One of the publications that you have is an invited publication called, "Growing Pains: Problems With Pubertal Suppression in Treating Gender Dysphoria," correct?

A. That is correct.

Q. And this an article that you published in 2017, correct?

A. Yes, I believe that was the year.

Q. And that was in the New Atlantis?

A. Correct.

Q. And that's not a scientific journal, correct?

A. Not by the standard definition, no.

Q. And the New Atlantis is not a peer-reviewed scientific journal, correct?

A. It was editorially reviewed, not sent out to people outside of the editorial board.

Q. So the answer to the question is, it's not peer-reviewed, correct?
A. Correct.
Q. And you also published two articles in the National Catholic Bioethics Quarterly, correct?
A. Yes.
Q. And the National Catholic Bioethics Quarterly, that's not a peer-reviewed publication, correct?
A. Correct. Similar to the New Atlantis, it was an editorially-reviewed, to the best of my knowledge.
Q. But when you say, "editorially-reviewed," that's different than peer-reviewed, correct?
A. It means that the paper itself was critically evaluated, and I had to make edits to the article to satisfy the concerns by those. If you consider the editors themselves are also ethicists that are peers in the field, it would be peer-reviewed, but, to my understanding, it wasn't sent out beyond the NCBQ.
Q. Because a peer review is when you send it out to other experts in the field and have other experts opine and look and review the particular article, correct?
A. Not necessarily true. There are some papers that are reviewed by the editor as the primary peer reviewer for paper if it fits within in their area of expertise.
Q. But you have said it's not a peer-reviewed journal,

correct?
A. In the definition that you stated, as far as sending it out to external reviewers, correct.
Q. Do you remember testifying in the Katle deposition?
A. Yes, in deposition.
Q. And you were under oath in that deposition?
A. Correct.
Q. And you recall being asked: "Is the National Catholic Bioethics Quarterly a peer-reviewed journal," and your answer was "no"?
A. And, again, with the same caveats, the way the question was asked was more along your definition, as far as being sent out to external reviewers. At least that's how I interpreted that question being asked.
Q. When you were asked the question, you didn't provide that additional clarification, correct?
A. Correct.
Q. The National Catholic Bioethics Center also published a book chapter that you wrote, correct?
A. Correct.
Q. And that was called -- what was that called?
A. I published a lot of things. I can't remember the exact title.
Q. Does "Transgender Issues in Catholic Healthcare" ring a bell?

A. Yes.
Q. And the National Catholic Bioethics Center, they have -- do they have a position on gender-affirming care?
A. Yes. I believe you can read it in their publications.
Q. And are you familiar with it?
A. Yes.
Q. And it states that "insisting on affirming a false identity and in many cases mutilating the body in support of that falsehood"?
A. I'm aware of that statement, yes.
Q. Are you involved with any organizations that publicly oppose gender-affirming care?
A. What do you mean by "involved with"?
Q. Are you a member of any organizations that publicly oppose gender-affirming care?
A. Not that I'm aware of, no.
Q. Are you a member of -- are you involved with the Alliance for Defending Freedom?
A. Am I -- I'm sorry. Can you repeat the --
Q. Are you familiar with the Alliance for Defending Freedom?
A. Am I familiar with it? Yes, I'm familiar with that organization.
Q. And you have been and traveled to their office in 2017 about a meeting regarding the types of healthcare at issue in this case, correct?

A. That is correct.
Q. And you have been to their offices at two separate times, correct?
A. That is correct.
Q. And both times relating to the treatment of gender dysphoria in adolescents; is that correct?
A. That is correct.
Q. And you are familiar with an individual by the name of Dr. Lambert?
A. Yes, I am.
Q. Was he with you at any of those meetings at the ADF?
A. He was present at one of those two meetings.
Q. And in 2017 you filed an *amicus* brief in the Supreme Court in a case called *Gloucester County versus Grimm*, correct?
A. Correct.
Q. And that was a case that related to whether a transgender individual be permitted to use the restroom aligned with their gender identity, correct?
A. That's correct.
Q. And on the brief that you signed on to that was filed with the Supreme Court, it stated:
Such treatments encourage a gender dysphoric child like the respondent to adhere to his or her false belief that he or she is the opposite sex. These treatments would help the

child to maintain his or her delusion, but with less distress by, among other aspects, requiring others in the child's life to go along with the charade. Correct?

A. Correct.

Q. And also in that *amicus* brief that you signed on to, it said that:

Conditioning children into believing into a lifetime of impersonating someone of the opposite sex achievable only through chemical and surgical intervention is a form of child abuse. Correct?

A. If the statement said that, I recall -- I wouldn't challenge that reading.

Q. And your name was on the brief, right?

A. Correct.

Q. And you signed on to other briefs as well, other *amicus* briefs, correct?

A. Correct.

Q. For example, in *Doe v. Boyertown*, again, an *amicus* in the Supreme Court opposing gender-affirming care, correct?

A. Yes.

Q. And, again there in that brief, it stated:

Conditioning children into believing that a lifetime of impersonating someone of the opposite sex achievable only through chemical and surgery interventions is harmful to youths. Correct?

A. Yes, I did.
Q. And in 2020, you signed on to another brief called *Meriwether versus Hardtop*, correct?
A. Yes.
Q. And that was a brief supporting -- in support of a professor who objected to the state's requirement that faculty and staff address students according to the student's preferred form of address, including the use of the student's preferred pronouns, correct?
A. I'm trying to remember that. You know, there's many things I've done over the years.
Q. Would it help if I refreshed your recollection?
A. Yes, it would be helpful, yes. I believe you're saying it accurately, but I just want to be sure.
MS. RIVAUX: May I approach, Your Honor?
THE COURT: You may.
BY MS. RIVAUX:
Q. Does this refresh your recollection?
A. The main author of this, I -- yes.
Q. I'm sorry. I think I have given you the wrong document. I apologize. You can put it down.
A. Okay. Thank you.
Q. But you did testify in the Brandt trial, correct?
A. Yes.
Q. In the Brandt trial, you stated that you recalled signing

on to this brief, correct?
A. Yes. Often when I'm asked these questions, I accept what is presented. I don't usually, as you just did, give me the actual document, yes.
Q. But you had recalled it then?
A. I will accept that I signed on to that *amicus*, yes.
Q. Do you want to see a copy of your testimony from the Brandt trial?
A. Oh, no, I don't need to see that, no.
Q. And in that brief, you said:
The popular notion regarding, quote, gender identity that says a person has a, quote, boy mind in a girl body is not true. If it is supposed to be taken even more or less literally, it is an idea that should be summarily dismissed.
Correct?
A. I would be happy to explain the scientific justification for that statement if you'd like.
Q. Okay. But my question was: Did you say that in the *amicus* brief?
A. If you are reading it from there, I said it, yes.
Q. Did you sign on to an *amicus* brief that seeks to criminalize providing gender-affirming care?
A. I need more specific information about that.
Q. In a case in Alabama, did you sign on --
MS. RIVAUX: Excuse me.

BY MS. RIVAUX:

Q. I'm sorry. Clarification. Are you an expert in a case called *Boe v. Marshall*?

A. Yes.

Q. In that case, they are looking to criminalize the gender-affirming care in minors, correct?

A. I am involved as an expert witness to talk about the scientific evidence related to gender-affirming medical interventions. I make no assessment of the actual legislation that is being proposed on the merits of that. I'm not a politician. I'm not a lawyer. I'm a physician scientist.

Q. Understood. When you are asked to be an expert, you can choose to be an expert or not in a case, correct?

A. Correct.

Q. And you understand that the goal in that case, right, relating to that -- to the law that -- the Alabama law is to make a felony providing gender-affirming care to minors, correct?

A. The legislative initiative stands as of itself. My role is to make sure that the proper science is discussed so that the decision can be rendered accurately.

Q. I understand. But that was a choice to participate in that case, correct?

A. That's correct.

Q. You mentioned -- you talked a little bit about WPATH, correct?
A. Correct.
Q. You've never been a member of WPATH?
A. That is correct.
Q. You have no personal experience with WPATH, correct?
A. I actually have met with individuals with WPATH including Eli Coleman, who I had an extended conversation about the scientific evidence and challenged him about the research that needed to be done. So I have interacted with members of WPATH, but that is my extent.
Q. So your experience with WPATH is interacting with other doctors that are also involved in WPATH and talking about the science, correct?
A. Correct. I have not been a member, participating in their meetings.
Q. And your opinions here today are contrary to the recommendations of WPATH regarding the care for gender dysphoria, correct?
A. That is correct.
MS. RIVAUX: Exhibit 37, please.
BY MS. RIVAUX:
Q. And you told us, Dr. Hruz, that it's very important for you to keep up with the positions of not only what is happening in the United States but internationally. So it's

very important for you to keep up with these positions. So Exhibit 37, do you recognize -- let's scroll up.

And this is a document from the American Academy of Family Physicians and their position statement on the care for transgender and gender nonbinary patients, correct?

A. Correct.

Q. And the American Academy of Family Physicians, they support access to gender-affirming care for gender-diverse patients including children and adolescents, correct?

A. That is what they advocate for based upon the same concerns of evidence that I presented in this case.

Q. And gender-affirming healthcare is part of a comprehensive primary care for many gender-diverse patients, correct? That's what it says?

A. That's what the document says.

Q. And their position is also that this care includes gender-affirming hormones, puberty blockades, medical procedures, and surgical interventions, correct?

A. Correct.

MS. RIVAUX: I would like to admit this document into evidence, Your Honor, plaintiffs' 37.

MR. PERKO: Same objection subject to rulings.

THE COURT: Plaintiffs' 37 is admitted.

(PLAINTIFFS' EXHIBIT NO. 37: Received in evidence.)

MS. RIVAUX: Exhibit 38, please.

BY MS. RIVAUX:
Q. Exhibit 38, that is the policy statement, right, from the American Academy of Pediatrics?
A. That is correct.
Q. And you understand that the American Academy of Pediatrics support gender-affirming care, correct?
A. I would say that the committee that put forward this statement does. It's never been put up to a vote of the entire membership; therefore, it's inaccurate to say that the entire society supports this.
Q. Well, the American Academy of Pediatrics has put out a position statement supporting gender-affirming care, correct?
A. That statement is correct.
Q. Okay.
MS. RIVAUX: I would like to move this document into evidence, Your Honor.
THE COURT: Give me the number again.
MS. RIVAUX: Exhibit 38.
THE COURT: Plaintiffs' 38 is admitted.
(PLAINTIFFS' EXHIBIT NO. 38: Received in evidence.)
MS. RIVAUX: Exhibit 36, please.
BY MS. RIVAUX:
Q. And this is a document, a position statement from the American Academy of Child and Adolescent Psychiatry, correct?
A. Yes.

Q. And this is their position statement responding to efforts to ban evidence-based care for transgender and gender-diverse youth, correct?
A. The title threw me for a -- so, yes, at first it read that they were against evidence-based care, but it's clear from the reading of this that they are making a statement that it's evidence-based and making a statement on it being banned. So I think it's important to recognize what the document is actually says.
Q. It says: *The American Academy of Child and Adolescent Psychiatry. Statement responding to efforts to ban evidence-based care for transgender and gender-diverse youth.* Right?
A. The document states that. I challenge whether their recommendations are actually -- when we talk about evidence-based what that constitutes. But the document itself does say that.
Q. Okay. And they oppose any ban on gender-affirming care, correct?
A. Correct.
Q. Okay. And specifically, they state that they support the youth -- and this is the third paragraph at the bottom -- it says:
The American Academy of Child and Adolescent Psychiatry supports the use of current evidence-based clinical care with

minors. Correct?
A. They are stating that they are satisfied with the low-quality evidence, yes.
Q. Well, that's not what they say, right?
A. They say evidence-based, and I've shared what that evidence is.
Q. I understand what your position is, but that's not their position, correct?
A. As you read the statement, that's what it says in the document.
Q. And *the AACAP strongly opposes any efforts, legal, legislative and otherwise to block access to these recognized interventions*, correct?
A. You read that correctly.
MS. RIVAUX: At this time, I would like to move in Plaintiffs' Exhibit 36, Your Honor.
THE COURT: Plaintiffs' 36 is admitted.
(PLAINTIFFS' EXHIBIT NO. 36: Received in evidence.)
MS. RIVAUX: Exhibit 39, please.
BY MS. RIVAUX:
Q. And this is an opinion document from the American College of Obstetricians and Gynecologists, correct?
A. Yes.
Q. And it gives their recommendations for the healthcare for transgender and gender-diverse individuals, correct?

A. That's what it states, yes.
Q. And they, too, support the provision of gender-affirming care, correct?
A. Based upon their acceptance of the evidence, the low quality of evidence, yes.
Q. Well, that's not what they say, right? They don't say because of their acceptance of the low quality of evidence. Those are your words, correct?
A. Correct. They fail to recognize the low quality of the evidence.
Q. That's your opinion, correct?
A. Correct.
Q. Okay. And the American -- at the bottom here, under *Recommendations and Conclusions*, the second paragraph says:

The American College of Obstetricians and Gynecologists oppose discrimination on the basis of gender identity or public and private health insurance claims to cover necessary services for individuals with gender dysphoria and advocates for inclusive, thoughtful and affirming care for the transgender individuals. Correct?

A. You read that correctly.

MS. RIVAUX: I would like to admit 39 please.

THE COURT: Plaintiffs' 39 is admitted.

(PLAINTIFFS' EXHIBIT NO. 39: Received in evidence.)

MS. RIVAUX: Moving on to Exhibit 40, please.

BY MS. RIVAUX:

Q. And this is a statement from the American College of Physicians, and it is their position statement on the attacks on the gender-affirming care and transgender healthcare, correct?

A. You read that correctly.

Q. And they, too, oppose any efforts that seek to ban or restrict access to the gender-affirming care, correct?

A. That is what the document states.

Q. Okay.

MS. RIVAUX: I would like to move to admit Plaintiffs' 40, please.

THE COURT: Plaintiffs' 40 is admitted.

(PLAINTIFFS' EXHIBIT NO. 40: Received in evidence.)

MS. RIVAUX: Exhibit 41, please.

BY MS. RIVAUX:

Q. And here is another position paper from the American College of Physicians, correct?

A. That is what the title says, yes.

Q. And here, again, they are reaffirming their position on any bans on gender-affirming care, correct?

A. I would have to read through the whole paper, but by the title, it looks to be that, yes.

Q. Well, if we turn to -- at the bottom, 1240, next page, number two:

The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender healthcare services and provide all covered services to transgender persons as they would all other beneficiaries. Correct?

A. You read that correctly.

MS. RIVAUX: I would like to move Plaintiffs' Exhibit 41 into evidence.

THE COURT: Plaintiffs' 41 is admitted.

(PLAINTIFFS' EXHIBIT NO. 41: Received in evidence.)

MS. RIVAUX: Exhibit 42, please.

BY MS. RIVAUX:

Q. And this is a document from the American Medical Association. It's a letter to the National Governor's Association, correct?

A. That's who it is addressed to, yes.

Q. From the American Medical Association, correct?

A. By the letterhead, yes.

Q. And it states:

On behalf of the American Medical Association and our physician and medical student members, I write to urge the National Governor's Association and its member governors to oppose state legislation that would prohibit the provision of medically necessary gender transition-related care to minor patients. Correct?

A. You've read that correctly. Their interpretation of what is medically necessary, yes.

MS. RIVAUX: I move to admit Exhibit 42, please.

THE COURT: Plaintiffs' 42 is admitted.

(PLAINTIFFS' EXHIBIT NO. 42: Received in evidence.)

MS. RIVAUX: Exhibit 45, please.

BY MS. RIVAUX:

Q. This is the guidelines for psychological practice with transgender and gender nonconforming people from the American Psychological Association, correct?

A. You've read that correct.

Q. And it states --

MS. RIVAUX: If we can go to what is Bates-stamped PLAINTIFFS1486, please.

BY MS. RIVAUX:

Q. At the bottom left-hand side, last paragraph:

Because of the high level of societal ignorance and stigma associated with transgender nonconforming people ensuring that psychological education, training, and supervision is affirmative and does not sensationalize, exploit, or pathologize transgender and nonconforming people will require care on the part of educators. Correct?

A. You read that correctly.

MS. RIVAUX: I move Exhibit 45 into evidence.

THE COURT: Plaintiffs' 45 is admitted.

(PLAINTIFFS' EXHIBIT NO. 45: Received in evidence.)

MS. RIVAUX: I believe we already moved 46 into evidence. Correct.

Exhibit 47, please.

BY MS. RIVAUX:

Q. This is the position statement from the American Psychiatric Association, correct?

A. From April of 2020, correct.

Q. And it's a position statement on treatment of transgender and gender-diverse youth, correct?

A. That's what it states, correct.

Q. And it states in the second paragraph, beginning:

Gender-affirming treatment of trans and gender-diverse youth who experience gender dysphoria due to physical changes of puberty may include suppression of puberty development with GnRHa, commonly referred to as puberty blockers, use of GnRH agonist, despite potential side effects, hot flashes, depression, can allow the adolescent a period of time, often several years, in which to further explore their gender identity and benefit from additional cognitive and emotional development. Correct?

A. I've already stated the error in that statement, but that is what it says.

MS. RIVAUX: I would like to move Exhibit 47 into evidence.

THE COURT: Plaintiffs' 47 is admitted.

(PLAINTIFFS' EXHIBIT NO. 47: Received in evidence.)

MS. RIVAUX: Exhibit 48.

BY MS. RIVAUX:

Q. And this is another position statement from the American Psychiatric Association, correct?

A. That's what it appears to be, yes.

Q. Okay. And it states that they take the position that the -- that the American Psychiatric Association, under number one at the bottom, *recognizes that appropriately evaluated transgender and gender-diverse individuals can benefit greatly from medical and surgical gender-affirming treatments.* Correct?

A. Without stating the evidence behind that statement, that is correctly read.

Q. So you are saying that it is important for you to see the evidence in making these position statements?

A. Absolutely.

MS. RIVAUX: Moving Exhibit 48.

THE COURT: Plaintiffs' 48 is admitted.

(PLAINTIFFS' EXHIBIT NO. 48: Received in evidence.)

MS. RIVAUX: Exhibit 49.

BY MS. RIVAUX:

Q. This is a statement from one of the associations that you are involved in, the Pediatric Endocrine Society, correct?

A. That is correct.
Q. And you understand their position on transgender health is here in Exhibit 49?
A. In this particular, because I am a member of that organization, I can state directly that the entire membership was not asked to approve this statement; and, therefore, it does not represent the opinion of the members, merely the committee that put this forward.
Q. With that understanding, this is the position statement that has been put out by the Pediatric Endocrine Society, correct?
A. Correct.
Q. And they, too, support gender-affirming care, correct?
A. "They," meaning the committee that put this together.
Q. Correct. And that's what they state here, correct?
A. That's correct.
MS. RIVAUX: Moving Exhibit 49 into evidence, please.
THE COURT: Plaintiffs' 49 is admitted.
(PLAINTIFFS' EXHIBIT NO. 49: Received in evidence.)
THE COURT: We're going to need to get to an afternoon break at some point. Tell me how we -- we can finish up with Dr. Hruz, if we can finish up.
MS. RIVAUX: I still have a little bit to go. If we want to take a break now, that's totally fine with me.
THE COURT: Let's take the break. Let's take 15

minutes. We'll start back at five till 4:00.

(*A recess was taken at 3:40 p.m.*)

(*The proceedings resumed at 3:55 p.m.*)

THE COURT: Please be seated.

Dr. Hruz, you are still under oath. You may proceed.

MS. RIVAUX: Thank you, Your Honor.

One last of these position statements, while there are so many more, I don't want to spend all of our time doing this, but Exhibit 43, please, if we can go to the second-to-last page, please, the first full paragraph at the beginning of the page, starting with "Improving."

BY MS. RIVAUX:

Q. Before I start, this is the American Medical Association and the health professionals advancing LGBTQ equality position statements on health insurance coverage for gender-affirming care of transgender patients, correct?

A. You zoomed in. So I can't see the --

Q. It's on the first page.

A. Yes.

Q. And if you scroll down, you'll see it's published by the American Medical Association.

A. I don't see that.

Q. Scroll down a little bit. Right there.

A. The footer?

Q. Correct.

A. Correct.
Q. Do you see that?
A. I do.
Q. And the second-to-last page, the paragraph starts with:
Improving access to gender-affirming care is an important means of improving health outcomes for the transgender population. Studies demonstrate dramatic reductions in rate of suicide attempts with one metaanalysis finding that suicidality rates dropped 30 percent pretreatment to 8 percent post-treatments. The studies have also demonstrated a decrease in depression, anxiety, and that a majority of patients reported improved mental health and function after receipt of gender-affirming care. Correct?
A. That is read correctly. They do have the references here. It would be nice to go through the science in those papers.
MS. RIVAUX: Right now I am looking to move this into evidence, Your Honor.
THE COURT: Tell me again the number.
MS. RIVAUX: Exhibit 43.
THE COURT: Plaintiffs' Exhibit 43 is admitted.
(PLAINTIFFS' EXHIBIT NO. 43: Received in evidence.)
BY MS. RIVAUX:
Q. Dr. Hruz, you talked a little bit about keeping up with the international positions of certain countries.

One of the positions that you looked at was the United Kingdom, correct?
A. That is correct.
Q. And you referenced the Cass review, right?
A. That is correct.
Q. And it's an interim report, right?
A. That is correct.
Q. You don't have personal knowledge about healthcare provided in the U.K., Correct?
A. I do not live in the U.K., but I do know what they have stated explicitly as far as how they are reorganizing their healthcare system based upon this interim report.
Q. But you don't treat patients in the U.K., correct?
A. That is correct.
Q. Not licensed in the U.K.?
A. That's correct.
Q. In this interim report, one of the things that Dr. Cass states is that:
It is important to note that the references cited herein do not constitute a comprehensive literature review.
Correct?
A. It is based upon the information in the NICE reviews that we've already discussed, which is a systematic review of the evidence related to -- at least from my analysis, cross-sex hormones and puberty blockers.

MS. RIVAUX: Can you pull up Defendants' Exhibit 10, please. If you go to page 7, please.

BY MS. RIVAUX:

Q. Right at the first paragraph, the last sentence, it says -- this is a page about this report. It says it does not set out final -- excuse me.

It's the bottom on the right-hand side, bottom paragraph:

It is important to note that the references cited in this report do not constitute a comprehensive literature review and are only included to clarify why specific lines of inquiry are being pursued. Correct?

A. That is referring to the references in the report itself, not to the systematic reviews conducted by the NICE studies.

Q. This says the references cited in this report. Did I read that correctly?

A. "In this report," correct.

Q. And then the last sentence of that paragraph it says:

A formal literature review is one strand of the review's commissioned work, and this will be reported in full when complete. Correct?

A. That is correct.

Q. And that hasn't been reported yet, correct?

A. That is correct.

Q. And at the top of page 7, this report also says, the first paragraph:

It does not set out final recommendations. These will be developed over the coming months informed by our formal research program. Correct?

A. Yes. And Dr. Cass has actually spoken more on the plan to be able to incorporate that as far as what is being proposed in the revision of the original Tavistock model.

Q. Right. Doctor, my question was if I read that correctly.

A. You read that correctly.

Q. On page 9 -- on page 9, Dr. Cass writes a letter to children and young people, and what she states here is in the second paragraph:

I have heard that young service users are particularly worried that I will suggest that services should be reduced or stopped. I want to assure you that this is absolutely not the case -- the reverse is true.

Did I read that correctly?

A. You have read that as it is stated in the document.

Q. And if you can turn to page 23, and this page 23 is part of the summary and interim advice, right?

A. Correct.

Q. And at the top of page 23, it says -- it refers to hormone treatment, correct?

A. Correct.

Q. At the last sentence of paragraph 1.41, it states:

Standards for decision-making regarding endocrine

treatment should also be consistent with international best practice. Correct?

A. That is what it states, correct.

Q. And they cite then three footnotes. The first footnote, can you tell me what that is?

A. These are the 2017 Endocrine Society guidelines.

Q. And then on the right-hand side under paragraph 1.42, then there is a 12, it says:

Pediatric endocrinologists should become active partners in the decision-making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.

Correct, that's what it says?

A. That is what it states.

Q. And so they have not banned treatment in the United Kingdom, correct?

A. No, and I don't think that I said that.

Q. You also mentioned France, correct?

A. Correct.

Q. And in France, you have no personal knowledge about how healthcare is provided in France, correct?

A. I have general knowledge. I don't practice in France.

Q. Okay. And you -- you're aware that this is not a certified translation of the document, correct?

A. No, but I did read the original French.
Q. But you did not translate it, right?
A. This document that is presented was not my translation, no.
Q. And it's a press release, right?
A. I believe so.
Q. And it's not peer-reviewed?
A. Correct.
Q. Is it typical for you to rely on press releases in making decisions?
A. I would not say that I rely entirely on this document. I only include that with my other assessment of the other information.
Q. And this press release doesn't actually include other than five references, right? That's all it includes is five references?
A. Correct, and a reference to the Swedish experience.
Q. Okay. But this press release is not a scientific review?
A. No, it is not.
Q. It's not a comprehensive literature review, correct?
A. That is correct.
Q. You don't know how they came to the decision in this press release, correct?
A. Only from what they state in the document.
Q. Okay. And according to this translation of this press

release, France does not prohibit hormone blockers, correct?
A. They explicitly state that.
Q. Right. They explicitly say that they are available in France, correct?
A. That is correct.
Q. And they also explicitly say that the French medical system allows hormones at any age, correct?
A. I would have to read if they say "any age," but --
MS. RIVAUX: If we can pull up Exhibit 15, please.
THE WITNESS: I have it right in front of me here.
MS. RIVAUX: I'm sorry. Defense exhibit.
THE WITNESS: As stated by your experts, it is not given when kids are prepubertal. So that's why I am questioning your wording.
BY MS. RIVAUX:
Q. It does say:
Although, in France the use of hormone blockers or hormones of the opposite sex is possible with parental authorization at any age. Correct?
A. I'll accept it.
Q. That it says that, correct.
THE COURT: It should be on your screen.
THE WITNESS: Thank you.
BY MS. RIVAUX:
Q. And you, in fact, prescribe hormone suppressants to some

younger patients, correct, some adolescents for precocious puberty?

A. That is correct.

Q. What is the youngest age that you prescribed it for?

A. Probably about three years old.

Q. Three years old?

A. Probably -- yeah, about three years old.

Q. You also mentioned a position statement from Australia and New Zealand, right?

A. That is correct.

Q. And in this statement, do they ban the use of puberty blockers for gender dysphoria?

A. They prioritize psychological intervention.

Q. My question was: Do they ban the use of puberty blockers in adolescents?

A. That's not what the document says, no.

Q. Do they ban the use of cross-sex hormones in adolescents with gender dysphoria?

A. No.

Q. And you have no personal knowledge of how healthcare is provided in Australia, correct?

A. I don't practice medicine in Australia.

Q. You also mentioned Finland, correct?

A. That is correct.

Q. And the document you reviewed, did you read that in the

original Finnish?
A. No.
Q. Do you know how it was translated?
A. The copy that I have is an official translation from Lingua Franca, and the person that translated, I recall a name of like Arbelaez or something. I can't remember how I was given that copy. It was a while ago.
Q. What is Lingua Franca?
A. It's a translation agency, and it's certified and signed.
Q. This translation is certified and signed?
A. It looks identical to the version that I have in my files.
Q. But there is no certification on this exhibit, correct?
A. It was not given to me today.
Q. Okay. And where is the certification -- who makes the certification for Lingua Franca? Who provides the certification for those translators?
A. I'm not sure I understand your question. I don't know who sought the official translation or not.
Q. Well, you said that Lingua Franca is a translation service.
A. Correct.
Q. In what country?
A. I have no idea where they are based.
Q. Do you know the qualifications of the translator?

A. I can only state what I stated.
Q. So the answer is "no"?
A. I can only state that I saw a copy that was translated by something called Lingua Franca that was signed by an individual by the name of Arbelaez.
Q. And this copy does not have that certified translation?
A. What I have seen of that document is identical to what I had seen in that translated document.
Q. You compared this document to the translation?
A. Not in its entirety, but what I have been able to see today.
Q. Okay. And, again, in Finland you have no personal knowledge of how they provide healthcare, correct?
A. Other than what I know from the United States, I do not have a license to practice medicine in Finland.
Q. And this document is not peer-reviewed?
A. In the sense -- again, we're getting into this question of what is meant by "peer review." But it was a systematic review that you can say that the people putting it through were the peers themselves. So it wasn't a single individual submitting this for publication. It was a healthcare organization where they are their own peers.
Q. But it would not be what we would consider a peer review of a scientific journal in the United States, correct?
A. In the sense that we talked about earlier, as far as

sending it out to external reviewers, I don't believe it was.
Q. And the version that we have here doesn't have any of the citations of any literature to it, correct?
A. I believe that there is. Let me make sure. This is the summary. It does not.
Q. And the document also says that:
Puberty suppression treatment may be initiated on a case-by-case basis after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are present and there are no contraindications. Correct?
A. In the experimental setting.
Q. But does it say what I just read?
A. And the section that you are reading?
Q. Paragraph 2.
A. My recollection, when I read this document, is that they specified the need for this to be done as part of a research study.
Q. And there are two hospitals that are providing this treatment in Finland, according to this document, correct?
A. Correct.
Q. And, again, they also provide for the provision of cross-sex hormones, correct, for gender dysphoria?
A. Recognizing it as being experimental.
Q. And you also talked about a summary from Sweden, correct?

A. Correct.
Q. Did you review the translation of this document as well?
A. No, but I did read the systematic review that was used as it was published in English.
Q. But that's not what we have in front of us, right?
A. This is the Swedish policy statement.
Q. Right. So it just says "Summary," right?
A. Which I believe uses the same language that's included in that systematic review.
Q. But this one only references eight articles, correct?
A. I would have to look at the references, but it doesn't have the full references in there, correct.
Q. And you have no personal knowledge about how healthcare is provided in Sweden, correct?
A. As a practicing physician, I do not have a medical license in Sweden.
Q. And they're still able to receive treatment in Sweden for gender-affirming care in adolescents for gender dysphoria, correct?
A. As part of an experimental procedure.
MS. RIVAUX: Your Honor, if I can have one moment.
THE COURT: You may.
MS. RIVAUX: I may wrap up.
Could you pull up Exhibit 170, please, plaintiffs', please. It's been a long day. I'm sorry.

BY MS. RIVAUX:

Q. Dr. Hruz, early in your testimony, you mentioned that under watchful waiting there is no medical intervention that is provided, correct?

A. That is not correct.

Q. You said that there's no medical care that's provided under watchful waiting?

A. No. In fact, I think that's an erroneous portrayal of the expectant model. In fact, the expectant model does recommend provision of care to address underlying psychiatric comorbidities.

Q. Well, not just psychiatric care, correct?

A. That's correct. All of the needs of the patient can be provided, the needs of their psychiatric needs and regular well healthcare. It does not mean doing nothing.

Q. Right. So under -- this is the Adolescent Health Medicine and Therapeutics article called, "Gender Nonconforming Youth, Current Perspectives."

And if we go to page 61 of the document at the bottom, it has a Bates number 6627 at the bottom, and the paragraph that reads, "Under the Watchful Waiting Model," it says:

The watchful waiting model was designed by the members of the interdisciplinary team at the Amsterdam Center of Expertise on Gender Dysphoria, VU University Medical Center under the leadership of Dr. Peggy Cohen-Kettenis, borrowing

from the medical use of GnRH agonists for children exhibiting precocious puberty. The Netherlands team is responsible for introducing the use of puberty blockers for gender purposes to put a pause on pubertal growth and allow more time for a youth to explore their gender and consolidate their adolescent gender identity with the future possibility of cross-sex hormone therapy to align their bodies with their affirmed gender identity.

Did I read that correctly?

A. You have read that as stated in the document.

Q. And continuing on to the next page, under this watchful waiting model as explained under this article, on the top, on the left-hand side:

If a child's cross-gender identifications and affirmations are persistent over time, interventions are made available for a child to consolidate a transgender identity once it is assessed through therapeutic intervention and psychometric assessment as in the best interest of the child. These interventions include social transitions, the shift from one gender to another, including possible name change, gender marker change, and gender pronoun changes, puberty blockers, and later hormones and possible gender-affirming surgeries.

Is that correct under the watchful waiting model?

A. Are you asking whether it's a correct portrayal of the

model or is it correctly read from the document?

Q. Is this the explanation provided for the watchful waiting model under this article?

A. Under this article, you have read that correctly.

MS. RIVAUX: Dr. Hruz, I don't believe I have any more questions for you, but thank you.

THE COURT: Redirect?

MR. PERKO: May it please the Court?

REDIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Hruz, you were asked a number of questions on redirect -- I'm sorry -- on cross-examination about some *amicus* briefs that you signed on to.

A. Yes.

Q. Do you recall that testimony?

A. Yes.

Q. Did you write any of those *amicus* briefs?

A. I was not the author of these *amici* briefs.

Q. Do you know how many others signed on to the briefs?

A. There are multiple other peoples who signed on to the briefs. I did mention that some of the wording I would have worded differently.

Q. I would like to refer you to an exhibit that my friend on the other side referred you to, Plaintiffs' 38.

Do you recognize this document?

A. Yes.
Q. And that's a position statement from the American Academy of Pediatrics?
A. That's correct.
Q. Do you know whether a majority of the pediatricians, members of the American Academy of Pediatrics support the statement in P38?
A. My understanding is that a single individual that is listed here as the author of this paper crafted this statement. It was not -- at the time this statement was published, I was a member of the American Academy of Pediatrics, and I was never given the opportunity to review this document, nor have any of the other members outside been able to comment on this before it was published.
Q. If I can zoom in on this second paragraph, second column, it begins "Dr. Rafferty." It says that:

Dr. Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, and approved the final manuscript as submitted and agrees to be accountable for all aspects of the work.

Is that what it says?
A. Yes. It says that Dr. Rafferty was the sole author of this paper and was responsible for it being put together.
THE COURT: That's just not what it says, but on to the next question.

BY MR. PERKO:

Q. Do you know who Dr. Rafferty is?

A. I believe at the time he was a medical student when he wrote this or he was in training.

THE COURT: I hate to interrupt, but when you put a document up and it says that Dr. Rafferty drafted the initial manuscript, and then the witness says he was the sole drafter, it just doesn't match. I mean, and who wrote this document doesn't make much difference. But how willing a witness is to take an observable fact and just jump ahead, that doesn't matter.

MR. PERKO: Yes, Your Honor.

BY MR. PERKO:

Q. Dr. Hruz, Judge Hinkle asked you a question to the effect of whether you would prescribe hormonal treatment for gender dysphoria if the evidence showed them to be safe and effective.

Do you recall that?

A. I do recall that, yes.

Q. And what type of evidence would convince you that it is safe and effective?

A. As I have long maintained, the evidence that needs to be done in this area is a solid randomized controlled study showing the efficacy of this intervention; and, again, in a way that it is -- cannot be provided with another

intervention with lower risk and greater efficacy.

Q. And what type of evidence would you want to see?

A. A randomized controlled trial.

Q. The plaintiffs have suggested that the randomized controlled trials are unethical in this context.

What do you say to that statement?

A. I think it's based upon a false presentation of how a randomized controlled trial would be done. Generally, it's conceived that that would involve an experimental group and a controlled group that received no care. I have long advocated for the design of a randomized controlled trial that would be ethical, and in the initial stages of proposing these interventions could be done in a way that ensured the safety of these individuals. And this is based upon, for example, comparative group that received psychological intervention.

I base that on even some early evidence, for example, the 2015 Consta paper that actually compared in a nonrandomized way psychological intervention alone in comparison to psychological intervention and pubertal blockade.

In that study, both groups showed improvement during the course of observation. That would be a modest randomized controlled trial that would allow one to begin the process of designing larger trials with more ambitious gains, outcome measures, and that is the type of information that one needs

to be able to make the conclusion that this would be supported by the evidence as being both safe and effective. So, again, very carefully delineated what we mean by "safe" and what we mean by "effective."

And that's the basis for my concern in this area, is that that evidence does not yet exist, and there is not a willingness to even construct these trials. And I believe it's based upon not only a false conception of the way that randomized controlled trials are done, it's actually a distortion of the normal scientific method.

The basis for saying the randomized controlled trial is not ethical is to accept the conclusion without the evidence. As I may have said previously, the way science is normally conducted is to begin with the state of skepticism with your hypothesis assuming that there is no difference between intervention and control, and then looking for evidence to disprove that null hypothesis.

What is being portrayed as unethical is to begin with a forgone conclusion and then to look for evidence to support that conclusion, and that is not the way science is conducted.

MR. PERKO: Thank you, Dr. Hruz.

I do not have any additional questions. I was remiss. I don't believe I moved the exhibits that we talked about on direct.

THE COURT: Give me those numbers.

MR. PERKO: Plaintiffs' 8, 9, 10, 11, 12, 13 and 14.

THE COURT: So 8 through 14, those are defense exhibits?

MR. PERKO: Yes, sir.

MS. RIVAUX: Those are the ones we objected to as they related to the different report summaries from the different countries.

THE COURT: And if I didn't rule, I need to. It's the same ruling I made on the rest of these. Those are admitted for the purposes indicated earlier.

MR. PERKO: Thank you, Your Honor.

THE COURT: Doctor, a couple of things that are kind of detailed in clarification, and then some more important questions.

There was some question on cross about your relationship to Alliance Defending Freedom. You said you'd gone there for two meetings.

I have a colleague who wrote in a published opinion that you had a connection to Alliance Defending Freedom. Sometimes my colleagues are wrong as I am, and different records have different things.

Is going to two meetings your entire connection to Alliance Defending Freedom or is there more to it than that?

THE WITNESS: There is no more to that. I have been

contacted by the Alliance Defending Freedom for information related to my knowledge of the scientific evidence in the same way that I presented this knowledge to dozens of other organizations. It's exactly the same information that I presented multiple times to multiple different groups.

THE COURT: It sounds like that judge just got it wrong.

THE WITNESS: It has been by many misconstrued and misinterpreted.

THE COURT: All right. You said that something -- and to be candid, I don't recall now exactly what -- produced a three-to-five-times increase in the stroke risk. What was it that has that increase?

THE WITNESS: That is the administration of estrogen to a biological male. The reference to that paper, I believe, is Gettahun. I don't remember the year of the journal, but I would have to look it up.

THE COURT: So what I wanted to ask about was three to five times more than a stroke risk of what? What -- just somebody walking around in society, the risk they are going to have a stroke?

THE WITNESS: So if you are asking the question in relation to a biological male or a biological female, so the comparison is what happens to an individual when they get put on estrogen with their stroke risk. And that is actually

known for both males and females. It's dependent upon the route of the administration of the estrogen and the dose.

THE COURT: So if you give estrogen to a woman as you do sometimes --

THE WITNESS: Right.

THE COURT: -- it has a stroke risk.

THE WITNESS: That is correct.

THE COURT: And if you give estrogen to a man, the stroke risk is three to five times higher.

THE WITNESS: That is what the evidence showed in that paper.

THE COURT: I take it the risk of stroke from giving estrogen to a woman is very low.

THE WITNESS: That is correct.

THE COURT: You've done it before; you've given this treatment.

THE WITNESS: Correct.

THE COURT: And you tell the patient, one of the side effects, you could have a stroke.

THE WITNESS: Correct.

THE COURT: But you apparently say it's not a very high risk because the patient takes it, and I take it if you said, by the way, you got a 70 percent chance of having a stroke, nobody would take it. So you must say this is a small risk.

THE WITNESS: Correct. Again, it's in relation to counseling a patient on the risk they are accepting by getting the medicine.

THE COURT: Got it. The risk of all of these medicines, and you make a benefit analysis and --

THE WITNESS: That is absolutely correct. And I think that is the key question, is to whether the risk that is assumed relative is acceptable to the purported benefit. That is key.

THE COURT: But at three to five times higher, three to five times more than a very small number is still a very small number. True?

THE WITNESS: The patients that die from the stroke still die.

THE COURT: Yeah, but it's a very small number, right?

THE WITNESS: Yes, but by the more people that get exposed, then that risk increases.

THE COURT: It is. I haven't done the study, but my guess is the risk of flying on a private jet is a substantial multiple of the risk of flying commercial. But people who can afford it, they take the private jet. Sometimes when a risk is very small, an increase in the risk still is a very small risk. That's true, isn't it?

THE WITNESS: That is true. To put it in context,

when you look at the absolute mortality rate with gender-affirming care, and you look at -- it's not insignificant. If you look at the Kaplan Meier curves to look at things that are not irritation or -- so, anyway, your point is well taken. It is true.

THE COURT: When you analyze this kind of medical care or any kind of medical care, does clinical experience matter?

THE WITNESS: Yes. I'm not going to say it's not important.

THE COURT: So assume for me that -- we have had evidence in this case of many hundreds of individuals who have been treated medically and have had very substantial improvements in their quality of life. Should that be a factor in the analysis at all?

THE WITNESS: So I would say that there is a longstanding history within the medical profession of practitioners making statements based upon a belief that they are helping their patients only to find out later that they have not. So that one needs to interpret with caution the clinical experience supported by the available scientific evidence.

THE COURT: My question was: Should the clinical experience be taken into account in assessing that?

THE WITNESS: It should be considered.

THE COURT: Now, I understand that you don't always know what the situation is medically. My experience is, when somebody thinks they are happy, they're happy. And when they think they are unhappy, they're unhappy. It's almost tautological. So if there are hundreds of patients that have been treated, and the record shows that the patient said that they were happy, they were better after the treatment, how is it that you are able to say they are probably wrong, or they may be wrong, or we can't rely on what they think their mental position is?

THE WITNESS: To be clear, Your Honor, I did not definitively conclude that they're wrong. I said that the scientific information is insufficient to make a conclusion about their long-term welfare. In this situation here, the existing data for those that undergo detransition or have regret is a very long time frame. And it's very well -- to make a conclusion based upon an outcome of just several years is not sufficient in light of what scientific evidence that we have about long-term effects.

Another factor that I did not have a chance to mention during my testimony is, in many of these clinical trials, there is a substantial dropout rate of patients; sometimes as many as a third.

THE COURT: I'm not talking about clinical trials. I'm talking about doctors who treat real patients. We had

patients sitting on that witness stand where you are sitting now, a young man who thinks he's a lot better off. Do you doubt that he's a lot better off?

THE WITNESS: I haven't had that conversation, but I have talked with people that are not happy with what they had, and they universally tell me that they want to stay as far away from their practitioners as possible.

THE COURT: And let me tell you the people on the private jet that went down, they were not happy either.

They quoted to you *amicus* briefs, one talking about false belief and delusion, and you signed on to that brief.

THE WITNESS: That's correct.

THE COURT: Do you think that, let's say, a 12-year-old girl at birth who identifies as a boy is delusional?

THE WITNESS: I have had this conversation with multiple individuals.

THE COURT: I really don't want to know about your conversation. I want to know what you think. Do you think that that person is delusional?

THE WITNESS: It depends on how you define the word "delusional." Delusional, whether one recognizes the discrepancy between biological sex and their gender identity versus somebody that does not.

THE COURT: Probably a bad question because

"delusional" may be a medical term, and I didn't mean to use it that way.

The other thing in the brief was that this was a false belief. Do you think that the person who was assigned male at birth who identifies as female has a false belief?

THE WITNESS: Again, the statement is in reference to whether a male can become a female, and the argument from a biological -- and this is why it's very central to my discernment of this about the scientific premise about whether one can be born in the wrong body -- that the assertion that is made, I say that it is false to say that sex can be changed.

THE COURT: This is in reference to a false belief. Look, maybe I'm not describing it very well. Let's just get it out in the open and talk about it.

There are people who believe that a trans individual is indeed trans; that the person was born with male physical characteristics, assigned male at birth, but identifies as female, that that is a thing. There are people that believe it's all poppycock, and it's just a decision that somebody made, and that it's a false belief. I would have thought that when a brief said this is a false belief and delusion, and these are people impersonating someone else, that that was the view, the second view I described, the view that this is not really a thing; that this really is not a case that somebody

is born in a male body but identifies as female. That's not what is going on. It's just a false belief. I just need a straight-up answer.

Do you think it's a false belief or do you think there are really people that's who they are? They are born in a male body but believe, identify as females.

THE WITNESS: I accept that there are people that are born that are biological males that identify as females. The falseness is in whether they truly are females. They identify as, and they have a gender identity as, that's a different question. I would say that I do not deny that people present with a perception of their gender identity that is discordant with their gender, their biological sex.

THE COURT: Their perception. But, I mean, are they wrong or is -- is there somebody that their whole life identifies as a different gender from the sex assigned at birth?

THE WITNESS: I would imagine that there may be, yes.

THE COURT: You gave puberty blockers to a three-year-old once.

THE WITNESS: More than once.

THE COURT: More than once. Tell me the grade of evidence using the GRADE system that supports providing puberty blockers to a three-year-old. And then I'm going to get you to give me the control random studies that support it

or whatever for a three-year olds.

THE WITNESS: Correct. To my knowledge, there has not been a clinical practice guideline using the GRADE system to assess that question.

THE COURT: Are there any randomized controlled trials that support giving puberty blockers to three-year olds?

THE WITNESS: No.

THE COURT: Did you just use your clinical judgment to decide that this would improve this child's prognosis?

THE WITNESS: No. I used much more than my clinical judgment. I looked at the existing literature as far as the use of the medication for that purpose, the outcomes, and also in consideration of risk and benefit in that setting.

THE COURT: And was there a lot of literature about three-year olds?

THE WITNESS: It covers the -- yes, there is literature on three-year olds.

THE COURT: I have known of a couple of situations where a child was too young to swim at a cocktail party or whatever. The pool is there. The child winds up in the pool. The adult jumps in and gets the kid out. That's the right thing to do, right?

THE WITNESS: Yes.

THE COURT: What quality of evidence, using the GRADE

system, supports the view that the right treatment for that child is to get the child out of the pool?

THE WITNESS: There is no need for a GRADE system for that. Again, there are -- it's not unique to the gender dysphoria endocrine guidelines using the GRADE system. But at any time when one assesses a medical intervention and a recommendation, it is consideration of the relative risk versus the relative benefit. I would say that your example, hypothetical, is vastly different than the situations that we're talking about.

THE COURT: Vastly different. I did it for that very reason. You get a five-year-old with a peanut up the five-year old's nose. There are probably not any randomized studies for that either. You just take the peanut out of the nose the best you can, right?

THE WITNESS: Correct.

THE COURT: Now, there are two possibilities, and I think they are exhaustive. They exhaust the universe of possibilities. You have a 12-year-old, for example, who presents with a belief or identity of the other gender. So male sex assigned at birth, 12 years old says, I'm a girl, and has been saying this consistently for a long time.

I think there are only two or -- there are variations, but there are two possibilities that exhaust the universe. You can provide medical care or you cannot provide

medical care. Tell me the quality of evidence using the GRADE system that supports not providing medical care.

THE WITNESS: I would disagree with the way that you presented that because the two options are not the same.

THE COURT: Nobody ever likes my hypotheticals. But tell me what's wrong with the idea that that exhausts the universe. It's either yes or no; it's got to be one or the other.

THE WITNESS: No, it is not. The reason why it's not is that it's what type of medical care you provide. Nobody would argue to give more medical care.

THE COURT: Let me back up and try to straighten this out. By "medical care," I mean puberty blockers, hormone -- cross-sex hormones or eventually surgery. So define medical care as those. That's the medical care we are concerned about in this case, so define it that way. This child either gets medical care or does not get medical care.

THE WITNESS: Again, they could either receive the affirmative approach or they could receive psychological interventions that don't require those hormones. That's not no care.

THE COURT: I didn't say no care. I get it, and we can dance around this as long as you want to dance around it. Sooner or later you're either going to answer this question or you're not. And I'll draw whatever conclusions from that I

draw.

I think it's either you get medical care or you don't get medical care. That -- I'm not a medical doctor. I've had a few philosophy classes. It's got to be one or the other. You either got medical care or you didn't get medical care.

So you talked a lot today about the quality of evidence using the GRADE system that supports providing medical care. My question is: What quality of evidence supports providing no medical care?

THE WITNESS: I'm not able to answer the question as you phrase it because I would say there is significant data in the existing scientific literature that has not addressed whether the improvement that is seen is due to psychological intervention versus the affirmative hormones and surgery. And, therefore, when we're talking about how you care for these individuals, it's not give them the affirmative approach or give them nothing. It is to be able to give them the affirmative approach or an alternate approach that actually explores and addresses other aspects.

THE COURT: List for me the high-quality evidence that supports not providing medical care.

THE WITNESS: I'm not advocating nor I know anybody advocating no medical care.

THE COURT: Yes, you are. Maybe I missed it. When you define medical care as puberty blockers, hormone therapy

or surgery, unless I just totally missed your testimony, I thought what you were advocating was no medical care. Did I miss that?

THE WITNESS: Yes, you did.

THE COURT: What medical care do you advocate?

THE WITNESS: I advocate for high-quality research studies looking at alternative methods including psychological intervention.

THE COURT: When it comes to closing argument, I take the answers to be, he knows of no high-quality evidence that supports providing no medical care; and, frankly, I think that's correct. There is not. I think that -- you can address this when we get to closing. I think that you really do either get medical care or you don't get medical care. It's a decision one way or the other.

Your side seems to say, the Doctor seems to say, oh, we don't have good evidence to do it this way, and so the default is to do it that way. But that way is a choice, too. And I haven't heard any high-quality evidence for that way; and, frankly, I think, it's the same thing.

So you keep hammering this low-quality evidence, and I hear the argument. But if you want to persuade me with it, you are going to have to explain why what you're going to do is provide no medical care, because I think that's a decision, too.

Doctor, I have done the best with it I can.

Any questions just to follow up on mine?

MR. PERKO: No, Your Honor.

MS. RIVAUX: No questions, Your Honor. Thank you.

THE COURT: Thank you, Dr. Hruz. You may step down.

Ten to 5:00. You probably don't have a ten-minute witness. We haven't had a lot of those in this case.

MR. PERKO: No, Your Honor.

THE COURT: Where do we stand?

MR. PERKO: We have Dr. Levine next, Dr. Lappert after that, and then Dr. Kaliebe, and then we have two fact witnesses from AHCA, Ann Dalton and Matt Brackett. Oh, Dr. Scott, I forgot. She will be participating by Zoom. She's in the U.K.

THE COURT: They are five hours off. It's okay with me if she testifies at odd hours, but it's probably better for her if she testifies during her day. If you need to switch things around to accommodate that scheduling, we can do that.

MR. PERKO: Thank you, Your Honor.

THE COURT: 9:00 tomorrow. Anything else we need to do tonight?

MR. GONZALEZ-PAGAN: Not from the plaintiffs, Your Honor.

THE COURT: 9:00 tomorrow morning.

(*The proceedings adjourned at 4:50 p.m.*)

* * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy are noted within the transcript.

Judy A. Gagnon *5/17/2023*

Judy A. Gagnon, RMR, FCRR
Registered Merit Reporter

Date

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Dekker v Weida: 4:22-cv-325

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE, FLORIDA

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
vs.	)	Tallahassee, Florida
	)	May 18, 2023
JASON WEIDA, et al.,	)	9 A.M.
	)	
Defendants.	)	
_____	)	

VOLUME IV
(Pages 963 through 1151)

TRANSCRIPT OF FIFTH DAY OF BENCH TRIAL
BEFORE THE HONORABLE ROBERT L. HINKLE,
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiffs,

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.org
120 Wall Street
19th Floor
New York, New York 10005

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

APPEARANCES: Cont'd

For the Plaintiffs:

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: SHANI RIVAUX
Attorney at Law
shani.rivaux@pillsburylaw.com
600 Brickell Avenue, Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall, Suite 1800
Sacramento, California 95814

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: WILLIAM C. MILLER
GARY J. SHAW
Attorneys at Law
william.c.miller@pillsburylaw.com
gary.shaw@pillsburylaw.com
1200 17th Street NW
Washington, D.C. 20036

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorneys at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DeBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

National Health Law Program
By: CATHERINE ANNE McKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

APPEARANCES: Cont'd

For the Plaintiffs:

National Health Law Program
By: ABIGAIL K. COURSOLLE
Attorney at Law
coursolle@healthlaw.org.
3701 Wilshire Boulevard
Suite 315
Los Angeles, California 90010

For the Defendants:

Holtzman Vogel Baren,
Torchinsky & Josefiak, PLLC
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

THE COURT: Good morning. Please be seated.

Mr. Perko, please call your next witness.

MR. PERKO: Defendants call Dr. Stephen Levine.

DEPUTY CLERK: Please stand and raise your right hand.

***STEPHEN B. LEVINE*, DEFENSE WITNESS, DULY SWORN**

DEPUTY CLERK: Be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: Stephen B. Levine. L-e-v-i-n-e.

DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Levine, what academic and professional positions do you presently hold?

A. I'm clinical professor of psychiatry at Case Western Reserve University in Cleveland, Ohio. I am the staff -- a staff psychiatrist at a private practice, and I'm the head of the gender diversity program at that private practice.

Q. And what do you do in those positions?

A. Well, as a professor, a clinical professor, I teach, I write papers, I supervise. And as a clinical psychiatrist, I see patients five days a week.

Q. And could you please summarize your educational background?

A. I graduated summa cum laude from the Washington & Jefferson College in Pennsylvania, went to Case Western Reserve Medical School, graduated in 1967. Did a medical internship for one year at University Hospitals, went to the public health service and worked at the NIH field studies unit in Phoenix, Arizona, studying diabetes in the Pima Indians.

I then went back to University Hospitals of Cleveland and had a three-year psychiatric residency, and then I obtained a Robert Wood Johnson Foundation two-year fellowship in research and academic pursuits. And then I have been practicing psychiatry ever since.

Q. Could you briefly explain your professional experience since obtaining your degrees and fellowships?

A. I'm sorry?

Q. Can you briefly summarize your professional experience since obtaining your degrees and your fellowships?

A. I'm sorry, I am confused by your question. I thought I just explained my professional degrees.

Q. Yes, I was asking about your professional experience since obtaining your degrees.

A. Well, my degree as a board-certified psychiatrist required passing exams and a certain number of years of clinical experience. The Robert Wood Johnson Foundation was -- I didn't even apply for, I was given by the chairman

of the department who had arranged it because he's -- I guess because he saw that I had some kind of developmental potential.

And I've always been interested in how things work and how people get to be mentally ill and how people get to be mentally unwell -- get to be mentally well with therapy and medications and so forth.

So I consider myself to be a student of various subjects. And, oh, I think I now understand your question. I'm sorry.

My specialty since the beginning of my academic career has been human sexuality, and I was originally hired by the department to develop a curriculum in human sexuality for medical students. And in the process of developing those lectures in that curriculum, I was known in my community as a young doctor interested in human sexuality. And I began to see all kinds of patients with sexual problems that I never even heard of when I was a resident, and that includes gender identity problems.

And in the process of coming to grips with all of these new things coming at me, I established five or six clinics within our system and gathered people around me to help me understand marital problems, sexual dysfunction, professionals who sexually offend, paraphilic problems, and male and female sexual dysfunction.

And for our purposes today, in 1974, I started the first

clinic for gender -- what we called in those days under a different name. We called it transsexualism. And so I was the first colleague, and I started the Case Western Reserve Gender Identity Clinic in 1974.

Q. Dr. Levine, do you have any experience with the treatment of gender dysphoria?

A. Well, I've continuously been involved in the evaluation and treatment of gender identity disorders since one month after I started my academic career. And within nine months of that first patient, a colleague and I started the Case Western Reserve Gender Identity Clinic. And that clinic has evolved into different -- under different names and has been in place at different locations. But I have been continuously, without interruption, taking care of gender patients and their families since 1970, middle of 1973, and formally since 1974.

Q. And have you -- approximately how many patients have you treated with gender dysphoria?

A. Well, the emphasis is on the word "approximately," and I would say 3 to 400.

Q. Dr. Levine, have you authored any peer-reviewed publications?

A. Many.

Q. Approximately how many?

A. Close to a 150, 160, and that doesn't include chapters,

but chapters are peer-reviewed in a sense, too. So I think at last count I have about 180 on publications.

Q. Have any of those involved gender dysphoria?

A. About 30, 35 of them have.

Q. Dr. Levine, did you attach a curriculum vita to your expert report?

A. I'm sorry?

Q. Did you attach a curriculum vita to your expert report?

A. Yes, I did.

Q. Is that a true and correct summary of your professional experience?

A. Except that on April 14th I published another paper, and I'm not so sure it's in my CV. But other than that, it's correct.

Q. Okay.

MR. PERKO: Your Honor, I believe Dr. Levine's CV is on the stipulated exhibit list as Exhibit Number DX32. We'd offer it into evidence.

THE COURT: DX32 is admitted.

(DEFENDANTS' EXHIBIT NO. DX32: Received in evidence.)

MR. PERKO: Your Honor, at this time I would tender Dr. Levine as an expert in psychiatry.

THE COURT: Questions at this time?

MR. LITTLE: No, Your Honor.

THE COURT: You may proceed.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. Dr. Levine, what is gender dysphoria?

A. Gender dysphoria is a DSM-5-TR diagnosis that is characterized by fundamentally a current incongruence between the sense of one's self and one's gender and the biologic sex the person inhabits.

It has certain criteria, including duration criteria of at least six months and an impairment of social, vocational, educational function and other important areas of function. And it has to fulfill a certain specific criteria like the aspiration to have -- have the sexual -- secondary sex characteristics of the opposite sex, dislike of one's body, et cetera, et cetera.

Q. Dr. Levine, is gender identity biologically based?

A. Well, if you mean by biologically based biologically determined, the answer is definitely not. But the origin of gender identity disorder is a complex interaction between biologic givens, temperamental tendencies, developmental factors, psychological developmental factors, interpersonal factors, and cultural factors.

So these are the four great forces that shape all sexual behavior including identity, behaviors that stem from identity, biologic, developmental, interpersonal, and cultural.

So if we can accept that general principle, we would never say it's simply biologically determined.

Q. What are the different models of therapy for gender dysphoria?

A. There are three basic models.

Well, I'm sorry. Would you ask that again?

Q. What are the models for therapy -- different models of therapy for gender dysphoria?

A. For therapy, yes.

One is to characterize the problem that is accurately diagnosed, the presence of the current gender identity and meeting criteria for the gender dysphoria and then follow the family and -- the patient and the family over time without any intervention, knowing that development itself helps a child or a minor discern how he wants or she wants to live their lives.

So without anything but a follow-up, watchful waiting we sometimes call that, that's the same term we use, for example, if people have mild prostate cancer or low grade prostate cancer, we watch them over time rather than intervene. We monitor them over time to see what the course of the illness is. So watchful waiting is one approach.

The other approach because many of these children and their families have multiple forces that are adverse or negative or tense, tension, and the child developmental ideal

concepts how to raise children are not present in that family, so the second approach would be a psychotherapeutic approach addressing the symptomatic expressions of the child, like bed wetting or anxiety or depression and so forth, without a focus on gender identity at all, but a focus on helping the family function better to enable a healthier developmental process for the child.

And the third general category is the affirmative care where the child's current gender identity is supported, and maybe even the child is socialized. A grade school-aged child, a prepubertal child might be socialized in the opposite or aspired to gender, followed by medical, hormonal and then eventually surgical intervention.

So in summary, there is watchful waiting. There's a psychological approach to address the underlying developmental forces that are less than ideal in the family, and then there is the watchful waiting, which privileges gender identity to treat the gender identity. And so the psychological, the second force, the psychological force privileges the associated psychological problems in the child and in the family, whereas the affirmative care approach privileges the symptoms of gender identity.

Q. Is the psychological approach --

THE COURT: Let me -- when you say "privileges," would another word for that be prioritizes?

THE WITNESS: Prioritizes, yes.

THE COURT: I just wanted to make sure I understood your use of the word.

BY MR. PERKO:

Q. Dr. Levine, you mention the psychological approach. Is that conversion therapy?

A. In my mind it is not conversion therapy. It is just prudent traditional psychiatric approach to any other psychological problem that a child may have. This is a really pejorative term, and it frightens many mental health professionals from even being involved in the evaluation and treatment of kids with gender identity disorder.

I just need to emphasize that prudent, judicious and traditional psychiatric care that begins with an evaluation of the child and the family circumstances is how we approach every other psychiatric condition in a minor or a teenager.

Q. Are you familiar with the term "standard of care"?

A. I am.

Q. What does that mean?

A. A standard of care is a formal document that is derived by every medical specialty for each major disorder in that specialty. It is hopefully derived by a scientific review every five years of the current literature of the research, and it issues a brief recommendation for how a particular problem should be handled. I mentioned low-grade prostate

cancer. There is a standard of care for a low-grade prostate cancer. It is written by urologists and people who have great expertise in evaluating the quality of science.

So standards of care generally are to be issued every five years because science changes. It's to be constructed by people in the field, at least the minority of people in that committee in the field but also with people outside the field who have expertise in research -- development and research evaluation of papers, often people from epidemiology and different fields who have sort of expertise in how to construct research and how to the interrupt research.

So that's the standards of care. Standards of care are often used almost synonymously with clinical guidelines, but clinical guidelines -- well, let me say this again.

Standards of care have a highfalutin kind of connotation that it's kind of almost universal that the world agrees that the way to take care of low-grade prostate cancer is this, and the alternative is this. Clinical guidelines tend to be much more regional, much more local and not necessarily universally accepted.

Q. Dr. Levine, are you familiar with an organization called the World Professional Association for Transgender Health or WPATH?

A. I am.

Q. And what is your experience with WPATH?

A. I was one of the original members from the early '70s, and I was in the organization for 25 years, and I was asked to be the chairman of the development of the fifth edition of the Standards of Care which were published in 1999.

I attended their every-two-year meetings, and in those early years, my association with -- it wasn't called WPATH then. It was called The Harry Benjamin International Gender Dysphoria Association. But in those years, it was an international organization of people who were interested in answering the question, what is this thing called transsexualism and why do people want to do this, and what are we supposed to do about it?

We were a group of people, international academic people or just people interested in this subject who came together to try to figure out the answers to those questions. So it was in my view, a young doctor's view, a scientific organization seeking answers to vital questions.

But when I presented the WPATH the fifth Standards of Care to the executive committee of HBIGDA -- it was called -- the chairman of the department -- the president of HBIGDA had read the 21-page report that our committee created, and he objected to one aspect of the recommendations. And that was that people should have two independent psychiatric evaluations that recommended hormone therapy.

He thought it should be one, and he was really quite upset with us, and he told me at the meeting where it was accepted -- or the fifth version was accepted that he was going to appoint a sixth committee because he thought it was excessive that we asked -- he thought it was too conservative that we asked two independent psychiatrist to -- or psychologists to make an opinion that this is a reasonable choice for this particular person. And, in fact, I think in 2002, the next Standards of Care was issued, and if I remember correctly, it's almost word-for-word, that -- for our Standards of Care except that it asked only for one letter of recommendation for hormone treatment.

So that -- so I guess I wasn't pleased, but I was also reassured that my language or the language of my committee persisted in all but one section in the sixth Standards of Care. But I had attended the meeting and then the next meeting, and I realized that Dr. Green was committed to advocacy for trans care, and he was -- and the entire organization had become committed to advocacy rather than understanding the answers to these fundamental questions. And instead of a bunch of scientists and clinicians attending these meetings, they were suddenly cross-dressed people who were booing when they heard things that they didn't like.

And so I decided that I no longer could be a member of HBIGDA, and I think about 2002, I didn't renew -- after

attending a meeting, I didn't renew my manipulate.

Q. Dr. Levine, are you familiar with the WPATH Standards of Care Version 8?

A. Yes.

Q. Do you consider those to be true standards of care?

A. No. I think -- true in a scientific sense, you mean? True in a way that is -- accurately reflects the state of understanding. I think it's much more -- it's much more comprehensive. The fifth and sixth Standards of Care were 21 pages. The seventh Standards of Care were 121 pages. The eighth Standards of Care are over 300, I think 360 pages.

So if you ask a doctor to read the standards of care and follow the standards of care, you are asking the doctor to read a book which is not going to happen. But the construction of the standards of care are not based upon an accurate balanced view of the state of science. They are based upon a consensus of people in the field who have agreed that, even though the quality of the data, the scientific data is very low or low, the standards of care recommend that hormonal treatment be the first step for teenagers in affirmative care.

So the relationship between the tradition of how people have been cared for versus which I might call fashion-based treatment versus scientifically based or evidence-based treatment, those things are very different. And in the

eighth Standards of Care, 360 pages of rhetoric of talking about evidence and -- lead to the conclusion that the fact that there is a low quality of evidence does not mean we shouldn't use hormones and surgery when patients want them.

So I'm not impressed with the standards of care. They certainly are not universal. Certainly you have already heard that the European countries don't follow those standards of care anymore. And not -- the standards of care have been written by people who believe in hormonal treatment, and they do not include people who have any skepticism about it.

Q. Could you please explain how WPATH's standards of care historically dealt with psychotherapy as a treatment for gender dysphoria?

A. Well, in those early years, the '60s, '70s and '80s, psychotherapy was a tool for evaluating and understanding the answers to the basic questions. By the seventh standard of care in 2012 -- 2011, '12 and '13 were the years where the seventh edition became widespread -- psychiatric evaluation and the previous recommendation for psychotherapy before we had endocrine treatment, that was downgraded dramatically. So the psychiatric evaluation extended the psychiatric evaluation which had been previously the standard recommendation was downgraded, and people like me who performed these psychotherapeutic evaluation processes were

called gatekeepers.

And because there was a great influence from the community of trans adults themselves who wanted a particular form of treatment, this -- "a gatekeeper" a pejorative name. And so when psychotherapy as a reasonable process to begin the evaluation of people who wanted to change their gender expression suddenly became an enemy of the trans community.

And so nowadays when you read psychotherapy in the eighth edition of the Standards of Care, it's usually preceded by the word "supportive." So you have to have supportive therapy. And what supportive mean is helping the people live with all the conflicts and dilemmas that they may feel about being trans and all the environmental problems they encounter, and you have to support their concurrent gender identity.

Whereas psychotherapy used to be an evaluation of the psychological developmental conflicts and ambivalences that the person had, the worries that they had about this transition. So psychotherapy used to be respected, and now it's viewed -- you have already introduced this word, "conversion." It went from an expected prelude to considering medicalization to being some kind of an enemy of the trans person. And that's been the dramatic transformation over 40, 50 years, especially actually over the last 20 years.

THE COURT: At some point, I'm going to make sure I understand that, if you are still on the same subject and want me to wait just a minute. Is this a good time as any to interrupt.

MR. PERKO: Yes, Your Honor.

THE COURT: Let me make sure I understand this. I'm not going to put a meaningful timeframe on it, but basically I'm going to talk about early in your career as you were starting into this. And I take it the approach that you would think would be appropriate now, the idea is good psychiatric care, psychotherapy, an analysis of the individual, supporting the individual but not necessarily supporting the individual -- the individual's current gender identity, not necessarily opposing the person's gender identity but evaluating the gender identity and trying to come up with a plan for the individual.

Basically is that the approach?

THE WITNESS: That is the approach, but I want to add one thing to that. In evaluating the individual, we want to understand the forces that may have influenced the solution, I am a trans person. See, a new current gender identity is a solution. We're asking the question, what is the problem?

So what we want to know through the psychotherapeutic process over time is what things are disturbing this person in such a way that they imagine that, if they transfer -- if they

change their gender expression, all their preceding problems, which I can enumerate, the recurrent serious preceding problems, all those problems will be ameliorated.

So a psychotherapy is an attempt to identify what is -- in the courtroom it's called comorbidities -- and to see if we can address the sources of those comorbidities and attenuate the symptoms of those comorbidities if not eradicate them entire.

THE COURT: How did we get here and how do we solve any problem going forward, essentially?

THE WITNESS: Exactly. How did we get here?

THE COURT: So prioritizing hormone treatment or medical care is not what you advocate. What's been called conversion therapy resisting the gender identity is not what you advocate. What you are saying is you need to figure out how we got here and how we ought to go forward without a preconceived notion of which of those is appropriate.

THE WITNESS: Right. And ultimately, it is the individual patient's decision on how to live his or her life. And if that person chooses to medicalize after a period of careful evaluation, which is not done in one hour or two hours or three hours, you know, that's their right as an individual person, especially if they are 18 years old, an age of majority.

THE COURT: Jumping to medical care -- by "medical

care," I mean puberty blockers, hormone treatment, something other than therapy but medicines -- jumping straight to that inappropriate -- and you've talked about conversion therapy. You understand there are some places where the preconceived determination is we're going back to the natal sex and without the individual evaluation already know the answer.

Just like there are some people that know the answer is medicine. There are some people on the other side that know the answer is going back.

That's true, isn't it? Aren't there some people that do that?

THE WITNESS: Well, you know, the word "know" in your sentence is really "believe" that they know.

THE COURT: Absolutely.

THE WITNESS: What we're talking about here is long-term negative impact on sterility, on sexual dysfunction, on the ability to form and maintain lasting relations with a pool of people who are interested in participating in long-term stable relationships, and the fact that we know that there is premature mortality in the trans populations.

So when we say people know what is the best way of treatment, if -- they need to know what the long-term impact is of the comorbidities, plus the current gender identity, and so --

THE COURT: You're jumping ahead to stuff that I need

to let Mr. Perko deal with first before I start following up. So you answered. I think I understand what you told us to this point.

Mr. Perko, you may carry on.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. Dr. Levine, are you familiar with the longitudinal studies by de Vries, et al.,?

A. Yes, I am.

Q. And can you tell us about those studies?

A. First, I want to tell you about the amazing significance of this study, that when this study was published in 2014, the world accepted the results of this and began at rapid acceleration, what we call rapid defusion of the new treatment standard of taking minor children, giving them puberty blockers and cross-sex hormones and surgery.

So nobody really right after this -- with one exception, no one tried to replicate the study. There was a replication attempt in England and it failed. But here are the problems with the de Vries study. This study is often referred to as "the Dutch protocol. "

The Dutch had 197 families, of kids and families. They offered the Dutch protocol to a 111 of them. The reason they didn't give them to the rest was their family was not supportive or the child was too mentally ill, too

symptomatic. So they had a 111 families that they offered this to, and 70 families agreed to enter into the protocol. When the protocol finished, there were 55 children reported upon.

Now, this study was not controlled. So you couldn't -- when a study that doesn't have a control, even though you may interpret that this -- we did this and this is the result, scientifically you can't know that because many things could have determined that result.

And one of the things that is very important to know is the Dutch protocol selected healthy families who were supportive and children who were not very symptomatic. Number one, they cherry-picked healthy people predisposed to have good results.

Number two, they only took into this protocol children who were cross-gender identified consistently during this prepubertal ages. They did not -- so no child was socially transitioned before because the de Vries group at that time knew -- at that time we already knew there was a very strong desistance rate for the cross-gender identified children. That means if you do watchful waiting in the cross-gender identified children, up to 85 percent of them will eventually reidentify with their biological sex.

So they waited. They took kids that were not socialized, who continued to be cross-gender identified and who entered

into puberty and got more symptomatic. Those were the children that were selected for the Dutch protocol. In America and elsewhere, today most of the children -- and by the way, the Dutch protocol had a preponderance of male children who would the cross-gender identify.

THE COURT: Natal males.

THE WITNESS: Natal males.

Today in America, the vast majority of the people now asking to be hormonally treated are females, and the vast majority of them did not have cross-gender behaviors and identifications during grade school.

So today's treatment is not based upon the same kind of kids that the de Vries study did. And in 2020, I think de Vries and the second author reminded the world of that, and more research needed to be done on the children who were beginning to be cross-gender identified only after puberty. So that is not controlled.

The children and the families in the Dutch protocol had concomitant at the same time they all had psychotherapeutic intervention, the child and the family. So there were two things going on at one time there. There was a hormonal treatment, and then there was the psychotherapeutic treatment.

They knew at that time these children needed a lot of help. So they did both things. And because it wasn't

controlled, you see, you can't conclude that those children did better, did okay.

Now, what they said was -- in 2014 is that the 55 children who constituted the end product of the Dutch protocol were between 12 and 18 months post surgery. There was no long-term follow-up. And they said that it cured a gender dysphoria. Cured gender dysphoria.

And as you heard yesterday, that is thought to be an artifact to the fact that when you are a natal male you were given a questionnaire before you started for a natal males, and when you were done with your surgery, you were given a questionnaire for the natal females.

And so questions about are you satisfied -- are you distressed -- what level of distress you have when you have erections, which at age of 11 or 12 -- I should say 12 or 13, because they waited longer in those days -- of course, the kid was distressed because he had an erection. So there was no question about that -- so the question is, are you distressed when you menstruate, for example, well, to -- at the end of protocol. So the new female is not distressed when they menstruate.

So what we think is by -- and de Vries herself has recognized that switching the protocol was -- the protocol -- switching the questionnaire was not an ideal way of evaluating this.

The other thing is of 15 people didn't complete the protocol. And some of the reasons that they didn't complete the protocol had to do with the development of diabetes, a development of obesity, and there was one death. So in some of the papers, there are eight different criticisms for the limitations of this study. I have given you five.

BY MR. PERKO:

Q. Does the use of puberty blockers and cross-sex hormones for the treatment of gender dysphoria been shown to improve mental health outcomes?

A. It depends who you ask and what studies you use, but a recent review of this by Thompson and published, I think, in 2020, published in -- was an attempt to do a systematic review of exactly that question, and they could not conclude that mental health was improved.

More recently, there was a study published in the *New England Journal of Medicine* whose lead author was Dr. Chen, and they studied, I think, 315 kids at age 16 who were given cross-sex hormones, and they found that statistical significance to the children at age 18 were highly happy, were very happy with their new appearance.

But when they study depression and anxiety, although, looking at the 315, there was some improvement for the whole -- the group as a whole for depression and anxiety, the actual experience is if you look case by case, there were

many kids that got worse and some kids got a little bit better. So it was all over the place. And as Dr. de Vries, who wrote a commentary on this in the *New England Journal of Medicine*, said there is no mention in the study about the physical complications of this; it was just about the mental health.

Now, if you look closely at the study, there is some reason to doubt about the mental health improvements, but there were definite improvements in the happiness with one's appearance, you see. They've had two of those kids suicided during the course of those two years. So obviously -- and there was no -- I think no mention of who got admitted to the psychiatric hospital during those two years.

So with the data presented, the glib conclusion is that -- by this group is that the mental health is improved. But when you talk about improved mental health, it's very important to say what parameters are you using.

And from one study to another, the parameters that are used to support the idea that mental health is improved varies from study to study. There is a very little consistency.

Q. In your opinion, Doctor, has the use of puberty blockers and cross-sex hormones been shown to the improve the mental health condition in your opinion?

A. No.

Q. In your opinion, has sexual reassignment surgery for the treatment of gender dysphoria been shown to improve mental health outcomes?

A. By "sex reassignment surgery," you mean mastectomies?

Q. Yes.

A. And genital re -- conformations?

Well, here again, we have a tradition --

Q. I'm asking for your opinion, Doctor.

THE COURT: Let him answer the question.

THE WITNESS: I will answer the question this way:

In the last three years, there have been two studies by advocates of sex reassignment surgery, whose introduction have said that it's unclear whether sex reassignment surgery improves mental health, and they undertook two studies to demonstrate one way or another did it improve the mental health.

The most famous of the studies was published online in 2019 in the *American Journal of Psychiatry*, which the prestigious journal in our field. Twelve people immediately wrote letters to the editor saying that the conclusions of this study were not -- could not possibly based upon the facts that were presented, the data that were presented. So the American -- the editor the *American Journal of Psychiatry*, after it had peer reviews and got accepted, sent it out to two different statisticians who independently concluded the same

thing, the same way that the 12 letter writers concluded.

So when this published -- when this study was published, not online but in print in August of 2020, Dr. Kalin, who is the editor in chief, said that -- what he did and explained the method and agreed with the letter writers that the conclusions of the study were not based -- could not be scientifically be based on the data presented, and so he asked the two authors of the study to write a retraction.

They concluded that more sex reassignment surgery should be done, and when they retracted the study, they said more scientific studies needed to be done and that the answers to their original questions were still unclear.

So when you ask me, do I believe the sex reassignment surgery improves mental health, I say to you that many of the of the people -- I would say all of the people who recommend sex reassignment surgery believe that it improves mental health, but we haven't been able to prove that it improves mental health.

Again, we get back to what are the parameters of the mental health that an individual study uses to conclude that it improves mental health, because it's admittedly a complex subject of what is mental health, how do you measure mental health, you see.

And what we are longing for is an international

consensus about how to evaluate mental health and when to evaluate mental health. Is it one year, three years, five years, ten years, you see? And under what parameters.

The diagnosis of gender dysphoria has to include an impairment in social, vocational, educational or other important areas of function. Other important areas of function probably include sexual capacity or relational capacity, you see? And many of the consequences of sex reassignment surgery on the genitals impair the sexual capacities of the patients.

MR. PERKO: Thank you, Your Honor. Nothing further.

THE COURT: Cross-examine?

MR. CHARLES: Good morning, Your Honor. Carl Charles for the plaintiff.

CROSS-EXAMINATION

BY MR. CHARLES:

Q. Dr. Levine, you have been a psychiatrist seeing patients since 1973, correct?

A. My residency began in 1970.

Q. So you were an officially credentialed psychiatrist starting in 1973?

A. Yes.

Q. And the overwhelming majority of your patients have been adults, correct?

A. Well, in the -- probably early 30 years of my profession,

that's true.
Q. You have previously estimated that you have seen about 15 minor patients in your more than 50-year career, correct?
A. Yes, I always emphasize the estimate. I -- somewhere along the line I've testified to that number.
Q. And you've also seen personally approximately six prepubertal children?
A. Directly, yes.
Q. Dr. Levine, earlier this morning you used the word "minor" to include both prepubertal children and adolescents; is that correct?
A. Yes.
Q. In my questions, I'm going to make a distinction between those two groups for clarity for the record.
Will you understand when I do that?
A. Certainly.
Q. When you evaluate adolescents for gender dysphoria, you meet with their parents or legal guardians as well, correct?
A. I do.
Q. And you take reports from the parent and legal guardians about the adolescent when you meet with them, correct?
A. Yes. You see, parents know what happened during pregnancy, they know what happened in early life bonding processes, they know about their own mental availability to the infant and toddler child, they know about the experience

of two and three-year-olds, and no adolescent can tell me anything about anything substantial and verifiable about his early or her early life.

So it's imperative that the evaluation of adolescent trans people or adolescent any patient, we get that kind of information because one of the aspects of evaluation is development, you know. If there are four things that influence the development of gender identity, biology, interpersonal, psychological development and culture, you need the parents to teach you about the early parts of the child's life.

Q. And so those parent and guardian reports contribute to your assessment about whether an adolescent meets the criteria for gender dysphoria, correct?

A. No, no. No, what --

Q. Parent reports don't contribute to your assessment?

A. They contribute to the assessment of the origin, the influences of the child. Whether a child meets criteria depends on what the child says, not what happened to them in pregnancy.

I don't seem to be clear to you. You asked --

Q. Let me ask a different question.

When you diagnose any patient for conditions like depression or bipolar disorder, you rely on the self-report of the patient, correct?

A. Depending on the age of the patient, I rely on self-report and parental report. And the parental report is very -- is very important to any psychiatrically-symptomatic person who is brought to us.

Q. And reliance on self-report from the patient and information from the parents or guardians is not, as you said, unique to the diagnosis of gender dysphoria?

A. Correct.

Q. So it would be fair to say that diagnosing patients based on self-report, and in the case of an adolescent information from others who know the patient, parents, guardians, is ideally how the practice of psychiatry works?

A. Yes.

MR. CHARLES: Your Honor, I would like to show the witness what has been parked as DX16 from the stipulated exhibit list.

BY MR. CHARLES:

Q. Dr. Levine, it should appear on your screen in just a moment.

THE COURT: It's slow.

MR. CHARLES: It will just take a moment.

THE COURT: I said it will get there based only on my clinical experience. We have no studies to confirm that.

THE WITNESS: It's here now.

BY MR. CHARLES:

Q. Okay. If you could please turn to S50?

Oh, I'm sorry, S48.

THE COURT: We're in DX16, and you are going to page S48?

MR. CHARLES: Yes, Your Honor.

BY MR. CHARLES:

Q. Dr. Levine, how small is that print on your screen?

A. I can read it now.

Q. You can read it now? Okay.

A. Uh-huh.

Q. Dr. Levine, this is DX16, the WPATH Standards of Care, Version 8, that you were discussing earlier.

Would you like to look at title page or did you see the title page before we scrolled to the --

A. I saw it.

Q. Okay. So if you would please look with me at about --

A. May I ask you to speak a little louder?

Q. Yes, of course.

A third of the way down the page, 6.3, do you see that, Dr. Levine?

A. Yes.

Q. Okay. And this is a recommendation, 6.3: *We recommend healthcare professionals working with gender diverse adolescents undertake a comprehensive biosocial assessment of adolescents who present with gender identity related concerns*

and seek medical surgical transition related care and that this be accomplished in a collaborative and supportive manner.

Did I read that correctly?

A. Yes, you are an excellent reader.

Q. Thank you.

And if then if you look a little bit further down, Dr. Levine, the bottom third of that section, statement of recommendations, at 612(d), and I'll read the italicized font at the top of this section:

The following recommendations are made regarding the requirements for gender-affirming medical and surgical care (all of them must be met)?

Did I read that sentence correctly?

A. Yes.

Q. And then back to 612(d):

The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed?

A. Would you give me the name of that? Is it 12(a) or 12(b)? Which one is --

Q. I was reading 612(d) as in dog.

A. Oh, D. Okay.

Q. Would you like me to read it again?

A. No, I'll reread it.

I read it.

Q. Okay. Did I read it correctly after your reading?

A. I have a feeling you are going to ask me this question 15 times, and I would like to compliment you on your ability to read. So I'll just --

Q. Thank you, Doctor.

A. We're wasting time.

Q. I appreciate your understanding of our -- the requirements of the legal practice in this regard.

Dr. Levine, you testified earlier this morning that you have treated patients with gender dysphoria, correct?

A. Correct.

Q. And without specifying an age group, you have supported some patients' social transition, correct?

A. Yes, we used to refer to this as the real life test.

Q. I'm sorry, Dr. Levine, I appreciate your speaking to the judge. But when you do so, you turn away from the microphone and I can't hear you.

A. I'm sorry.

No, we used to -- in supporting some people's transition, social transition, we used to refer to this as a real life test. Please live your life in the aspired-to gender for a while, go to school, do -- present yourself and see what the problems are both intrapsychically and interpersonally, and then that will help you to decide whether you want to go

further.

That was a standard in the fifth version, sixth version of standard of care. That real life test has disappeared from the current standards of care. In other words --

Q. I'm sorry. Dr. Levine, just a moment.

You have written letters of authorization for adult patients for gender-affirming surgeries, correct?

A. Correct.

Q. And you have done this as recently as within the past two years, correct?

A. It's probably now two and a half years. Probably to be safer, three years. I'm not sure. It was for a 26-year-old.

Q. Dr. Levine, do you recall a deposition that you sat for in a case called *Brandt versus Rutledge* in May of 2022?

A. I think that was North Carolina, in North Carolina?

Q. Arkansas.

A. Arkansas, sorry.

Q. You do recall that?

A. Yes.

Q. Do you recall testifying in that deposition under oath?

A. I do.

Q. And in that deposition you testified that you had written letters of authorization for adult patients as recently as 18 months ago.

A. Okay. If that was 12 months ago, so it would now be 30

months. So that's two and a half years.
Q. Thank you for helping me with that math.
A. My pleasure.
Q. And you've also written letters authorizing hormone therapy for adult patients with gender dysphoria, correct?
A. Somewhere in the past, yes.
Q. And these are letters that patients can take to an endocrinologist?
A. Yes.
Q. And you have written such letters authorizing hormone therapy for adolescents in a few cases in the last five or six years, correct?
A. Oh, yes.
Q. Dr. Levine, you would not write a letter supporting hormone therapy for an adolescent if you did not believe the patient had gender dysphoria, correct?
A. Correct.
Q. Dr. Levine, it's your understanding that there is no medical intervention that is appropriate for prepubertal children, correct?
Let me -- let me re-ask my question.
Aside from psychotherapy, it's your understanding that there is no appropriate medical intervention, puberty blockers, cross-sex hormones, surgery, for prepubertal children, children who have not reached Tanner Stage 2?

A. Well, as asked -- as phrased, the question -- the answer to your question is, yes, there is no appropriate medical intervention. But it really raises -- we really have to answer that question by saying that if you socially transition a six-year-old, it does have long-term medical implications.

Q. I appreciate that, Dr. Levine, but my question was very narrow and specific.

A. Your narrow question -- I've answered your narrow question.

Q. Thank you.

And Dr. Levine, you would not write a letter authorizing hormone therapy for an adolescent without first determining that they had a longstanding, stable gender identity?

A. Yes. May I elaborate on your question?

Q. No, not right now, Dr. Levine. Defendants' counsel will give you an opportunity in redirect.

Dr. Levine, you testified earlier this morning that standards of care should be re-renewed every five years. What empirical data or reference are you referring to for that assertion?

A. Well, I don't know if there are any empirical data. I think that's the standard across the medical profession. I don't think it's the result of studies. It's the result of experience, about new research appears, and we -- and the

seriousness of what we do needs to be reconsidered approximately every five years.

Q. I appreciate that, Dr. Levine. But let me make my question broader.

I'm asking your assertion that it is standard, what is that based on? Is that your clinical opinions?

A. No, that's based on a 2021 study by Sara Dahlan. I forget where it appears, but you can readily find it where they -- this study evaluated the seven standards of care and enumerated the -- what you're asking about.

Q. Thank you.

A. This is the understood standard throughout medicine.

THE COURT: Spell Dahlan for us.

THE WITNESS: D-a-h-l-a-n.

BY MR. CHARLES:

Q. Dr. Levine, your view -- isn't it your view that if parents and guardians are fully informed about the risks and the state of the science, the decision about whether to pursue hormone therapy for adolescents should be made by parents, patients and doctors?

A. That's not quite true. I kind of think that doctors don't know enough about the future of the patient to make a strong recommendation for what should happen. I think that doctors need to inform the parents about the state of science, what is known and what is not known, and they, the

patients with the child, should make the decision.

When you asked me previously about do I write letters of recommendation and you didn't want me to further elaborate, what I needed to tell you is that I don't actually say I recommend this person to have surgery.

Q. I appreciate that, Doctor.

THE COURT: I want to hear the rest of the answer.

THE WITNESS: What I say is the person and I have gone through a process that satisfies my ability to understand the forces that shape this decision. And as I believe the patient gets to choose how he or she lives their life, I see no reason to sustained in the patient's way of doing this if the patient continues to want to have the hormones. I have written letters for people who never actually do what the letter allows them to do, whether it's take hormones or to have orchectomies and so forth.

I don't think I know enough to recommend that this is the best course for the future of this patient. I recognize that my job is to teach the parents what science knows, and if they and the child in conjunction with me or some other clinician think this is the best thing to do, then they may do it.

I don't think I know enough about the long-term outcomes for this child to say I recommend this is the only and the best treatment for this child. So I don't want you to

confuse a letter that says this is what the child is about and this is what I know about the child with a strong recommendation from Dr. Levine that the only treatment for this is hormones or surgery.

THE COURT: Doctor, do you think the Florida legislature or the governor has enough information to make that decision for any given child?

THE WITNESS: I think doctors, myself are aware of the uncertainties, and legislatures and governors, I don't know what they know. I think they are responding to a kind of sense of political and moral concerns that generally are not my concerns.

BY MR. CHARLES:

Q. Dr. Levine, do you recall testifying in November 28, 2022, in a trial in Arkansas for that case we discussed earlier, *Brandt versus Rutledge*?

A. I was there, yes.

Q. When asked the same question I just asked you, your response was yes, that you do believe if parents, patient and doctors are fully informed about the state of the science, the decision about whether to pursue treatment for minor adolescents should be made by that same group?

A. Well, I'm older now, and I have had a chance to reflect upon your term "recommendation," "recommend," and I stand by my statement today. I'm a maturing person, and I'm allowed

to change the emphasis of my answers.

Q. And, Dr. Levine, you understand you testified under oath at that trial?

A. It was true. I wasn't being -- you evolve; I involve. My answers can change. I read new papers since that time, for example. You know, just to give you an example, sir, in January of this year, there was a paper published in the JAMA, the Journal of American Medical Association by a group led by Jackson that demonstrated an increase mortality of young adults with transgender identifications.

It was a further study about reduced -- an additional study that demonstrated, as previous studies had done, the limited life cycle, the increased mortality of trans people. Now, when you talk about making recommendations and informing parents, it's very hard to inform a parent that there is data out there that had been consistently been present for the over a decade that there is an increased death rate of people who are transgender identified. That's very hard to tell a parent.

And so the question is, is the informed consent process going on actually telling the parent what science knows?

Q. But, Dr. Levine, you yourself do not write letters of authorization unless you are sufficiently satisfied that you have informed parents and the patient about those risks and benefits as you just mentioned?

A. Well, I haven't written a letter of recommendation since that study was published; that's just in January of this year.
Q. But in the past, in your clinical experience.
A. In the past I have -- as I explained to you, I believe that it's the parent's decision, and I have told the endocrinologist what I know about the patient and I don't stand in the way of getting hormones if they continue to want hormones. But kids are much more ambivalent than they seem on initial presentation, and sometimes they get a letter for either surgery -- actually this is true for adults as well. They get a letter for hormones and surgery, and then they don't go through with it. And as you had me --
Q. I'm sorry, Dr. Levine. You agree that there are some people who benefit, including long-term, from gender-affirming medical treatments?
A. I hope that is true, yes.
Q. And, Dr. Levine, you have testified previously that discontinuing treatment for adolescents who are current receiving hormone therapy could create a psychological and physiological problem, correct?
A. I have.
Q. And you have concerns about youth who have already been stabilized in their new gender having to discontinue that treatment, correct?

A. I have expressed concerns about that in the past under oath.

Q. Dr. Levine, you've previously testified that in your estimation, there are roughly 70 or more gender clinics in the United States?

A. At that point, yes. I've subsequently seen reports on the internet that there are even more; there are closer to 400. But I have no way of ascertaining that, especially you see that there are clinics associated with hospitals, and then there are individual practitioners who specialize or who write letters or who see patients.

So it's -- and probably before 2014, there was a handful of places associated with universities, and now most major universities have gender clinics. For example, in Cleveland today, besides our clinic, we have three major hospital systems, and we have three -- every one of those hospital systems has a clinic for gendered -- for gender youth.

Q. And, Dr. Levine, you said you heard -- you read on the internet there were 400 clinics, but you don't have any evidence to point to to support that?

A. Yes.

Q. And, Dr. Levine, you personally don't know how different practitioners or clinics provide care, correct?

A. Yes. Neither do you.

Q. I'm sorry, I couldn't hear that.

THE COURT: Neither do you.

BY MR. CHARLES:

Q. Dr. Levine, you understand you are under oath today, correct?

A. Yes.

Q. And I'm not.

A. Okay. I didn't presume you were.

THE COURT: If you think that means that you are free to say things untrue, I choose to differ with you.

MR. CHARLES: No, Your Honor.

THE COURT: I expect you to be just as honest as the witness on the stand.

MR. CHARLES: Yes, Your Honor.

THE COURT: With an advocate's privilege mixed in there.

MR. CHARLES: Appreciated, Your Honor, thank you. My apologies.

BY MR. CHARLES:

Q. And so, Dr. Levine, you personally do not know how common it is for clinicians to provide gender-affirming hormone treatments to adolescents without the careful assessment and fully informed consent of their families?

A. I'm just reviewing the phrase that you uttered.

Q. I can repeat the question if it would be helpful.

A. Yes, please do. Perhaps you could change the wording a

little.
Q. So you, Dr. Levine, don't know how common it is for clinicians across the United States to provide gender-affirming care, that is, hormone treatments to adolescents without careful assessment?
A. Well, of course, the answer to your question on the surface is that I don't know how it's done everywhere. But I do have sources of information that let me know that it's not done carefully, and I am certainly am aware of the informed consent processes in other places. And some of the sources of my information are the parents who have come to me and told me about their children being diagnosed and recommended for affirmative care after one hour.
So -- and I have spoken to -- on two occasions in the last year to groups of parents who have invited me and in the question-and-answer period, they have told me this story repeatedly. That they took their child, their minor child, and before they knew it, before the hour was over, there was a recommendation for affirmative care. One of my -- the mother of one of my patients went to a nurse practitioner, and in 45 minutes at the first visit to the nurse practitioner got an estrogen prescription. This is very common in my experience and in the experience of parents.
So the answer to your question is, as you phrased it, of course I don't know what's happening everywhere in the

United States, but I do have lots of clinical experiences that you would call anecdotal that tell me -- consistent antidotal experience about the parents' concerns that their child is not getting a thorough comprehensive psychiatric evaluation.

MR. CHARLES: Your Honor.

THE COURT: You ask an argumentative question; you get an argumentative answer. I'm going to hear everything he has to say.

MR. CHARLES: Thank you.

THE WITNESS: So the answer is yes, I don't know, but -- and I've told you but.

BY MR. CHARLES:

Q. But, Dr. Levine, sitting here today, you don't know and can't point to empirical data about how most practitioners around the country, how credentialed they are or how they provide care. Yes or no?

A. I know to be credentialed by WPATH, you have to attend the WPATH conference, educational conference. And so you can have various degrees of clinical experience, and you can be credentialed. And being credentialed by WPATH means that you accept the principles of WPATH. And so again, the answer to your question is I don't know, but I have lots of reasons to believe that the credentials to qualify as a knowledgeable gender expert is quite variable.

Q. But you couldn't say, Dr. Levine, based on your personal experience whether that number of practitioners is a minority or a majority, correct?

A. In some empirical way, meaning having counted, correct.

Q. Dr. Levine, you don't have any knowledge about how gender-affirming medical care is provided to adolescents in Florida, correct?

A. Correct.

Q. Dr. Levine, in your report in this case, you stated that there is no credible scientific evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents and men or return to female identification for genetically female girls, adolescents and women.

Do you recall including that in your report?

A. Yes. We need to be honest not just because we are under oath. We need to be honest about this. In my field of psychotherapy, psychiatry, we have a paucity of studies that are controlled that demonstrate the long-term impact of psychotherapy. We only have a tradition of doing psychotherapy and helping people.

We think we help people; sometimes we're wrong. But the only controlled studies in psychiatry about psychotherapy are usually short-term studies based upon cognitive behavior therapy. They are usually six weeks or two months follow-up

using questionnaires.

So we've practiced in psychiatry on a kind of psychiatric faith-based notion that human attachment and investigation in a caring, confidential way helps many people get over the things that are ailing them. But when you ask about empirical studies, what you're quoting from my report is the statement that alternate treatments for psychotherapeutic approaches. Whether we are talking about the psychotherapy versus affirmative care, we do not have strong empirical evidence that were effective.

That being said, I have helped people and I currently am supervising a child psychiatrist who I know is helping people with added skills, hopefully that I'm helping her to achieve, that she has helped people. Last Tuesday, a week ago Tuesday in our gender diversity conference, we heard about a case who has reidentified and through psychotherapy and is being benefited.

But this is what you would call anecdotal evidence, and I just say to you that in my expert opinion report, I shared the lack of controlled studies. But nonetheless, psychiatry has been providing psychotherapy for over a hundred years, and so that is a tradition-based assumption, and it's considered prudent by many of us.

Q. Dr. Levine, in your clinical experience, you've had only two patients who have detransitioned after medical

interventions, correct? I should add that you are aware of?
A. Well, I have written a paper about -- you're referring to that. I'm just trying to think about the other one. There was a child that I never saw, but I saw their parents, and I helped their parents to be witness to the reidentification as a little girl. Perhaps that's the second one.
I've certainly talked to many adults who are considering and then reconsider this. So I guess you would say at least two, but I think there's probably more.
Q. And just to clarify, I was speaking about your clinical experience.
A. That's what I'm talking about. As I think about it, there have been more than two.
Q. Dr. Levine, you testified earlier today generally about the concept that the dissenting views in the treatment of gender dysphoria are not well tolerated.
Do you recall generally that testimony?
A. I'm sorry. You mumbled. Will you please repeat?
Q. Sure. Let me re-ask the question.
Dr. Levine, you presented at an American Psychiatric Association annual conference in May of 2022.
Do you recall that?
A. I certainly do.
Q. And it was in a symposium on reexamining best practices for transgender youth.

Do you recall that?
A. That was the title of the symposium.
Q. And, Dr. Levine, it's correct that your co-presenters on that panel included Ken Zucker, Lisa Marchiano, and Sasha Ayad, A-y-a-d. Is that correct, Dr. Levine?
A. Correct.
Q. And is it fair to say, Dr. Levine, that all four of you, yourself and those three individuals, have generally dissenting views from the American Psychiatric Association policies on transgender healthcare?
A. Yes.
Q. And the American Psychiatric Association was aware that the four of you were presenting ideas that were not in keeping with those official policies, correct?
A. Yes.
MR. CHARLES: Just to be clear, I'm to speak up not to shout at witness but just so he can hear me properly.
THE COURT: I wasn't concerned about you being too loud. And even a little louder would be --
MR. CHARLES: Okay. Yes, Your Honor. Thank you.
THE WITNESS: Your Honor, may I have a bathroom break?
THE COURT: Absolutely. Let's take the morning break. We'll come back at ten minutes to 11:00 by that clock.
(*A recess was taken at 10:35 a.m.*)

(*The proceedings resumed at 10:50 a.m.*)

THE COURT: Please be seated.

Dr. Levine, you are still under oath.

Mr. Charles, you may proceed.

BY MR. CHARLES:

Q. Dr. Levine, before the break we were discussing a symposium where you and four other people presented a discussion about reexamining best practices for transgender youth.

Do you recall that?

A. I do.

Q. And the American Psychiatric Association that put on the conference was aware that all four of you were presenting ideas that were not in keeping with the official policies of the American Psychiatric Association, correct?

A. I can modify that slightly, sir. The American Psychiatric Association reviewed the abstract for the proposal that was written by me, and it didn't state that -- that we were against the policy or anything. We just -- the idea I summarized for the abstract was: Is it time? I think there is evidence that we ought to re-exam this official policy of what is called a quote, best practices. So whether the APA knew that Sasha Ayad felt one way or the other, they had no idea.

Q. And while you were speaking, Dr. Levine, on the panel,

the audience group was polite and no one interrupted you, correct?
A. No one interrupted me. The discussion session was not polite, but the presentations were.
Q. Dr. Levine, you've prescribed medications to patients for off-label use in your clinical practice, correct?
A. Yes.
Q. And off-label drug use is common in the field of medicine, correct?
A. Correct.
Q. And the fact that a drug is being used off-label does not alone make that drug experimental, correct?
A. It really means it's unproven for the use that a doctor is employing it for. Whether "unproven" is the same as "experimental" depends on your concept of experimental.
THE COURT: Let me interrupt one point about that. It means that it's unproven in a formal submission to the FDA --
THE WITNESS: Exactly.
THE COURT: -- not that it's not proven in some other forum, right?
THE WITNESS: Yeah. For example, I don't think trazodone as a sleep aid has ever undergone controlled studies but is commonly prescribed by psychiatrists for insomnia, especially for people who are on SSRI antidepressant medicine.

So fashion has created that. Word of mouth has created that.

THE COURT: But you know from FDA approval that taking the drug without more isn't so dangerous that it should never be done, and then you know from clinical experience that it works for what you are using for and it's not --

THE WITNESS: Yes. And the drug was originally approved for some other purpose. It's very common.

THE COURT: And part of the reason for that is it's really expensive to get FDA approval of a drug. So if you are the pharmaceutical company and you've gotten our drug approved by the FDA, there is really no reason to go spend all of those hundreds of thousands of dollars or millions of dollars.

THE WITNESS: Closer to a billion.

THE COURT: A billion dollars.

No reason to spend that money for further FDA approval, because once it's approved by the FDA, doctors can prescribe it.

THE WITNESS: Nonetheless, in certain psychological -- drugs for psychiatric conditions, drug companies do approve -- go to the FDA for approval for another indication. I don't think it costs them a billion dollars to do it, but it does cost a lot of money. You are certainly right about that.

THE COURT: And one reason to go back for a second approval is because if doctors are prudent, they are going to

look at the studies and the literature and make a determination. And so if what you are trying to do is get doctors to prescribe your drug, if you can show them a controlled study of the kind that would lead to FDA approval, might be a good idea to go get the study done.

THE WITNESS: Exactly.

BY MR. CHARLES:

Q. Again, Dr. Levine, you recall testifying November 28, 2022 at trial in *Brandt versus Rutledge*?

A. Yes.

Q. And do you recall when asked that same question, the fact that a drug is being used off-label does not alone mean it's experimental, you stated, "I would agree with that."

Do you recall that?

A. Yes. I've agreed with that just now.

Q. Dr. Levine, you're not an expert in health insurance coverage, correct?

A. Correct.

Q. And you're not offering any opinions about whether defendants should have an exclusion for gender-affirming medical care in their state Medicaid program, correct?

A. Yes.

Q. Dr. Levine, you're aware that cross-sex hormones were used to treat gender dysphoria prior to 2014 and prior to Annelou de Vries' study you mentioned earlier, right?

A. Yes.
Q. And some clinicians also used puberty blockers in the United States before that 2014 study, correct?
A. I think it began in 2009 in a Boston clinic.
Q. You said -- I'm sorry, Dr. Levine. You said 2009 in the Boston clinic?
A. Yes.
Q. And the Endocrine Society guidelines from 2009 provided a recommendation for the use of puberty blockers, correct?
A. I'm not certain.
THE COURT: While you are going to the next, 2009 in Boston clinic, do you remember which clinic?
THE WITNESS: It was -- there was a man named a Norman Spack who went across to see the Dutch group and came back very enthusiastic and started promulgating that this is a treatment of choice and this is saving people's lives.
THE COURT: Was he associated with one of the established institutions in Boston?
THE WITNESS: You know, the famous Boston clinic is the Fenway clinic, and I'm not sure that -- whether -- I don't know whether he was part of that or had his own clinic. I think he's an endocrinologist.
BY MR. CHARLES:
Q. Dr. Levine, is Dr. Spack affiliated with Boston Children's Hospital's GeMS clinic?

A. That's what I just said. I wasn't sure what his affiliation was.

Q. I missed it. Thank you.

A. If you are telling me -- you must -- perhaps you know, and I would trust your information.

MR. CHARLES: Your Honor, I would like to show the witness an article. May I approach?

THE COURT: You may.

MR. CHARLES: Your Honor, should I also give you a copy of this?

THE COURT: Depends on what you are going to do with it.

MR. CHARLES: It's just going to be reviewed.

THE COURT: I don't need to see it. You should give Mr. Perko a copy, but I take it you already have.

MR. PERKO: I've got one, Your Honor.

MR. CHARLES: Yes.

THE COURT: Okay.

BY MR. CHARLES:

Q. Dr. Levine, earlier today you were speaking about -- I'm going to refer to her as doctor; I think that's accurate -- Dr. de Vries and her 2011 and 2014 studies.

Do you recall that testimony?

A. Would you repeat that question, please?

Q. Yes.

Earlier today you discussed on your direct Dr. Annelou de Vries and her 2011 study and her 2014 study.

Do you recall that?

A. Yes.

Q. And I'm showing you an article titled "Ensuring Care for Transgender Adolescents Who Need It: Response to Reconsidering Informed Consent For Trans-Identified Children, Adolescents and Young Adults" written by Dr. Annelou L.C. De Vries.

Have you seen this article before?

A. Of course.

Q. Okay. And if you would, Dr. Levine, please turn to page 110 in the upper-left-hand corner.

At the bottom, Dr. Levine, of that page, you do you see the highlighted text?

A. Yes.

Q. Okay. So if you will please follow along with me.

In the design of these follow-up studies, the UGDS scales were flipped as Levine states. At baseline, according to the birth-assigned gender, after treatment according to the experienced gender (Levine, et al., 2022) questions whether the improvement in the gender dysphoria does then not stem from this switching and not from the treatment. However, this seems turning the matter around. What the measure shows, the disappearance or resolution of the gender

dysphoria is what the gender-affirming treatment is aimed to resolve. Medical-affirming treatment alone might not have resulted in this improvement.

I'm going to continue on, Dr. Levine, but did I read that highlighted portion correctly?

A. You are excellent.

Q. I feel like I've only asked you that a few times, which I think is a record for our conversations.

As stated in the conclusion of the 2014 paper, clinicians should realize that it is not only early medical intervention that determines the success but also a comprehensive multidisciplinary approach that attends to the adolescents' gender dysphoria, as well as their further well-being and a supportive environment.

Did I read that correctly?

A. You did.

Q. *Further, the UGDS was not specifically designed to be used after treatment and is, as such, not ideal. (Steensma et al., 2013 and properly referenced by Levine et al., 2022.) But that does not imply that UGDS falsely measured the improvement in gender dysphoria. Using the version of the assigned birth gender would also make no sense.*

Did I read that correctly?

A. You did.

Q. And do you recall earlier today, Dr. Levine, when you

testified that Dr. de Vries admitted that the scales used were incorrect?

A. They were not ideal. They have subsequently I think redesigned their follow-up scale.

MR. CHARLES: No further questions, Your Honor.

THE COURT: Redirect?

MR. PERKO: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Levine, if there is a paucity of evidence for your psychotherapy approach to treating gender dysphoria in the gender-affirming approach, why is your approach better in your mind?

A. Well, it's better because, number one, I don't think gender dysphoria ought to be an exception to how psychiatrists -- how the medical profession approaches any psychiatric difficulty. So I don't see any reasons for an exception.

Number two, the affirmative care model will result in, if followed through its entire spectrum, will produce certain outcomes that go against age-old medical principle of above all, do no harm and do not operate on normal -- do not change normal anatomy, un-diseased anatomy, and do not change unimpaired physiology.

So we are rendering a child where -- and I think I could

use the word child meaning adolescent as well as. So we are rendering a minor, if they follow their entire affirmative care, sterile and with the consent of parents of a 12 or 13-year-old child. So we are causing sterility. What is rarely mentioned in informed consent processes we are causing sexual dysfunction, the inability of the -- the current or the new gender, new genital organs to not function normally. We are reducing the pool of human beings who are available to trans people for stable adult emotional connections, marriage, for example.

And as I've tried to emphasize today, we have a number of studies that demonstrate that the average life expectancy of a trans person is significantly reduced.

So given these -- given sterility, sexual dysfunction, limited capacities to enter into stable relationships, premature mortality and predisposition to cardiovascular disease, for example, I think it's very prudent that we should approach the child's distress in a psychiatric way without medicalization, a psychiatric way and a thorough way before we can consider a medicalization.

We are not talking about the treatment of some minor condition here. Because if you look -- the natural -- I'm sorry, the concept of natural history in medicine means what happens if we don't treat this disease? The natural history, will it get better on its own, will it cause other problems

or will it lead to premature death?

So when you think about premature death, there is -- I mean, all of us disagree that there ought to be treatment for these children because -- and these children and these adolescents and these adults because the natural history of this is negative.

So the question only becomes what is the treatment, what treatment should be offered? And because we are talking about changing the body and the body's anatomy, the body's physiology and the social implications of those changes, it seems very prudent to be conservative and thorough in the evaluation not just to state these are the comorbidities but the treatment of those comorbidities, you see? And the comorbidities that we have are serious things like eating disorders and self harm and depression and anxiety and school avoidance and so forth. These are very serious conditions, and we know that the prognosis for that person is negative.

So we want to treat them, but the question is how to treat them. So the other aspect about why psychotherapy ought to be treated is that there has been a dramatic tsunami, a change in the sex ratio of people coming -- there are two things. One, there's been an increased number of people who say they want this treatment, the affirmative care, and the switch in sex ratios we have now a tsunami of teenage girls who never before seemed to indicate a

repudiation of their female gender who are presenting as transgender. This is unexplained. And if we go back to my concept, that biology, development, interpersonal relationship and culture all contribute to this, we need to understand why it is we are having this tsunami of girls that want to present themselves as trans males.

And so given all these facts, what is known and what is unknown, that is, what is unknown is why these girls are doing this now, I say be conservative, be thoughtful, be traditional, pay attention to the parents who know this child for more, far better than the evaluating pediatrician, you see. And let's take our time because we have this person's future at stake.

Q. Mr. Charles asked you some questions about a presentation you made at a symposium of the American Psychiatric Association. Do you recall that?

A. Yes.

Q. Would you explain the circumstances that led to your presentation?

A. Yes. In July I submitted an abstract to the American Psychiatric Association. As is in keeping with months before, the year before the meeting, people, investigators, present abstracts, submissions to be accepted. I don't remember exactly the date, but I'm going to arbitrarily say on November the 9th, everyone should have heard about whether

they have been accepted or rejected. November the 9th came and I heard nothing. Another couple of weeks passed, I heard nothing. I wrote to the APA and I said, how come I haven't heard? Within 24 hours I got a rejection. I wrote back a little outraged, could you explain, number one, why you didn't tell me on deadline, and would you tell me why this was rejected? I heard back in two days I was accepted.

Now, wait a second, one more thing. In the prelude to -- this symposium was at 1:30 in the afternoon. We gathered about 1:00. And the presenters and other people I didn't know were there and talking, and I told this story. And one of the people there, who was a child psychiatrist, said same thing happened in the American Academy of Child & Adult Psychiatry. Every time they submit anything that seems to be against the policy, the affirmative care policy, they get rejected.

We're well aware that there is a suppression of any -- and institutions who have made these commitments to affirmative care, there is a suppression of alternate views. We can't even get on the symposium. And so my experience with the November 9th deadline I found out was not just from the APA but other institutions as well.

This is not what we consider to be science. This is what we consider to be a politic suppression of alternate views. And there is more and more, but there is plenty of

information that is going on. There is such a partisanship here that it interferes that even being allowed to express an alternate opinion.

Q. Dr. Levine, Mr. Charles asked you some questions about the American Psychiatric Association's position on gender-affirming care. Do you remember that?

A. Yes.

MR. CHARLES: Objection, Your Honor. Outside the scope of cross.

THE COURT: I don't know what he is going to ask, but he started by saying that you asked questions about the subject he's going to introduce. So if indeed it's something you asked him, it's almost by definition not outside the scope.

Overruled, but let me hear the question.

BY MR. PERKO:

Q. Dr. Levine, did the American Psychiatric Association ask for your views on the position statement?

A. No.

Q. Do you know if the majority of the members of the American Psychiatric Association agreed with the position statement?

A. Oh, I have no way of knowing that.

MR. PERKO: Thank you, Your Honor. I have nothing else.

THE COURT: Doctor, I appreciate you being here, and I appreciate your candor. You've taught me some things, and I'm going to give you a chance to teach me some more.

You referred just a moment ago to the tsunami of adolescent women presenting identifying as males. The experts on the other side have suggested that the reason for that is that 20 or 30 years ago treatment was not available, now it is, and one would expect the number of people presenting for an available treatment to be more than the number of people presenting for an unavailable treatment.

I get the argument. And, of course, at one level it's just true as a matter of plain logic, the number of people that presented ten years ago for a COVID vaccine was zero. In that case, it's because there was no COVID ten years ago. The number of people presenting today for some other kind of a vaccine may just reflect the availability of treatment, even though the disease has been with us for the whole time, shingles, for example.

And so if you looked at the people presenting for the shingles vaccine and said, well, there's a tsunami of people presenting for a shingle vaccine today compared to 30 years ago, that's certainly true, and it would tell you absolutely nothing about the number of people with shingles.

On the other hand, the tsunami you're talking about doesn't necessarily reflect the change in available treatment.

There may be other factors. And I think I understood what you to say is we need to figure out why that is. And my question is:

Part of the explanation, at least, could be the availability of treatment or the change in social acceptance of the possibility that somebody is trans. True? I mean, is the answer we just don't know?

THE WITNESS: Well, I think the truth is that every explanation is a -- is a guess. But I should point out, which I think I heard earlier yesterday, that before the turn of this last century, a number of studies have shown that between 3.5 and four boys who wanted to be girls, there was one girl that wanted to be a boy. So in the 20th century, that was the pattern almost all over the world. There were two exceptions. Australia and Poland for some reason didn't show that, but every other country that measured it got data between three and a half and four boys for every girl presenting.

Suddenly in this century, there's been a reversal. So that the usual clinic today, if you looked at say the last 12 months, the usual clinic has, number one, had an increase number of requests from boys and girls, but ratio of girls to boys, instead of being 3.5 to one is now closer to seven to one. And so --

THE COURT: Seven to one the other way?

THE WITNESS: The usual thing is for say five, six or

seven girls. For every five, six, and seven girls, we now have a boy that wants to be a trans woman. Now, that's going to vary from clinic but --

THE COURT: And previously it was three and a half boys to one girl?

THE WITNESS: That's right. And so the explanation is we had -- you know, we've had testosterone available since the 1930s. And in the 1950s, there were a few rare endocrinologists that were giving testosterone to girls, you see. So it's not that the treatment was available.

What has become -- what is also true is that society is talking about this issue, you see. And one of the hypotheses for the explanation for the tsunami is that, one, the transition from little girl to young woman, adolescent, the onset of the body changing and menstruation, it's not unusual for 12-year-old girls, 11-year-old girls to be distressed about bodily changes. Puberty has been well known to be an arduous process. All you have to do is ask most adult women what it was like for them at this stage in life. Parents of those kids will tell you it's difficult.

But what is happening now is that we have the internet, and all kids -- almost all kids are on the internet. And there are -- there are sites that -- that help people to understand that they may be a transsexual person because they're distressed over menstruation, they're not happy with

their breasts, the presence of their breasts.

And so when I talk about one of the four major influences on the creation of transgender phenomenon, I'm talking about culture and culture in this century is characterized by access to the internet. And so almost everybody who has de-transitioned from being a trans man to going back to a living as a woman with or without breasts or uterus, these transitional people, they mostly -- many of them say how influential the internet has been. They created -- if they didn't have a lot of friends in their local community, they had virtual friends who were trans friends from the internet.

And so we do not want to affirm that culture has caused this, but culture is a part of this, you see. I think we have a disturbed -- disturbed about what is happening in puberty, and often in a girl who has been disturbed psychiatrically before, people with eating disorders, people with prepubertal depression and anxiety and school avoidance and autism and, you know, the variety of the problems, they hit puberty. They undergo the natural processes of being distressed about their bodily changes, and then they start having sexual attractions, which may or may not be, quote, their concept of normal, you see. So they say they're bisexual or they're queer or they're a lesbian. And then finally they say that they are trans.

So these are intrapsychic, interpersonal. Some of these people declare they are trans after they have said they have been rejected in a relationship. So we have cultural, interpersonal, biologic and psychological reactions to normal biologic processes.

So what psychiatric approach to a transgender person who previously did not seem to be highly distressed about being a girl and now with puberty is highly distressed is to evaluate and treat through continued therapy the investigation of why they have solved, why they declared this identity. What are they escaping from?

Now, some people think, for example, that most people who have eating disorders hate something about themselves. They are trying to get rid of something that's hateful, some sense of themselves that is not acceptable to them. And so what they do is they starve themselves. And many of those kids go -- before they are transgender identified have been anorexic. They have been starving themselves, you see, or they are depressed or they're anxious, or they're skill-avoidant where they are having social problems.

They have an intrapsychic creative solution. I'm trans. That's often been helped by someone on the internet that they don't know, you see.

So I think what I'm giving you is another speculation. It's as speculative as, oh, I've always a trans

and their parents didn't know and all that stuff.

THE COURT: Some are actually trans.

THE WITNESS: Actually, "trans" means will be consistently identified and happy in that identification until they discover the consequences like they can't have a child, or their sexual life is impaired, or they can't find somebody who wants to spend -- sojourn with them for the rest of their life. So we don't want -- we say that one can be happy being trans. It's okay with me, they are trans, right? But if you want to look at the outcome of a trans identified in a 14-year-old that is stable, that we are going to label a trans person as though that's some kind of entity, you see, then we need to evaluate what is going to happen to that person over time.

THE COURT: I was going to ask you about eating disorders, and -- not related to trans individuals but just eating disorders separate and apart. There are people that are anorexic -- people with anorexia that are not trans and trans doesn't figure into it.

THE WITNESS: Yes, most people with eating disorders are not trans.

THE COURT: And if a person comes to you with an eating disorder, you provide psychotherapy. That's the primary way to deal with it, I take it. There is no drug you can give somebody to fix that. You are going to counsel the

person, true?

THE WITNESS: It's largely correct what you just said, but there is now a drug that we tend to use.

THE COURT: Many of my questions will reflect my lack of medical training.

There's now a drug. Let's just posit a world where there wasn't. Was there a time in your practice when there was not a drug and the way you treated anorexia was with counseling?

THE WITNESS: Absolutely.

THE COURT: Were there any studies where some people with anorexia were treated with counseling and some people got no treatment at all, and you did this study to see which was better?

THE WITNESS: There have been -- Your Honor, I'm not an expert in this subject.

THE COURT: Well, surely there was none because nobody is going to see a patient with anorexia and say, you're on your own. I'm doing a study. And so even though counseling may help, you're on your own. I have got to do my study. Nobody would do that, right?

THE WITNESS: I think there have been studies that have looked at the rate of resolution of the eating disorder when they had psychodynamic psychotherapy. And then there were studies of when they had specialized treatment programs

where they got hospitalized and they were fed and so forth. So there have been comparative studies, but they are not -- in the light of what we have been talking about the last couple of days, they are not high-level studies.

THE COURT: Low-level evidence, and yet you treat those patients.

THE WITNESS: Absolutely, absolutely.

THE COURT: You said that the life expectancy of a trans patient was reduced. I want to make sure I understand what you're talking about.

You're talking about all trans individuals. Whether they got one kind of a treatment or another or no treatment, it's just that trans people don't live as long on average as others.

Is that what it was or is there something else?

THE WITNESS: I think these are based on insurance data, and so most of the people that were trans identified have been treated with medications. One of the earlier studies that identified an increased death rate were people who were being treated with hormones. It also was a Dutch study.

There's been a VA study in the United States that demonstrated reduced life expectancy, and I mentioned in my testimony a recent study from the U.K. I think most of those people have been people who have had one form of affirmative

care or another.

THE COURT: Your testimony is studies show that people who get medical care -- I'm going to define medical care as puberty blockers, hormones or surgery. Your testimony is studies show that people who get medical care have shortened average lifespans than trans people who don't?

THE WITNESS: No, than the general population.

THE COURT: Than the general population.

THE WITNESS: Yes.

THE COURT: That's what I wanted to find out.

THE WITNESS: And you know --

THE COURT: And that would be -- the same was true if I said people with anxiety and depression -- I'm going to guess people with anxiety and depression at a clinical level have reduced life expectancy as well.

THE WITNESS: They do. When you add puberty blocking to that, since some of the older studies were done before puberty blockers were used, so I think the safest thing to say is cross-sex hormones and surgery.

THE COURT: You may have been in the courtroom yesterday when I was talking to Dr. Hruz.

THE WITNESS: Yes, I was.

THE COURT: I'm going to ask you a similar question; it's not going to be identical. Again, I'm defining medical treatment as puberty blockers, hormones or surgery.

It seems to me that it is the whole universe; somebody either gets that treatment or they do not. It changes over time, but at any given point in time, if you look at people, you could say either that person did get medical treatment or that person did not get medical treatment. That's just like saying the robe I have on is black or it's not black. One of the other of those statements has to be true. You're wearing a necktie or you're not wearing a necktie. One of those statements has to be true. And you do have a necktie.

As a matter of pure logic, proposition A and proposition not A fill up the universe, it seems to me. And so if a 12-year-old presents to you, then either the person will get medical treatment at some point or the person will not get medical treatment at any point. One of the other of those propositions has to be true; that's correct, isn't it?

THE WITNESS: Okay.

THE COURT: So the defense has made a big deal out of the fact that the evidence in favor of providing medical treatment is low-quality evidence. It seems -- and that's true, I think. I think the record shows that it is low-quality evidence.

THE WITNESS: Can I just add to your summary? It's low-quality evidence, and there is the absence of long-term follow-up on the interventions that were offered. That's

really the concern. It's not simply low-quality evidence. It's you are giving these 12-year-old children things, and you have no idea what happened to the -- ten years ago the 12-year-old children that you gave medical treatment to. And we have evidence from the adult transsexual community they are not doing so well. Not just dying; they have more substance abuse, for example. So that adds to it. It's low-quality evidence and there is no long-term follow-up.

THE COURT: I understand. Different problem. We'll double back to that. But it low-quality evidence that supports medical care. On the GRADE system, what is the quality of evidence that supports not giving medical care?

THE WITNESS: I don't think we have any studies of that.

THE COURT: It's not just -- it's not just no high-quality evidence; it's no evidence.

THE WITNESS: It's no evidence. But you see, I think you probably heard testimony the terrible outcomes will happen if we don't give these children. That they have no follow-up studies of people who haven't given the treatment. There is no systematic evidence about that.

THE COURT: But we have anecdotal evidence, and we know that some people who have gotten medical treatment have had bad outcomes.

THE WITNESS: Yes.

THE COURT: And many people who got no medical treatment have had bad outcomes. Sometimes trans kids that don't get medical treatment commit suicide; that's true, isn't it?

THE WITNESS: Yes, and at an increased rate, people who have had medical treatment have committed suicide.

THE COURT: Well, now what study shows that? When you compare the people that get medical treatment to people that don't get medical treatment, the suicide rate is higher for those who got treatment?

THE WITNESS: No, we don't have that -- I don't think that study has been done. The studies that have been done is that the suicide rate of everyone in Sweden over a 30-year period published in 2011 show that are the suicide rate compared to controlled groups of non-trans people both males and females was 19 times higher.

THE COURT: And you would -- absolutely, even if you never seen the study but you lived on this either in our society, you would absolutely expect the suicide rate among trans individuals to be higher than the rate among the population at large; would you not?

THE WITNESS: Because for many reasons, I guess I would, yes.

THE COURT: You would agree with that.

THE WITNESS: But 19-fold higher. And actually, if

you look at females who were living as males, it was 40 times higher. That's not insignificant. That's not something that we can just ignore, and that's not the only study that demonstrated that at every stage in affirmative care, there is a higher suicide rate.

THE COURT: Compared to the general population.

THE WITNESS: Yes. And we don't know the controlled group of people who are trans identified who elect not to have or don't have access to -- we don't know their suicide rate. And so this is part of the uncertainties that parents should understands and judges, I mean, all politician should understand.

THE COURT: Even politicians.

THE WITNESS: Even politicians.

THE COURT: You said something about we don't do surgery to change unimpaired physiology.

THE WITNESS: Yes.

THE COURT: I don't want my next question to suggest that I disagree with the wisdom of not doing surgery to change unimpaired physiology, but unless I'm missing something, there are a whole slew of plastic surgeons who make a darn good living doing surgery on unimpaired physiology.

THE WITNESS: We call that cosmetic surgery.

THE COURT: Absolutely. But we do that, and Florida hasn't prohibited that.

THE WITNESS: But they don't pay for it either. Medicaid doesn't pay for it.

THE COURT: Fair enough.

THE WITNESS: Out of pocket.

THE COURT: Fair enough. Medicaid doesn't pay for anything I get, but I grew up in this state, so I go to the dermatologist accordingly and there is always something there that can be removed. And sometimes the dermatologist says, that's -- and the dermatologist has some fancy name and says, that's never going to be bother. That's no problem unless it just bothers you, and I say, yeah, let's be done with it.

THE WITNESS: $35.

THE COURT: And they take it right off. Probably more. The dermatologist may get $35 and then the pathologist gets a hundred because if they took it off, they are going to a pathology test even though the doctor was more than willing just to leave it on there.

THE WITNESS: We could have a wonderful conversation about medicine.

THE COURT: Yeah, we probably aren't getting anywhere with that so enough of that.

There's been discussion all through the case about gender identity and gender dysphoria and the DSM-5 and what it requires to diagnose somebody with gender dysphoria. I'm going to tell you my understanding, but I'm not at all sure I

got it right, so I need you to tell me whether I have it right.

From the evidence and discussion at this point, it seems to me there are people whose gender identity is different from their natal sex but who do not have gender dysphoria. Is that correct?

THE WITNESS: Yes.

THE COURT: A lot of discussion about medical treatment has articulated it in terms of only gender dysphoria. Some people who get medical treatment have trans identity but not gender dysphoria. True?

THE WITNESS: Yes.

THE COURT: Mr. Perko asked you some questions right at the end of his direct, and I think he phrased his question very deliberately. I'm not going to be able to do it justice in terms of the actual substance of it, but the question was something like: These treatments have not been shown -- and the quotation is, not been shown or have been shown -- to improve mental health. I think that was the question. The treatment has not been shown to improve mental health.

Do you have an opinion?

Yes.

And the opinion is -- essentially was these have not been shown to improve mental health. My question -- and what has been shown is important. I'm not suggesting it's not, but

I have a different question. Not what's been shown but what's happened. There has been a lot of testimony in the case about clinical experience.

Sometimes medical treatment has improved mental health, true?

THE WITNESS: Happiness with their current state and improved happiness with their current state would be a -- one of the -- a criteria for improved mental health. And certainly after undergoing sex reassignment surgery that doesn't have any major complications and doesn't have to have yet a second surgery and so forth, or if the breast's removed, the chest does not feel painful or -- we call it dysesthetic. It doesn't feel normal.

Assuming people don't have complications to the surgery, people can be happy with it. And people like me say, initially, when you measure the happiness with it, we expect the people to be very happy and to say their quality of life is better because they are happier now; they are less dysphoric.

However, we want to see what happens over time, and we wonder what happens, for example, if you take off the breasts of a person of whatever age and they maintain their female genitalia at 70 percent, at least of those people maintain their female genitalia, they present themselves as a male in the society, and in their intimate relationships, they

have a vagina and a clitoris, vulva and so forth, there's a kind of incongruity that they bear every day for the rest of their lives, that incongruity between their body and their presenting gender and then their sense of themselves, you see.

So over time, we want to know what happens to those people, and that brings us back to the elevated suicide rates in people who've had sex reassignment surgery. So initial happiness for the vast majority of people, it's not in question.

A continued happiness is the question, and the presence of suicidality, the presence of the depression, the use of antidepressants and so forth.

THE COURT: Sometimes it works, and sometimes it doesn't.

THE WITNESS: Yes. And we really want to know, based on when we are measuring these events, what percentage of people are happy or have improved mental health or have the same mental health or worse mental health. They are natural reasonable questions to ask about these treatments, and the answers to the questions are "I don't know."

THE COURT: When you sit down to evaluate that question, you would love to see double blind studies. By definition, that's impossible because this can't be done blind. You would like to see high quality studies over long periods of time -- I shouldn't say a high quality. That's a

term under the GRADE system, but you would like to see good longitudinal studies?

THE WITNESS: Exactly, with a huge percentage of the people treated available for follow-up, not 30 percent.

THE COURT: Without that kind of long-term study, if you just -- if you're a parent today with a 12-year-old deciding are we going to have this treatment or not, what you would like the parent to do is to have all of the information, everything you've talked about and then an evaluation of the individual decision, individual circumstances.

One thing that parent might want to know is what's the actual clinical experience, true?

THE WITNESS: You mean of the doctors who is talking to them.

THE COURT: All the doctors, as many good doctors you could find that are honest about this. Look, part of the problem -- I'll grant you, part of problem is most of the people involved in this are partisan. You have said that about the folks that took over WPATH. These are people that are advocates of one position.

I don't think I'm giving away the defense trade secrets. There are some people on their side that are just advocates. So there's plenty of partisanship across the way. But what you would really like -- as the parent, what you would really like to know is a good honest assessment of

clinical experience. That would be important, wouldn't it?

THE WITNESS: Yes. And you want the doctor who you are working with to tell you what science knows, what the states of the controversies are, what the controversies are, rather than what the doctor believes him or herself.

THE COURT: Absolutely.

So you weren't here -- you might have been. Were you here when Dr. Shumer testified?

THE WITNESS: No.

THE COURT: Have you read Dr. Shumer's report.

THE WITNESS: No.

THE COURT: Dr. Shumer is a pediatric endocrinologist at the University of Michigan. It's not Case Western, but it's a pretty good school, yes?

THE WITNESS: Fine.

THE COURT: He's at a clinic. He has had over -- I think it was over 500 patients. He testified that many of his patients have had very good results and that if you deny treatment, you are needlessly going to cause --

THE WITNESS: Harm.

THE COURT: -- harm. That may not be a very good description of his testimony. Basically, you're going to worsen the outcome for many patients.

THE WITNESS: I mean, my point has been we don't have any long-term follow-up of those kids who don't have

treatment. We have doctors who believe in -- passionately believe that they are on the side of angels in giving children these hormonal treatments, and they have this concept that without the treatment, a terrible thing will happen to them.

But, Your Honor, the first phase of the puberty is distress for everybody. The second phase of puberty brings people into awareness of their sexual feelings towards others, and their own sexual feelings and their attractions to others sometimes lead to romantic situations and pleasures with the body that helps some kids retransition back to identifying.

So if we give puberty blockers or cross-sex hormones, we delay the positive impact of the socialization that comes from the sexualization of the body by the natural puberty. And so sometimes this idea that these kids will never change is not -- it's not in keeping.

One of the major people in Europe --

THE COURT: I mean, I understand all of that. Dr. Shumer is just wrong about this, when he says he's treated these kids and he's had a profound impact on their lives? He still gets Christmas cards five years later. I understood that five years is not 50 years. Is he just wrong that he helped these kids?

THE WITNESS: No, no. I believe he is helping these kids because the kids want this, and their parents have bought on to this. And so he has a 15-minute follow-up every three

months, and how are you doing? I'm fine. I'm happier now. This is not a psychiatric sophisticated reevaluation every three months.

THE COURT: How do you know what Dr. Shumer does with his patients?

THE WITNESS: I don't know, but I hear all these --

THE COURT: Do you have any reason to think that the clinic at the University of Michigan is providing substandard care?

THE WITNESS: If I was shown the portion of WPATH about how comprehensive evaluations should be done, Your Honor --

THE COURT: You don't have to persuade me that are partisans at WPATH. I'm talking about Dr. Shumer.

THE WITNESS: I have no idea about Dr. Shumer. I just know that clinics are busy, and when people are doing well, they don't have prolonged sessions. And a pediatric endocrinologist is responsible for lab results and physical health and ask a question about psychological well-being and gets an answer and moves on to the lipids and to the bodily changes and so forth.

THE COURT: He has a team. So there is a psychiatrist involved in this care.

THE WITNESS: Well, when you say "psychiatrist," oftentimes that's a mental health profession who is not as

trained as a psychiatrist. But listen, the devil is in the details about how things happen. Everyone doesn't follow the same standards or interpret the standards in the same way. But as you said, I don't know. I don't know anything about Dr. Shumer.

THE COURT: I was going to ask, do you know anything about the gender clinic at the University of Florida or the University of Miami?

THE WITNESS: No.

THE COURT: If I understood you correctly, before you would sign off -- sign off may be the wrong word. I did understood that when you write the letter that is part of process, you're not making a recommendation. You're just saying, this is really what the parent and child want to do after sufficient workup, it's okay with you, essentially.

The -- and before you got to that point, you would want to follow the patient for at least a couple of years, something along those lines. That's what one should do before approving or recommending medical treatment is have a couple of years. I get that, and it certainly seems like a good idea. Here's, though, the question:

Suppose this well-trained psychiatrist with a team of well-trained doctors participating in the process who share your skepticism, who understand the limitations, somebody presents it's a 12-year-old, they take the history from the

parent, the history shows long-term gender identity different from the natal sex. You've got pretty much all of the information that you would have gotten if you had been following the patient for the last, two, three, four, five years, but they didn't go to the clinic or to any doctor during that two, three, four, five-year period, they are just now showing up. But if you followed the patient for that whole time, you would be at the point of saying, yes, medical intervention is appropriate if that's what the parent wants to do.

Now, what do you do then? Maybe it's just a bad a hypothetical. But the idea is can't you have all of the same information, occasionally, and so that you can go ahead and make the decision for the 12-year-old until waiting till the child is 14?

THE WITNESS: Your Honor, the experience of being a psychotherapist for many years teaches, I think, many of us that people have no aspects about their lives that they do not want to share until they have a deeper level of trust. For example, sexual abuse is not something that is -- it's something that can be stated at the first visit, but I have experienced many times people tell me about the adversities in their lives six months after, two years into treatment and so forth.

So the idea that you can get a comprehensive view of

parents will tell you everything that they know about the child at their first one-hour visit or two-hour visit, they will tell you what you think you ought to know, and they will not tell you the things they are ashamed about. And so it takes time.

The other big issue about your question is the difference between children who are specifically and consistently cross-gender identified throughout their prepubertal years, and the vast majority of new presentations in this century of kids who were not cross-gender identified who now in retrospect tell you, oh, they were never comfortable with their body, you see.

So the question is -- I should say the hardest thing for a young psychiatrist to know is to realize that people don't tell us the truth. And one of advantages of long-term treatment is that more of the truth and sometimes prevarications are admitted.

I have had people that have been in treatment for two years who haven't told me for two years about extra-marital sex that they have been having, you see. So people -- we want to trust the narrative that is told to us, but they are not always trustworthy. And we ever never sure they are entirely a trustworthy.

I'm not saying that everyone is lying to us. I'm saying that everybody has a sense of what's appropriate to say

when, and it takes time for people to tell us more of the truth. Parents don't like to talk about their interpersonal relationship when the child is three years old.

THE COURT: I get it. It doesn't just happen to psychiatrists. Sometimes it happens to judges. Not everybody tells me the truth either.

If the governor of a hypothetical state came to you and the president and speaker -- president of the senate and the speaker of the house or whoever the legislative leaders came and the leading -- the surgeon general of the state, they came to you and said, "we want to make sure we are providing the absolute best care for the children of this state that can be provided, and for the adults. And so for trans individuals, we need to make sure that care is provided properly. Tell us what we need to do to make sure that we're not getting a 20-minute consult and then straight to the medical treatment. We need to do this right."

Could you tell them how to do it?

THE WITNESS: I would tell them to fund new programs for the treatment -- the evaluation and the treatment of autistic human beings with or without gender dysphoria.

THE COURT: Autistic human beings?

THE WITNESS: Autistic. That's number one because a large percentage of people who present with gender dysphoria have autism. In fact, many studies in several continents have

shown that the incidence of autism in transgender clinics is seven fold the incidents of autism in the general population.

So number one --

THE COURT: Hold the thought.

I trust you to remember the thought better than me, so let me interrupt and ask what occurs to me.

Is the increase that has occurred in autism a factor in the increase in the presentations for trans?

THE WITNESS: There is a worry that that's true.

THE COURT: All right. I interrupted you. So first, you treat the autism?

THE WITNESS: Well, so I would say in order to answer your question, all you politicians, you need to think about how to create mental healthcare in your state that approaches the problems that are commonly seen in the gender dysphoric populations, right? So autism is just one little new program I want you to support.

The other is I want you to train mental health professionals to do long-term psychotherapy and to evaluate families over time. So and then I want you to take the transgender child, whether the child is by a definition of prepubertal and the transgender adolescent, and I want you to ensure that they have a prolonged period of family and individual intervention with a qualified mental health professional. And I want you to set certain standards before

they have access to these medical treatments. And I would explain to these politicians those things I have explained to the Court about mortality and sterility, et cetera, et cetera.

So I want to give these trans children every chance that society, our profession has to improve their mental health before and during their medicalization treatment. I want to give them a chance not to have a premature mortality from all kinds of problems, you see. I want to increase their mental health, their capacity to cope. I want to have them identify the adversity and say, well, this is a child whose parents have sold them into -- I don't mean to be so dramatic. This is a family who has had dysfunction. There has been violence in the family, there has been physical violence to the child, there has been abandonment of the child by a parent. I need you to have programs and -- and people in them who understand these adversities that many of these children have. And when they're identified in the comprehensive evaluation, I want them in a treatment program for those particular adversities.

Whether we can overcome or not, we can help the child and the family appreciate the adversity and then help them deal with their feelings that they had about it and not escape by changing their sense of self, you see. See, "I want to reinvent myself as trans person" could be "I want to escape from the misery I have expressed as a boy or a girl."

So politicians I would say I want you to focus on mental health in a serious way that addresses the problems that 70 percent of these kids have when they are evaluated, you see.

Now, that's not what has been happening. That would be my advice. It's a long answer to a short question.

THE COURT: And then you would not prohibit medical care when appropriate after that whole evaluation, true?

THE WITNESS: Yes, but I would like them to provide medical care in a study, in a protocol that guarantees follow-up and that will compare people who get affirmative care and people who get psychotherapy only and people who, for various reasons, are just followed up with -- are just followed up without any intervention. That ideal thing.

But short of that, I would say if the politicians created programs and capacities within their state to address the mental health of those children and adolescents, then I would say, okay, although we don't have all the answers, affirmative care might be considered. But not without --

THE COURT: By that, you mean medical care as I defined it.

THE WITNESS: Yeah affirmative care, medical care, that's what I mean. Yeah.

THE COURT: Tell me what about the studies that were in progress at the Johns Hopkins Clinic or the University of

Florida or the University of Miami that now have been shut down were different from what you just outlined as the optimal way to treat this.

THE WITNESS: Well, the John -- the only one that I'm aware of is the Hopkins study.

THE COURT: They have a study in Florida, did you know that?

THE WITNESS: No.

THE COURT: They may not have a study. They had clinic in Florida, and there was a clinic at the University of the Florida and a clinic at University of Miami. And I know there were studies going on at a couple of those places. But --

THE WITNESS: I'm not aware.

THE COURT: All right. Fair enough.

Questions just to follow up on mine?

MR. PERKO: No, Your Honor.

MR. CHARLES: No, Your Honor.

THE COURT: Thank you, Doctor. I appreciate your input. You may step down. You're free to go about your business.

THE WITNESS: Thank you.

THE COURT: It's probably lunchtime. Anything we need to do before we break? Have anybody that needs to be handled or some short witness or some witness whose testimony

won't be long?

MR. JAZIL: I don't think, Your Honor, we have a witness that fits in that category. We have Dr. Lappert and Dr. Kaliebe in the audience who will be our next two witnesses.

THE COURT: Let's start back at 1:10 by that clock.

(A luncheon recess was taken at 12:07 p.m.)

AFTERNOON SESSION
(1:10 P.M.)

THE COURT: Please be seated.

Mr. Jazil, please call your next witness.

MR. JAZIL: Thank you, Your Honor. Dr. Lappert is our next witness for the defense.

DEPUTY CLERK: Please raise your right hand.

PATRICK LAPPERT DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: Patrick Walter Lappert, L-a-p-p-e-r-t.

DIRECT EXAMINATION

BY MR. JAZIL:

Q. Good afternoon, Dr. Lappert. What do you do?

A. I'm a physician and surgeon.

Q. What kind of physician surgeon?

A. Plastic and reconstructive surgery.

Q. Dr. Lappert, to speed things along a bit, I'm going to have my friend pull up DX31, which is your CV, which has already been admitted into evidence.

Doctor, does this CV accurately reflect your training and experience?

A. It does.

Q. Your publications and awards?

A. It does.

Q. I would like to ask you a few questions about this CV. It says here that you received an M.D. from the Uniformed Services University of Health Sciences. What is that?

A. USUHS is the federal medical school that trains physicians for service in the three branches of the military as well as the public health service.

Q. And it says you did a general surgery residency, Doctor. What is that?

A. For me that was a five-year program to train me to be a general surgeon that included training and management of cancer, gastrointestinal disease, pulmonary diseases. The whole gamut of general surgery.

Q. And it says you were chief resident, Department of Surgery. What does that mean, sir?

A. That's -- in the final year, if you're selected to be a chief resident, you also manage the day-to-day operations of the general surgery department including the management of

the surgical schedule and the training of the residents.

Q. It says that you did a plastic surgery residency.

First, Dr. Lappert, what do plastic surgeons do?

A. We are responsible for reconstructive surgery of defects caused by trauma, congenital deformity, cancer care, infectious illness. It's the restoration of form and function that may have been lost to any of those causes, and then there's also the additional dimension of cosmetic surgery.

Q. Understood.

And what exactly does the residency in plasty surgery entail?

A. So the majority of us are prior board eligible or board certified in general surgery, as I was. That is followed by a two- to three-year residency program that involves training in all of the aspects of reconstructive surgery, including the care of congenital deformities in children, the care of the elderly and chronic wounds, the care of limb salvage, hand surgery, cancer reconstruction of the head and neck.

Essentially what I used to tell my residents in training is that plastic surgery is surgery of the skin and its contents because we cover all body areas under a variety of different circumstances.

Q. If we scroll down on here, it says that you had a board certification in surgery from 1992 until 2002.

First, Doctor, tell us what a board certification in surgery means.

A. Well, if the American Board of Surgery approves your training program -- and that's a process in and of itself -- if you graduate from an approved training program, you are considered board eligible. You're invited to sit for the written examination; and that if you satisfactorily pass the written examination, you're invited to take the oral examination. And then having completed all those areas, you are then considered board certified.

Q. And it says that your board certification ended in 2002. Why is that, sir?

A. Beginning in the early '90s -- it used to be that board certification in general surgery, among others, was a lifetime thing. But beginning in the early '90s, they made it a recurrent recertification process. So in 2002, my general surgery board certification expired.

Q. And your CV says that you were board certified in plastic surgery from 1997 until 2018.

First, Doctor, tell us what a board certification in plastic surgery means.

A. Well, as with general surgery, if your training program is certified, at the completion of your residency, you are considered board eligible in plastic surgery. In the case of plastic surgery, it's a bit more rigorous because you, in

addition to having to pass the written examination, during the years that I was certified, the -- you are required to collect every case for an entire year and report those cases listed to the American Board of Plastic Surgery.

From among those hundreds of cases, they will select -- I think my year it was ten cases for critical examination. And you have to submit comprehensive records, everything from clinic visits, operative reports, anesthesia records, billing records, all of it; and then the oral examination is basically a review with you of those selected cases. And if you satisfy the examiners, then you are now board certified in plastic surgery.

Q. Sir, why did your certification end in 2018?

A. In 2018 -- having recertified, in 2018 I was within two years of my retirement from my life as an active surgeon. So being that at that point in my career I was a solo practitioner in a small town, it didn't seem reasonable to go through that whole recertification process only so that I could use it for two years. And at that point in my career, none of the hospitals I operated in even considered it a requirement, so I -- I deferred recertification.

Q. Doctor, I would like to ask about a couple your medical appointments.

It says here that you were chairman of the Department of Plastic and Reconstructive Surgery at Naval Medical Center of

Portsmouth. What were your responsibilities in that role, sir?

A. Well, as a department head, I had the care of the entire department including our five plastic and reconstructive surgeons, a number of enlisted service members who were responsible for the running of the clinic and the operating room. I had a number of a civilians working for us as well. And I was responsible to the director of surgical services. So our department was responsible for offering comprehensive reconstructive surgical services to all eligible service members and their dependents as well as retirees for a catchment area that included all of Virginia and south to Florida and all the way east to the Eastern Mediterranean. So all complex reconstructive issues within that catchment area were sent to us, and we were responsible for their care.

Q. Doctor, it also says that you were a clinical assistant professor at the Department of Surgery at the Uniform Services University of Health Sciences.

What did that job entail?

A. As a professor assistant, I was responsible for -- I was the point of contact for any medical students who were doing clerkship rotations at the Portsmouth Naval Hospital, responsible for not only their training but their care and feeding, if you will. And I was responsible for offering lectures on matters pertaining to surgery in general and

plastic surgery in particular.

Q. And the last line on this page, Doctor, it says here that you were a specialty leader, plastic and reconstructive surgery for the Office of Surgeon General, U.S. Navy?

A. That's correct.

Q. What did you do in that role, sir?

A. So, while I was the chairman of the department at the Portsmouth Naval Hospital, I was also in that position as specialty leader. What that required of me was that I was to assist the Surgeon General of the Navy in making policy decisions about coverage, care, eligibility for care, what we call the evacuation policy for any injured persons in that catchment area, how they were to be brought back stateside in the event of conflict, what the evacuation policy would be.

And then I was also responsible for advising him on the recurring issue of what constitutes reconstructive surgery and what constitutes cosmetic surgery, because it basically impinged upon how the local medical treatment facility commanders had to spend their money in the care of active duties and dependents, whether a covered benefit was available in the military treatment facility. If it was a covered benefit, we would have to pay for it in a civilian hospital if they were eligible beneficiaries. And if it was cosmetic surgery, basically the determination was made that it's not something that the military or the government is

responsible for.

Q. Doctor, how long have you been a plastic surgeon?

A. Thirty years.

Q. Can you approximate for me the number of surgeries you have done in that time?

A. It would be a rough approximation, but over that time period somewhere around 6,000 major surgeries and innumerable lesser procedures.

Q. Doctor, can you briefly describe for us the kind of surgery you did in your military service as a plastic surgeon?

A. Well, as I explained before, we covered all body areas and all demographics from neonates to the elderly and the dying. That included craniofacial reconstruction for children born with craniofacial anomalies like cleft pallet and things like that. We established and ran a comprehensive multidisciplinary cleft palate craniofacial board through which those children were brought.

We worked very collaboratively with the ENT surgeons doing head and neck reconstruction for cancer and trauma. We worked with the orthopedic department in doing limb salvage and hand reconstructive surgery for combat trauma victims or other victims.

We worked with the thoracic surgeons doing chest wall reconstructions, worked with the general surgeons doing

breast cancer reconstruction, and worked with urologists, again for congenital anomalies, developmental anomalies. Did I leave anything out here? I think that's probably all of it.

Q. I understand. And in your civilian practice, can you briefly describe the kind of surgeries that you did and do in that role?

A. A much simpler life because much of what I outlined to you earlier required multidisciplinary care as well as the presence of a lot of additional physicians to monitor the patients. So did a lot of breast cancer reconstruction, did a lot of breast reductions, did a lot of skin cancer care postoperative reconstruction. Some hand surgery, as well as operating a wound care center for the management of chronic wounds, and again a cleft palate board for the management of children with congenital deformities.

In that setting I wasn't doing a lot of the cleft palate surgery, but I was screening the patients, developing a care plan and referring them to university centers.

Q. Doctor, in your work do you keep up with the academic literature?

A. I do.

Q. Why?

A. It's my duty. It's my duty to stay abreast of the current literature in the event of new developments that

would give better results or make care available to people it wasn't available to before.

Q. How do you in your practice judge whether or not to follow a particular recommendation?

A. Well, one of the things we emphasize in surgical services is maintaining currency in the literature and doing things like having a journal club where practitioners get together and review current articles in recent journals. So the Plastic and Reconstructive Surgery Journal is one we use frequently where you review articles. You will select articles for particular doctors to review and then present and then discuss.

The American Society of Plastic Surgery offered us -- I think it was about 15 years ago -- an evaluation tool -- I think the lead author was Dr. Rod Rohrich -- where you can assess the value of scientific evidence presented in the article that enables you to judge whether what is being presented in useful in making clinical decisions or if it's just interesting and may inform research experimentation or further study.

So the system that the American Society of Plastic Surgery uses is a 1-to-5 grading scale to grade the quality of the evidence itself. So, for example, Level 5 evidence, which is entry level -- to get into a peer-reviewed journal, you at least have to have that -- and much what is published

in peer-reviewed journals is Level 5 evidence.

What does that constitute? Anecdotal report of an interesting case -- I have got a couple of those in my CV -- where something unusual happens, you see something going on with the patient that has not been previously reported, or you have a novel way of managing something that was previously reported, and you publish that literature. Level 5 evidence.

Anecdotal report, not sufficient to guide clinical decision-making. If I had of series of cases like that and I collected those cases over time, I might be able to say more about what's going on with those patients. But a case series, a retrospective review of my database, for example, that would be Level 4 evidence. And that's more compelling and certainly more useful in designing research.

So Level 4 evidence retrospective review, no case control group. There is no control group, so I can't emphatically say that what I did for these patients got me the result that I'm claiming. I can just say there is an interesting correlation here, and we need to examine where we're going to go in the treatment of these patients.

The next level in the ASPS scheme is where you do have a control group, Level 3 evidence. Longitudinal study, where not only do we have the case series that I'm reporting on, but I have a comparable control group that I'm following both

over time. That is a -- for example, if I see that in a journal article, then that is something that can guide my clinical decision-making, particularly if we're dealing with surgical interventions that can have long-term consequences.

When you get to Level 2, now you're talking about randomized trials, and then further on into the systematic review of randomized trials.

So that's -- the goal standard is randomized controlled trials or systematic review. But as was discussed earlier, you can't do that with surgical patients. You can't do sham surgeries. It's unethical. So you can't have that kind of control. But you can have comparison populations followed longitudinally and use Level 3 evidence to make those kind of decisions.

Q. What were you asked to do in this case?

A. I was asked to review the surgical procedures that are offered in the care, affirmation care of transgender persons, to look at the levels of evidence that are used to support that, to examine the issues of medical necessity, efficacy and the safety of those procedures, and to examine the scientific evidence as presented particularly by the plaintiffs' witnesses in support of those treatments.

MR. JAZIL: Your Honor, I can tender him as an expert in plastic surgery if the Court would prefer, or just go on questioning.

MR. MILLER: I do have brief voir dire, Your Honor.

THE COURT: All right.

VOIR DIRE EXAMINATION

BY MR. MILLER:

Q. Good afternoon, Dr. Lappert. My name is William Miller.

A. Pleasure.

Q. Dr. Lappert, you've never provided any kind of gender-affirming surgery as treatment for gender dysphoria; that's correct, right?

A. That's correct.

Q. You have not published a peer-reviewed article since 1998; is that correct?

A. I think that's correct, yeah.

Q. And over the course of your career, you've published six articles, none of which were about gender-affirming surgery, surgery?

A. Correct.

Q. You've never conducted or published research on gender dysphoria or transgender people, correct?

A. Correct.

Q. You agree that gender dysphoria is not your area of care, correct?

A. Correct.

Q. And you do not claim to be an expert in the treatment of gender dysphoria, do you?

A. I do not.

Q. Okay.

MR. MILLER: Your Honor, based on that testimony, I think we land in the same area we were with Dr. Hruz, and so we would not object to Dr. Lappert testifying to the field of plastic and reconstructive surgery, but we would object to any testimony that goes beyond his area of care and clinical expertise.

THE COURT: Mr. Jazil, I know he was part of what they relied on at the administrative area. What gives him any expertise relative to this case?

MR. JAZIL: Your Honor, as testimony will show and as Dr. Lappert will hopefully testify, we are going to walk through the surgeries that are used for the treatment of gender dysphoria, and he can talk about their efficacy, their use, the risks, et cetera.

THE COURT: Surgery he's never performed, true or not true?

MR. JAZIL: Not true. He has performed these surgeries, just not for gender dysphoria.

THE COURT: Isn't that their point? It's sort of the same thing I said before. I will let you tender the testimony, and probably the most reliable way to take the tender is by allowing you to ask the questions and then subjecting it to cross-examination.

It seems to me the plaintiffs are right that to the extent he wants to speak to the question of whether this surgery is appropriate for a trans patient, what trans patients need or don't need, how this affects a trans patient, those seem to me to be things that are just not his area.

Daubert, of course, is a rule that applies in all kinds of cases. If you had a malpractice case involving trans surgery and the question was whether the surgery was appropriate, how it impacted the trans patient; and you brought Dr. Lappert, there is no question in my mind that the testimony would be excluded. In *Daubert* it's difficult to say every judge with our considerable discretion would make the same ruling on any given set of facts, but I think we would all make that ruling.

Now, if there were issues in that case that dealt with how does one perform mastectomy, then I'm sure that is something that Dr. Lappert can speak to. But whether that's appropriate treatment for a trans patient, I don't think there is a judge in the country that would say he can give that testimony.

So some of the subjects and the reason I denied these motions in limine before we started was that all of these doctors -- all these experts had some things they could properly testify about, including Dr. Lappert. But it does seem to me that, when you get his testimony about how one

should treat a trans patient, you're beyond the pale.

But we're going to get it proffered anyway; and as I said, this is probably the best way to take a proffer, so carry on.

MR. MILLER: And just for clarity, Your Honor, you wouldn't want us to object question by question. Can we have a standing objection to the extent he testifies as we did with Dr. Hruz, or would you prefer to handle it differently?

THE COURT: Yes. I don't want you to object to every question. I probably should make it clearer than maybe I did when we brought this up before. I only ask for one clear chance to rule on any given issue, but I do ask for one clear chance. So if there is something other than just he doesn't treat trans patients, if there is some other difficulty, raise it.

MR. MILLER: Certainly, Your Honor. Thank you.

MR. JAZIL: Thank you, Your Honor.

DIRECT EXAMINATION

CONTINUED BY MR. JAZIL:

Q. Doctor, I'm going to ask you a couple of questions about surgeries generally.

What goes into your decision about whether or not to do a particular plastic surgery?

A. Well, it depends on whether it's a reconstructive operation or a cosmetic operation, because they differ

significantly, and I will get into that.

So the first question is: What is the nature of the patient's problem? In the case of a reconstructive surgery, what is the nature of the defect? What is the missing part? What is its dimensions? What's the history of injury or how that may have happened? What does it mean to the patient?

Loss of a helping hand is different than loss of a dominant hand, for example. So if he's a left-handed patient, it's different than if he's a right-handed -- those sorts of things.

So having defined the defect and what the defect means to the patient, then I have to go through what the options of reconstructive surgery are; and among those options, what am I capable of doing, so my skill level for that particular reconstructive challenge.

Then I have to be able to offer the options of care to the patient so that they can make an informed decision. And I have to be able to go through with them what the likelihood is of a successful outcome, what they're risking in having the operation.

So it begins with a definition of the defect, an examination of the patient's particular problems, and what are the options of care and reconstruction, am I capable of doing that, and what does the patient choose to do.

It's a different process when you are talking about

cosmetic surgery because such operations begin in the subjective life of the patient. They are not referred to you because something is wrong or something is missing. They are referred to you because something is going on in their interior life, and they're usually self-referred.

So the beginning of that evaluation is really an evaluation of what the patient is thinking, what they are seeing, what they are feeling, and whether or not I can see and understand what they see and understand.

And then having determined what their complaint is and what they are seeking from cosmetic surgery, I have to examine what's the likelihood that I can satisfy what it is that they want from the surgery.

So it may be something trivial, like the person just wants their two ears to match because one of them is loppier and the other one is not. And I can see the defect, I can define the defect, I can offer several options of care to the patient. And in discussing that with the patient, I can get a sense for what their expectation of the result is. Well, symmetry, and I would like people to stop looking at my left ear. That's a reasonable thing. So that's not a very challenging one.

But if I patient come in and say that they want their nose modified, I will -- getting into the details, if I see what they see, you know, I have a hump on the top of my nose

or the base of my nose is too wide, I think it looks ugly, well, if I can see what the patient sees, then I can proceed on.

If in the course of the evaluation the patient voices to me the idea that by changing the appearance of their nose, they are going to radically alter the course of their life; that they are going to go from a condition of great sorrow to a condition of joy. If they say things like, "The reason I'm not getting ahead in the firm is because I have this hump on my nose," I'm going to basically seek to disabuse the patient of the idea that changing their nose is going to change their career.

But that would be an example of a person ascribing to their physical appearance the causes of their sorrow, particularly if it's within the normal range of what humanity experiences.

So that's where you get into the moral and the ethical issue of reconstructive surgery versus cosmetic surgery. In both cases you have to have an understanding of what the likely outcome is going to be based on your skill and the patient's condition.

But in the case aesthetic cosmetic patient, you have the additional problem of recognizing, when a patient has a condition that we -- in our training, we learn it is called "body dysmorphic disorder." This is a very important thing

for cosmetic surgeons to understand because it's considered malpractice to offer surgery to a person who is suffering with body dysmorphic disorder. It unethical.

Q. Doctor, before we go on to specific surgeries, can you tell us briefly what the risks are associated with surgery generally?

A. Well, surgery generally, if you make an incision in the skin, you have a risk of wound infection. Depending on where on the body you make the incision, the risk may be higher or lower.

Anesthetic risks, unexpected reactions to medications, length of anesthesia, length of immobilization, all can be associated with significant risks of everything from adverse reaction to anesthesia to pulmonary embolus from thrombophlebitis, various things like that. Depending on where in the body you are operating, the potential risk can be higher.

MR. JAZIL: I would like to DX16, page 138.

BY MR. JAZIL:

Q. Doctor, take a look at these surgeries and look back at me when you have had a chance.

A. Okay.

Okay.

Q. Doctor, which of the surgeries on this list have you performed in your experience?

A. Let's see. Going from top to bottom under the heading of "Brow," I have performed all of those operations, lip, lip reconstruction, jaw modification, chin reshaping. I have not done a chondral laryngoplasty. That's not an operation I have done.

Breast surgery, all of those. Genital surgery. I have not done metoidioplasty. I have done vulvoplasties, vaginoplasties, phalloplasties. I have not done gonadectomy electively. All I have done is a removal of an infarcted gonad but not a bilateral. Body contouring, I have not done monsplasty.

Under "Additional Procedures," I have not done uterine transplantation or penile transplantation. And as far as the various options of those operations, I have done -- none of the things listed under metoidioplasty, but the others, I think I have done all of those.

Q. Doctor, can you tell us which of the operations on that list are reversible?

A. Well, all of those facial surgeries are reversible. Mastectomy is not a reversible procedure. Any operation that involves the -- you know, obviously the removal of the genitalia is not reversible, like gonadectomy, hysterectomy, those are not reversible surgeries. The ordinary body contouring procedures are reversible.

Q. Doctor, based on what you just said, my understanding is

you have done a phalloplasty?
A. For reconstructive purposes, yeah, on a couple of occasions, for management of infectious destruction as well as traumatic amputation.
Q. Can you briefly describe for us what that surgery is?
A. Well, in the one case it involved local regional flaps where we -- in order to do such reconstructions, you have to import soft tissue from adjacent places or from distant locations in order to get the reconstruction going.
So the penile reconstructions, one of them involved a replant with a local regional flap, and the other one involved reconstruction with local regional flaps and free skin grafts.
Q. What does that mean?
A. It means that you lift and you rotate an area of adjacent skin, keeping it on its blood supply, and shaping that tissue into the structure you are trying to reconstruct. And oftentimes when you do -- use that technique, you come back and do additional modifications to the result in order to achieve a more aesthetically normal result.
Q. What are the risks associated with the surgery?
A. Any time you lift and rotate tissue in order to achieve a reconstruction, you are challenging the blood supply to that area of skin. In simply making the incision around the skin, even while preserving its named blood supply, you are

compromising blood flow in that flap.

So to lift and rotate an area of soft tissue like that risks loss of blood supply and the concomitant wound-healing problems, and that sort of thing. When you are importing tissue from remote locations using the free flap technique or the microvascular flap, that's even more challenging, because now you are working under the microscope to reconnect blood vessels, and they have their own particular risks of infarction and thrombosis and that sort of thing.

Q. If you were to do the surgery on a natal female, would the risk be different?

A. Which operation are we talking about?

Q. Phalloplasty.

A. Phalloplasty. So in order to do a phalloplasty, you are importing tissue from remote locations, typically. Not exclusively, but the typical operation these days is a microvascular neurotized free flap reconstruction, which involves a couple of risks. One of them is the risk to the tissue that you've transplanted. The things that we talked about earlier, loss of blood supply and difficulties with wound healing.

Additionally, you have donor morbidity, which includes -- the typical donor site is the forearm. The donor morbidity there is exposure of muscles, tendons, nerves, joints, ligaments, that can comprise function of the hand, cause

lymphedema in the hand, besides the aesthetic problem. Because you're covering that with a skin graft, you have the potential of partial or complete loss of the skin graft that is being used to protect the previously exposed muscles, tendons, and so on.

And then you have what -- you have to put in the category of donor morbidity, which means what is the patient losing in order to achieve the reconstruction. There is the donor morbidity of the arm --

THE COURT: Doctor, I don't want to interrupt.

Do you remember what the question was?

THE WITNESS: Yes. I think the question was what are the risks.

THE COURT: No. That was not the question. The question was: What risks are there doing this to a natal woman as opposed to doing it to a natal male? What increase -- what different risks?

THE WITNESS: I understand, sir. Sorry.

So the difference in risk is that, in the natal male, it's what you're risking is the donor site and the fact that the flap might fail. In the natal female, there is the additional risk -- well, the additional penalty, I guess, of the loss of the reproductive capacity.

BY MR. JAZIL:

Q. Doctor, you said you've done a vaginoplasty. What are

the risks associated with that?
A. Similar risks. The particular vaginoplasty I've done were in the setting of essentially IED trauma. So, again, lifting and rotating tissue, the risk of loss of the tissue, the risk of fistula communication between the reconstructed structure and adjacent structures like the bladder and the rectum, where you can get communication between those structures and the external world.
Q. Doctor, you have said you have mastectomies before.
Can you approximate for me how many mastectomies you have done in your career as a plastic surgeon?
A. Somewhere between 3- and 400, I'm going to estimate.
Q. When do you typically do these mastectomies?
A. A mastectomy is a therapeutic operation, typically done in the setting of a diagnosis of malignancy or more recently in the setting of a diagnosis of increased risk of malignancy in people who have inherent traits.
It can additionally be done for other problems where you can have painful fibrosis of the breasts that the patient's having difficulty dealing with, and that would be a different kind of a mastectomy. It wouldn't be a total mastectomy but a subcutaneous mastectomy. You then replace it with either autologous tissue or an implant.
Q. Doctor, earlier in your testimony you talked about some of the ethical concerns associated with dealing with

surgeries.

Why aren't there any ethical concerns in your mind when you're moving healthy tissue from a woman who hasn't yet been diagnosed with breast cancer?

A. Well, there are a couple of circumstances where you might be doing that. So, for example, in a breast reduction, you are removing healthy tissue, but you're doing it -- it's considered a reconstructive operation because it doesn't begin in the subjective life of the patient. It begins in a known problem of orthopedic difficulties that the patient is having. Neck, back, and shoulder pain associated with overgrowth of the breast is a common problem, which I had to manage on active duty women.

So there what you are managing is a known objectively qualifiable diagnosis of neck, back, and shoulder pain, and the breast reduction has known benefit; that is to say, I know that if I remove x-amount of tissue, the neck, back, and shoulder pain will resolve.

So in the setting of removal of normal tissue, say from a woman who has a diagnosis of an inherited trait and has a family history of breast cancer, there you are, again, doing it to manage an objectively quantifiable disease.

And in this case, what's quantifiable is her lifetime risk of breast cancer. And so the operation is done there to manage that. Very different thing if I'm doing mastectomy to

manage a subjective complaint. So that's where the ethical problem would come in.

Q. Doctor, have you done breast augmentation surgeries before?

A. Many.

Q. And let's say a 40-year-old mother comes to your office asking for a breast augmentation surgery. What's the conversation you have with her to decide whether or not you can do the surgery on her?

A. Well, as we talked about before, it's characterizing what the patient's goals are, what she sees, and if I can see what she sees. Is she -- is she in a condition to tolerate the surgery, even though it's a relatively brief operation. Does she have any contraindications to implant augmentation? A woman who has chronic problems with infection would not be a good candidate for implant surgery of any kind.

If her expectations are reasonable, then it would be a reasonable thing to discuss with her. And then we would discuss what the options of care are, whether an implant or autologous fat grafting or something of this sort.

What I would be wary for in a patient like that is, again, motivation. If her expectations are the ordinary kind where she just would prefer to look like she looked before she had her children, that's the typical breast augmentation patient. If in the course of my evaluation she became

tearful and said something like, "I'm glad you're going to do this operation for me because I'm sure that if I don't do this, my husband will leave me," then that would be an unethical reason for me to offer -- I mean, that would be a circumstance of ethical problems because the patient would have an expectation of the surgery that obviously I cannot meet.

Q. Understood.

THE COURT: Did I understand you just to say that the typical reason why somebody presents for breast augmentation is because they've had children and want to be restored to where they were before they had children?

THE WITNESS: Yes, sir. I think that the most common breast augmentation patient is a woman in her forties who is multiparous. There is obviously a large cadre of patients who are young who are looking to enhance their appearance, and it also varies from one area of the country to another. When I was doing surgery in San Francisco, very different from when I was doing surgery in Tennessee, the expectations of surgery.

THE COURT: We've gotten so far from the issues in the case that we're just spending time.

MR. JAZIL: Your Honor, I will wrap this up quickly.

BY MR. JAZIL:

Q. Doctor, the surgeries on that list there, do you do any of those surgeries for transgender patients?

A. No.
Q. Would you do any of those surgeries for transgender patients?
A. No.
Q. Why not?
A. Because that is -- the problem we talked about earlier, the transgender patient --
THE COURT: This is particularly the area where this witness has no expertise and nothing to add. If I'm not mistaken, he was prevented from giving this testimony by the District Court in North Carolina, was he not?
MR. JAZIL: I don't know, Your Honor.
THE COURT: I don't think I'm the first judge to say this man has no expertise that passes *Daubert* on this subject.
MR. JAZIL: Your Honor, may I --
THE COURT: The earlier ruling -- go right ahead. Basically, you're going to testify that doctors providing a service he's never provided for patients of the kind he's never dealt with are committing an unethical practice, essentially malpractice, every day when they treat their patients. It's a remarkable assertion for someone who has never worked in the area.
Carry on.
BY MR. JAZIL:
Q. Doctor, why wouldn't you provide those surgical

treatments to patients who are seeking them for the treatment of gender dysphoria?

A. Because I would place those operations in the category of cosmetic surgery. And for the reasons we discussed earlier, cosmetic surgery, because it begins in the subjective life of the patient, in this case the expectations are not anything that I could offer even a glimmer of a prediction whether it would satisfy their needs because the expectation is very, very high that it would be life transforming. And because it is a cosmetic operation, I would consider it something I would not offer.

MR. JAZIL: Thank you. No further questions, Your Honor.

THE COURT: Cross-examine?

MR. MILLER: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. MILLER:

Q. Dr. Lappert, you've previously attended meetings sponsored by the Alliance Defending Freedom, correct?

A. Yes.

Q. Is it all right if I refer to that as the ADF? You'll know what I --

A. Certainly.

Q. The ADF is not a professional scientific organization, is it?

A. I don't think it is, no.
Q. Would it be fair to describe it as a Christian-based, legal advocacy organization?
A. That's my understanding. I'm not affiliated with them, so I don't understand the entirety of what they do. But I do know that they are Christian-based, and they seem to be an advocacy organization that's based in the law.
Q. And you attended an ADF meeting sometime in 2017; is that correct?
A. Sounds right. I'm -- I don't know the exact dates that I was there, but...
Q. The meeting certainly preceded the time that you've ever testified as an expert witness; is that correct?
A. Yes.
Q. And at that meeting there was a discussion about the lack of people willing to testify and the difficulty of finding expert witnesses on transgender issues?
A. I think that was discussed, yes.
Q. And people at that meeting were asked whether they would be willing to participate as expert witnesses, correct?
A. I don't remember that question being asked, but...
MR. MILLER: Anna, could you pull up Plaintiff Exhibit 81, please?
THE COURT: You have to say it where we can all hear.
MR. MILLER: Yes. Plaintiffs' Exhibit 81, please.

BY MR. MILLER:

Q. Dr. Lappert, do you recall testifying at the trial for *Brandt v. Rutledge* in Arkansas?

A. Yes.

Q. And that was in 2022, November?

A. Correct.

MR. MILLER: And, Anna, could you go to the page 1081?

BY MR. MILLER:

Q. I'll just read it out. You were under oath at that trial, correct, Dr. Lappert?

A. Yes.

Q. Do you recall a question being posed, and I'll quote:

"Question: And people at that meeting were asked whether they would be willing to participate as expert witnesses, weren't they?

"Answer: Yes."

Do you recall that testimony?

A. Well, I don't recall it, but I'm certainly confident that they recorded it correctly.

Q. Thank you.

And were you present in court yesterday when Dr. Hruz testified?

A. Yes, I was.

Q. And you're familiar with Dr. Hruz?

A. Oh, yes, we're good friends.
Q. Dr. Hruz was also present at that meeting, correct?
A. Yes, he was. In fact, that's where I met him.
Q. And it's fair to say that ADF is an organization that has moral objections to gender-affirming care to treat gender dysphoria?
A. I suspect that's true. Again, I don't have any association with the ADF. I was just invited to make a presentation there and met some people and had a discussion and left.
MR. MILLER: Anna, could you please pull up Plaintiffs' Exhibit 135?
BY MR. MILLER:
Q. Dr. Lappert, this is a 2019 article from LifeSiteNews titled, "Plastic Surgeons, Sex Change Operation Utterly Unacceptable and a Form of Child Abuse," right?
A. Yes.
Q. You're the plastic surgeon quoted in this article, correct?
A. Yes; that's correct.
Q. The article reports on your 2019 appearance in a radio interview on a broadcast called "Relevant Radio Trending With Timmerie," correct?
And you did appear on that radio program, correct?
A. That's correct.

Q. On the first page this article states:

Dr. Lappert, a Catholic Deacon in Alabama, says changing a person's sex is a lie and also a moral violation for a physician.

Did I read that correctly?

A. Yes.

Q. You hold that view, correct?

A. I do.

MR. MILLER: Would you go to page 7 of the document, please, Anna?

BY MR. MILLER:

Q. We're looking at the bottom two paragraphs, very bottom of the page. Thank you.

So the second-to-the-last paragraph quotes you as saying, quote:

It's leading us to see the human person as a commodity that is regulated by the government, by government institutions, universities and by laboratories, and that is a huge evil. It's a huge evil, and never forget that transgender surgery is right at the heart of that evil.

Did I read that correctly, Dr. Lappert?

A. You did.

Q. That's an accurate quote of your words?

A. Yes, it is.

Q. The article then indicates, you continue -- I'm going to

the last paragraph on that page. Quote:

First of all, because it utterly perverts our sense of human sexuality, it internally divides the human person from their very own bodies. And now it's separating the human community from their reproductive faculties in the era of assisted reproductive technology. So this is diabolical in every sense of the word. Diabolical.

Did I read that correctly?

A. You did.

Q. And that's an accurate quote of your words, right?

A. Yes, it is.

MR. MILLER: You can take that down, Anna. Thank you.

BY MR. MILLER:

Q. Dr. Lappert, you yourself have previously lobbied state legislators to pass laws banning the provision of gender-affirming care to adolescents, correct?

A. I have.

Q. And you submitted information to the Utah legislature in relation to such proposed law; is that right?

A. I think that's correct. I didn't -- the involvement with Utah didn't proceed I think beyond one -- one interaction, and I don't remember the details.

Q. Do you recall making a submission of information?

A. I think so, yes.

Q. And in that submission, with respect to gender-affirming care, you said, quote:

All that is happening is that the patient is undergoing an intentional mutilation in order to create a counterfeit appearance of the other sex.

Does that sound correct?

A. That's very correct, yes.

Q. And you consider gender-affirming surgeries to be an intentional mutilation, correct?

A. Part of it is intentional mutilation, yes, it is. So, for example, the intentional destruction of a reproductive faculty is considered mutilation as surely as if I mutilated somebody's hand, only in this case it's the genital. You are robbing them of a natural human facility through the process of destruction of natural human structures.

Q. And you think it would be a good idea to criminally prosecute doctors who provide gender-affirming care, correct?

A. Actually, I would hope it would be unnecessary to do that.

Q. But you do agree it would be a good idea if the care was still being provided?

A. Yes.

THE COURT: Let me make sure I -- what the last question and answer were. You think it be a good idea to prosecute doctors who provide the care?

THE WITNESS: What I think is that having publicly reviewed, first of all, what is going on, what is the level of scientific support, if it is, you know, the desire of the government to regulate that, then it would be -- as surely as we criminally prosecute the mis-prescription of anabolic steroids to children who want to be athletes, it's the same kind of duty that the government has. And I consider that one of the duties not only of the government, but I would hope that the medical community would take action to prevent those things first.

THE COURT: I was just to trying to make sure. The question was, you agree it would be a good idea, and you said yes. And I just wanted to make sure that a good idea that you were referring to was prosecution of doctors who participate in this care.

THE WITNESS: If it's -- yes, if they violated the law in doing it, yes, I would agree.

MR. MILLER: I have no further questions, Your Honor.

THE WITNESS: Redirect?

MR. JAZIL: Nothing, Your Honor. Thank you.

THE COURT: Thank you, Dr. Lappert. You may step down.

Please call your next witness.

MR. PERKO: Defense calls Dr. Kristopher Kaliebe.

DEPUTY CLERK: Please raise your right hand.

KRISTOPHER EDWARD KALIEBE, DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: My full name is Kristopher Edward Kaliebe. The last name is K-a-l-i-e-b-e.

DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Kaliebe, you might also want to spell your first name.

A. Oh, yeah. Kristopher is with a K., K-r-i-s-t-o-p-h-e-r.

Q. Dr. Kaliebe, what positions do you presently hold?

A. Yeah. I was just promoted to full professor at the University of South Florida in the department of psychiatry and neuroscience, and I teach there. I have a clinic which is an adult psychiatry clinic which is a resident clinic. The residents work with me.

I have a child psychiatry clinic, which the child psychiatry fellows who are trainees or adults who are training in child psychiatry do see patients with me.

I cover Tampa General Hospital on nights and weekends. I do some collaborative care with pediatricians around the state with the Medicaid hotline, and I also work in juvenile corrections. In addition to that, I do private forensic work.

Q. What did you do before you came to the University of South Florida?

A. Well, for 11 years, I was on staff at the Louisiana State University Health Science Center in New Orleans. So I started off as an assistant professor, and by the time I left, I was promoted to associate professor at LSU. There, I worked mostly in what are called federally qualified health centers. Those are centers where they have to have an underserved or disadvantaged population. I had one clinic that was outside of New Orleans, which is sort of -- it's a primary care setting where you're in a primary care setting, but you're doing psychiatric care.

So at that clinic, I saw about 80 percent children and 20 percent adults. About five years into being at LSU, we started to do a collaborative care initiative where we would go into family practice docs, pediatricians' offices, and this type of thing. Either you'd beam in via telepsychiatry or you'd do colocated or collaborative care onsite.

And you would go in and you would help those people, like handle mental health issues, you know, within primary care. They would still kind of own the patient, but you would be a consultant and help out.

In addition to that, I was doing lots of teaching of medical students, psychologists, you know, child psychiatry fellows, general psychiatry. I taught the psychotherapy

course for the residents in psychiatry. I was teaching their yearlong CBT course for much of that time. I also worked in juvenile corrections and a little bit in adult corrections during that time.

Q. What was your work with the corrections?

A. Well, ever since I finished my forensic psychiatry fellowship in 2005, I have worked in juvenile corrections. That includes in detention centers but also in what are called correctional centers, so detentions before you got locked up for a short term and the correctional centers are more longer term. I did do a little bit of adult correctional work also.

Q. What did that work involve?

A. Well, all work in corrections, you get an assessment, everyone, and a child when they come into the facility gets assessed. So I would do an assessment for everyone at the facility that was under my care, or if I was the only psychiatrist, then it would be everyone. And then you treat, following up everyone on medications and then also some, you may just follow up also for psychotherapies or other stuff, too.

Q. Could you please summarize your educational background?

A. Sure. I have a BA in biochemistry from Columbia University. I graduated from St. George's University School of Medicine. I went to -- I did my adult or general

psychiatry residency at UMDNJ at Newark which is now called Rutgers, so they have changed the name. So that would be Rutgers Newark.

I did a child psychiatry fellowship at LSU Health Science Center in New Orleans. I was chief resident during that time. And then I also did a forensic psychiatry fellowship.

Q. Have you authored any peer-reviewed publications?

A. I believe I have ten peer-reviewed publications.

Q. Have you served as a reviewer for any journals?

A. Yes. I probably can't remember the names of all of the journals, but I know for Pediatrics and Adolescent Health, I think it is. So probably for maybe about four journals I have done reviews.

Q. Are those journals listed on your CV?

A. Yes, it should be all on my CV.

Q. Are you member of any professional associations?

A. Yeah. I'm a member of the American Academy of Psychiatry and the Law. I'm a member of the American Psychiatric Association. And for the American Academy of Child and Adolescent Psychiatry, I was a co-chair of the media committee there from 2013 to 2021.

I was the liaison between the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics, I believe from 2015 to 2022. And I'm also a distinguished fellow at the American Academy of Child and

Adolescent Psychiatry, which was awarded in 2016.

Q. Have you received any awards for your work as a psychiatrist?

A. Yes. I was two years out of my residency in 2007, was the first time that I both a Best Doctors' award which is a peer recognition award for physicians. So I've continually received Best Doctors since then. So every year I've continued to get Best Doctors.

And I consider it a recognition that I was elected to office within what's called the Louisiana Council for Child Psychiatry. That is the state branch of ACAP, which is the American Academy of Child and Adolescent Psychiatry. I was the secretary-treasurer for a few years, but I was elected president also for two years.

Q. Do you have any clinical experience with gender dysphoria?

A. Yes, I do.

Q. Could you explain what that is?

A. Gender dysphoria is a condition where there is an incongruence between someone's gender identity or sense of self and their biological sex. It's a condition where they have intense distress related to that, and that distress causes a problem in functioning somewhere, at work, school, somewhere in their life. It has to be around for at least six months in order to meet criteria.

Q. I was really asking: Can you explain your clinical experience?
A. Yeah. I can see or treat patients with gender dysphoria in any of the places where I work which would include the adult psychiatry clinics at the University of South Florida. It would include the child clinics at the University of South Florida. It would include within juvenile corrections or in any of my consultation work.
Q. And do you keep up with the scientific literature regarding treatments for gender dysphoria?
A. Yes, I do.
Q. Why is that?
A. Well, it's essential, because I see patients, for one, so it's important for me to provide the best care to anyone who comes and sees me. So, of course, I want to be up to date on everything that I do. So I've following it in that regard.
Also, as a faculty member who does a lot of teaching, I have residents, you know, medical students, child psychiatry fellows, they all work underneath me, and so I need to be able to know what the literature is and teach them while we're seeing patients.
Q. Dr. Kaliebe, did you attach a copy of your curriculum vitae to your expert report in this case?
A. I believe I did.
Q. Is that a complete and accurate description of your

professional experience?
A. It may a little dated at this time; but, yes, I believe I submitted one.
MR. PERKO: Your Honor, I believe that is on the stipulated exhibit list as Exhibit DX30, and I'd ask it be admitted at this time.
THE COURT: DX30 is admitted.
(DEFENDANTS' EXHIBIT NO. 30: Received in evidence.)
MR. PERKO: And, Your Honor, at this time, we tender Dr. Kaliebe as an expert in psychiatry.
THE COURT: Questions at this time?
MR. GONZALEZ-PAGAN: Just briefly some questions for voir dire, Your Honor.

VOIR DIRE EXAMINATION

BY MR. GONZALEZ-PAGAN:
Q. Good afternoon, Dr. Kaliebe. Nice to you see you again.
A. Uh-huh, good to see you, too.
Q. Dr. Kaliebe, you have not published any literature regarding gender dysphoria; is that right?
A. That's correct.
Q. Or you have not published any literature regarding transgender people; is that right?
A. Correct.
Q. You have not done any original scientific research with regards to gender dysphoria?

A. That's correct.
Q. Nor have you done any original scientific research with regards to transgender people?
A. Correct.
Q. Or gender identity?
A. Correct.
Q. And you do not provide medical treatment for gender dysphoria?
A. Are you saying I do not administer hormones or surgeries? That is correct.
Q. And you were deposed in this case, if you recall?
A. Correct, yes.
Q. Previously you testified that, throughout your career, you have only diagnosed approximately a dozen patients with gender dysphoria.
A. Correct.
Q. And you have previously testified that some of these dozen patients have gone on to receive gender-affirming medical treatment; is that right?
A. Correct.
Q. You also testified that you would not be providing any treatment directly addressing this patient's gender dysphoria but rather providing treatment for their comorbidities; is that correct?
A. Well, I'm not sure exactly what the question was last

time, but I do believe that providing psychotherapy can also help with gender dysphoria. So usually when you have a patient come in, you're just trying to get to know them as best you can and provide the best care that you can. I wouldn't rule out that providing psychotherapy to them helps them also with their gender dysphoria, but I just come in and treat a patient as I see them and try to do the best care that I can.

Q. Understood. Thank you.

You actually, for regular psychotherapy, you refer your patients out; is that correct?

A. Well, I actually do do a lot of psychotherapy myself, and I am quite experienced and well-trained in psychotherapy. It is a tradition in psychiatry that we do export out because we have a lot of patients and only so much time for psychotherapy. It depends what setting and in what situation.

So I do do a fair amount of psychotherapy, but I'm also often -- more often referring people out for psychotherapy because there is only so much time that I have and ability to follow up.

Q. Dr. Kaliebe, I'm just showing a transcript of your deposition in this case.

Do you recall that it was taken on March 20, 2023?

A. Yes.

Q. And specifically you stated:

I don't know that what we would say we were giving therapy for gender dysphoria.

Those are your words, correct?

A. Correct. Yes; that's correct.

Q. So I guess, are you saying now that you treat gender dysphoria as part of your practice?

A. Well, I think when you are giving psychotherapy, you are treating the whole person, and that would include the mix of mental health concerns that they have, and I think that does include gender dysphoria, plus anxiety, depression, ADHD, autism, whatever else are comorbid.

So I think -- how I read that question before, are you like particularly -- when you see a patient with gender dysphoria, are you particularly honing in on the gender dysphoria as the thing that you are going to talk about in psychotherapy? I think you do therapy open to whatever will be most helpful. It may delve into issues related to gender dysphoria or it may not, depending on what happens with the patient.

Q. Okay. With your dozen patients that you have diagnosed or so, have you specifically sought to address their gender dysphoria with psychotherapy?

A. Well, I would say -- I would say, yes, in that, when you are doing general therapy with a patient, especially a

younger person, and you're talking to them about all of the issues in their life and exploring what's going on, that that would be and could be addressing their gender dysphoria. Although, when someone has a number of comorbidities, I'm not directly going at their connection between their body and their gender identity and the distress. If it comes to that, and they are willing to talk about that and they want to talk about it, I'm open to do that.

Q. But you previously testified that providing treatment for comorbidities doesn't necessarily address a patient's gender dysphoria?

A. Correct. It may or may not, yes.

MR. GONZALEZ-PAGAN: Your Honor, at this time we would posit that Dr. Kaliebe may be able to testify as to the diagnosis and assessment of gender dysphoria, and otherwise not speak about treatment of gender dysphoria, certainly not medical treatment of gender dysphoria.

THE COURT: Well, if we get to particular questions that you think he doesn't have the expertise to address, then object to them.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

THE COURT: I did have one question along those same lines.

Dr. Kaliebe, you treated 12 patients who have gender identity issues. How many of those were adults and how many

children?

THE WITNESS: I would have to also add that I have treated a number of patients since then. So the number is now -- that is what I gave at the deposition. But I did pick up that adult clinic, so I have a number more. So I have, you know, maybe four or five adult patients that I have now at least seen or overseen. Mostly it has been child -- I mostly functioned as a child psychiatrist and my child psychiatry clinic has been longer, so it's been mostly child.

THE COURT: So most of the 12 were children and --

THE WITNESS: And in the child clinic, you age out at 18. Sometimes we keep them on if there is something going on. And then in juvenile corrections, you know, I have had people who have aged into being 18 but came in before 18.

THE COURT: In talking with the children in the group of 12, I understand you're treating the whole patient. So you are trying to figure out what's going on. And do you sometimes talk specifically about gender identity?

THE WITNESS: I would like to get to a place where we are able to talk about it, and I would like to have openings to do that. It kind of depends on how close you are with the patient and what's going on. And I'm often working with others. It's multi-disciplinary team.

Like in juvenile corrections, all the patients I work with also have a therapist. So I'm working with their

therapist and seeing the person myself. So I will -- I'm willing to open those doors, but if that is a door that the therapist who does see them more often than me -- although, in reality, within a lot of the places I work, I'm actually the most experienced therapist there.

So they depend on me to sort of understand what's going on with the patient and make some suggestions where therapy may or may not go. So, yes, I think it would be great to explore those things. I think you don't want to push hard on things that are going to be overly sensitive.

THE COURT: That answer was kind of how you ought to do it. I was really asking what you actually did.

THE WITNESS: Okay.

THE COURT: So of the however many of those 12 children, how many did you actually talk about gender identity with?

THE WITNESS: Well, when you say "talk about," are you saying -- you know, because there's different depths of talking. Obviously, you do some reviews and find out what's going on. You're talking like more in depth. Is that the question? You're going to just ask questions about those things, just as diagnostically, that's a different --

THE COURT: Fair enough. More than just -- I don't know what that distinction would be in real life. You are talking to a patient, and the patient is, say, male assigned

at birth and says, "I'm really a girl," I'm guessing you don't just move on. That seems to be a show stopper, and surely you talk about that little bit, right?

THE WITNESS: Correct.

THE COURT: So I don't understand the differences. Did you really talk about it? Well, yeah, I assume if the child says that, then you really talk about it at least a little bit.

My question: Did you talk at least a little bit with how many of those 12 on the subject of gender identity?

THE WITNESS: Yes. So I would probably say that, you know, obviously, like I'm saying, we are doing superficial work some of the time, because we are just assessing, they are coming in, I'm working with other people. So I would say four of the group that I know well or have known for years even, so there's four that I have had more in-depth type. If that is what you're saying, more exploratory-type work, yes.

THE COURT: So real discussion about gender identity for children.

THE WITNESS: Correct, yes.

THE COURT: You may proceed.

MR. PERKO: Thank you, Your Honor.

DIRECT EXAMINATION

CONTINUED BY MR. PERKO:

Q. Dr. Kaliebe, what were you asked to do in this case?

A. I was asked to review the evidence-base regarding gender dysphoria. I was asked to speak about the increase in patients presenting with gender dysphoria. I was asked to talk about the scholarly and scientific dialogue related to gender dysphoria, and I was asked to talk about psychotherapy and other treatments for gender dysphoria.

Q. When you said evidence-base for gender dysphoria, did you mean evidence-base for gender-affirming treatments?

A. Treatments, yes.

Q. What did you do in order to assess the evidence-base supporting gender-affirming treatments?

A. Well, I have been actively involved in trying to figure out what is the evidence-base and what the best treatment is. Obviously, it is very complex science. I would say I have reviewed at least 50 papers that are directly related to gender dysphoria treatment. I go to conferences, and I particularly have been trying to see all of the presentations at APA, or the American Psychiatric Association, so that I'm up to date.

I have done the online review. I did an online review from the American Psychiatric Association.

In terms of reviewing the literature, I, of course, specifically looked at the systematic reviews and some of the other forms of coalescing the research to get a good idea of what the overall evidence-base is.

Q. Can you name some of the systematic reviews that you reviewed?
A. Well, there were systematic reviews done by Finland, by Sweden, they were done in England, and the Endocrine Society relied on reviews when they were making their recommendations, and then there was the review in the Florida report.
Q. What did you conclude about the evidence-base supporting gender-affirming treatments?
A. Well, overall the evidence-base is low quality, and that is consistent with all of the reviews.
Q. Did you review the report by Brignardello-Petersen and Wiercioch attached to the GAPMS report?
A. I did.
Q. And what did you conclude from that?
A. Well, it was similar to the other reviews in that it looked at -- it used a systematic method to review the evidence, and it did come to the conclusion that the evidence-base was overall low quality.
Q. Does the fact that the Brignardello-Petersen report is not peer-reviewed give you any pause for concern?
A. No, because for one, the -- one of the authors is a clinical epidemiologist from McMaster University, which is one of the premier, you know, where they developed the GRADE system. And for, two, the conclusions were similar to the

other reviews. So it wasn't really much different in terms of the conclusion.

Q. You mentioned that you were asked to discuss the recent increase in gender dysphoric diagnosis.

Can you please elaborate on that?

A. Yes. So the DSM-5, which was published in 2013, rated the incidents of gender dysphoria as 2 to 14 per hundred thousand, in 2013, right? So that's a very low number compared to what the current amount is. And that's consistent with my career. When I was medical school for four years, three psychiatry residences, and 11 years of practice in Louisiana, I didn't have a single patient present, complaining of gender dysphoria.

And I worked in multi-disciplinary teams. I consulted with pediatricians. I had medical students, psychologists. No one was seeing patients presenting with gender dysphoria, other than the very rare patient, and it just happened that I didn't get one of those rare patients.

And then now more recently, we have patients all of the time coming with gender dysphoria. So something has really significantly changed, and it's quite a puzzle. I had a clinic. I saw two patients with gender dysphoria yesterday. I had a clinic earlier in the year with three patients with gender dysphoria. So after years of not seeing patients with gender dysphoria, now we're seeing a huge increase.

Q. What are some of the --

THE COURT: I'm sorry. We just went through this, and it was 12 patients and four or five since then. And I asked you some more questions, and you had had a real discussion with four children. And now you say you see them all of the time. I don't get it. If you see them all of the time, how did we not get to more than 16 or 17?

THE WITNESS: I was comparing the incidents of what we are seeing now, compared to my whole career up -- for my first 20 years of not seeing a single patient, and now in one clinic seeing two patients or three patients, that's a huge increase from what it was. Maybe the way I said it, it wasn't as eloquent as it could have been, but that's a significant change.

THE COURT: Look, I'm going to be the least eloquent guy in the room. I'm not worried about how eloquently you said it. I just didn't seem to understand that. I thought, after the initial questions about your background, when I asked questions, I thought I had nailed this down. Twelve patients until recently. When you took over the adult clinic, you saw four of five more. So that seems to me 16 or 17 lifetime.

THE WITNESS: Correct.

THE COURT: But just a minute ago in response to Mr. Perko's question, you now said -- you didn't say

avalanche, but that was sort of it. We are now seeing something along those lines. We're seeing them all of the time. I just thought something you are seeing all of the time, if you have seen 17 in your life, that didn't seem to square. So that's why I stopped to say, what did I miss? I either misunderstood the prior testimony or I misunderstood what you just told me, or I'm misunderstanding something. So what is it?

THE WITNESS: Well, when you have a busy, busy career -- I mean, as a resident you see a ton of patients, in medical school you see a lot of patients. You work for a long time not seeing these patients, and then now you're seeing them, something has changed. Now, I don't know --

THE COURT: You are seeing them as what, four or five people?

THE WITNESS: Well, from a diagnosis that you didn't see at all for 20 years within medicine, it's a significant difference, yes.

THE COURT: All right. Got it.

THE WITNESS: Twenty years is a lot of time to be practicing psychiatry.

THE COURT: Look, I started to tell you when you started, it was evident to me, even before the other side started asking questions about qualifications, you have done a lot of stuff. You are a high energy guy, and I respect that.

I was going to tell you -- I was going to bring it up because the court reporter would appreciate it if you slow down a little bit; and, frankly, you are high energy guy. So got it.

THE WITNESS: I'll try.

BY MR. PERKO:

Q. Doctor, what are some of the potential reasons for an increase in gender dysphoria diagnoses?

A. Well, as we heard earlier today, any kind of psychiatric diagnosis -- and I think this included -- is a combination of, like, individual factors in the person. But also it's subject to, like, social, family, cultural factors. And, obviously, our genes have not changed in the last 30 years, but our society has quite a lot.

And so when you look, when you this rise in patients during that time, you also can see some parallel rises. For one, we just have more kids with depression and anxiety, and I think things have gotten harder for our kids. And so there are more kids that are struggling. We have an opiate epidemic and all sorts of other things that are contributors to kids having problems.

Then, in addition, it is clear, if you look at the literature with how stuff spreads through things like social media, there are social factors even with health, even with like heart disease, who you're around, who you spend time

with, that very much affects what kind of health you have and what kind of psychiatric or psychological problems.

There is even data going back to the Victorian era about how culture and the effects of society and how medicine characterizes illnesses changes how people present their suffering. And so that has changed through the years in different ways based on our diagnoses and views at the time.

In addition, we know that these media and social related, what some people would call contagions, have been shown for tic disorders and movement disorders, dissociative identity disorders, eating disorders, self harm, suicidality, all that stuff is in the literature, that those can spread through electronics. So there seems to be some mix of culture and stuff spreads more easily and more these days than it did before. That's my best guess.

Q. Doctor, you said you were also asked to comment on the status of the debate about gender-affirming treatments. Could you elaborate?

A. Yes. In my opinion the debate is quite dysfunctional. It's become very different from any type of debate that I have ever seen in the medical literature. At some point it seems like the major medical organizations, and I would say in particular the American Academy of Pediatrics, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, and the Endocrine Society, at some

point they decided that gender-affirming treatments were -- had a very strong evidence-base and that they also were morally or ethically the right type of treatment.

And it seems that since those organizations have come to that conclusion, that they have been really pushing that idea. And when they come out with press releases and when they are in the news promoting that type of treatment, clearly, the editors of their journals know what the major organizations are doing, and it seems that that has shut down the normal -- I mean, a lot of these proclamations from the professional organizations, I keep up with the literature and read it. I didn't see a back and forth in the journals about, well, this is the benefits of this going forward, this is the risk of this going forward. But all of a sudden we were presented with gender-affirming treatments as the only treatment.

In addition, like Dr. Levine was saying before, I attended his APA meeting, and I've never seen presenters treated as badly at a medical conference. I mean, it was quite unbelievable. The people who got up to ask questions afterwards were all, you know, heaping negativity and invective on the presenters rather than just asking -- it was a very thoughtful presentation, and it would give you pause to ever want to present at a conference when you see that.

Furthermore, you just see that the -- I myself have been

trying to get presentations in the -- especially in the child psychiatry realm, and I had one rejected last year. We had a research symposium, which I think in a highly unusual manner was rejected last year.

This year I had one of the high up, an M.D. and researcher from Finland, an M.D. and researcher from Sweden, I had a handpicked clinician who is a specialist in gender care from England, and I had the past president of the American Academy of Pediatrics, and I submitted to do a panel at the Child Psychiatry Conference, who says they love to have international work and international presenters, we got rejected.

I also asked to present from Sweden the same researcher, from Finland the same researcher, a researcher from England. Again, as a discussant, the former president of the American Academy of Pediatrics, again, shot down.

So it just seems that somehow if you're not -- anything is skeptical in your request to be on stage or get to be heard, you get shot down.

Q. Dr. Kaliebe, what are the types of psychotherapy and other alternative treatments are there for gender dysphoria?

A. Well, I think that, as we heard earlier, there's -- psychotherapy is a classic mental health approach. We've been doing psychotherapy for a very long time for all sorts of problems with people.

Psychotherapy, such as cognitive behavioral therapy, has been shown to be helpful for anxiety disorders of all types, trauma-related disorders, depressive disorders, personalities disorders, you know, eating disorders.

So we have a long history of success with psychotherapy for those disorders. Until recently, there wasn't as large of a population base with gender dysphoria and -- because it's hard to do studies and for many multiple other reasons. It seems like we don't -- we have not yet developed specialized treatments that are psychotherapies or they're kind of in their infancy for gender dysphoria compared to some of those other things that have been shown to be effective. But I don't see any reason that we couldn't come up with effective psychotherapies for -- for that.

In addition, there are modern twists on therapy that we could add that I think would make therapies even better. There is a very good evidence-base for mindfulness as a treatment for a number of mental health conditions, and mindfulness is just a mediation where you tune into your body, you get out of the future, you get out of the past. And when you spend time with that type of meditation, it helps you calm. It has very good evidence for depression, anxiety, a number of things. And there are moving mediations, I think Yoga was a particularly good one, that help you get more in touch with your body. And many trauma

experts actually really recommend those.

So I think we could add on some of these more modern techniques to some of the classic therapies in order to treat gender dysphoria.

MR. PERKO: Thank you, Your Honor. I have no further questions.

THE COURT: Cross-examine?

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Kaliebe, you would agree that gender dysphoria is a real condition that requires treatment?

A. Correct.

Q. You provided some testimony just earlier about the number of people presenting for care. Do you recall that?

A. Correct.

Q. You previously testified that the fact that more people have been showing up at clinics could be, could be explained by, (a), that the care is more available; and, (b), that more people feel comfortable seeking care; is that correct?

A. Yes.

Q. You were just discussing some more modern techniques to possibly consider for treatment for gender dysphoria; is that right?

A. Yes.

Q. Gender dysphoria has been an established diagnosis in 2013; is that correct?
A. Yes.
Q. And gender identity disorder was an established diagnosis from 1980 to 2013; is that correct?
A. Yes.
Q. And so are you saying that over the last 43 years nobody has studied the use of psychotherapy to treat this diagnosis?
A. Correct. I mean, there is some case reviews or minor -- I mean, there is some literature, but there is very little literature out there.
Q. And with regards to mindfulness, you previously testified -- well, you discuss as part of mindfulness the possible use of yoga in your report as a treatment for gender dysphoria; is that right?
A. Yes. It could be a component of treatment, yes.
Q. And you have previously testified that yoga has not been shown to effectively resolve any mental health conditions; is that correct?
A. Well, I just actually read -- we had a grand rounds presentation last week at USF, and he cited multiple systematic reviews on yoga. And they were quite positive actually. So I could revise my answer that the evidence-base for yoga is actually more impressive than I thought, and those are specifically for depression and anxiety.

Q. And they were studying yoga as a treatment for depression and anxiety?
A. Correct.
Q. And what's the name of the study?
A. Well, I don't have it in front of me, but there's two -- there's more than one, but there were two systematic reviews that were presented at the grand rounds last Thursday.
Q. I'm sorry. I was a little confused. Was it one or was it two?
A. There were two different studies that were systematic reviews of yoga that were presented. One of the residents did grand rounds, and he presented. So I don't have the names in front of me. I can easily find them for you, but it was two different systematic reviews that both found quite good results actually.
Q. And you had reserved the opportunity to supplement your opinions in this case, right?
A. Yes.
Q. You did not provide a supplemental report discussing these studies; is that correct?
A. No.
Q. Okay. You previously testified about social contagion as a possibility to explain the rise in gender dysphoria as you consider it?
A. Correct.

Q. You've also previously testified that you are hypothesizing on this point; is that right?
A. I think the evidence is pretty compelling, but I think it is -- how should I say -- there is -- everything is multifactorial. So I don't know that it's a complete solution, but it seems consistent with the evidence.
Q. I'm just asking if it's a hypothesis or a proven phenomenon.
A. Well, social contagion itself does seem to be a known and proven phenomenon, and it does -- in my opinion, it is in play in this situation.
Q. But is social contagion a proven phenomenon for gender dysphoria?
A. Proven?
Q. Yes.
A. I think that it's debatable. I think it's debatable.
Q. So you don't know?
A. I believe it to be a component of the rise in gender dysphoria. I think that's consistent with the evidence.
Q. I understand that's your belief, Dr. Kaliebe. I'm not trying to be difficult. I'm just asking: Is it a proven thing? Are there any studies documenting it?
A. Well, actually, if you look at the most recent Psychiatric Times, Paul Weigle just wrote an article on social contagion. So it's the Psychiatric Times that just

came out. And he talks about psychiatric contagion in a number of disorders, and he actually mentions the polls that were done at the American Psychiatric Association where 80 percent of doctors at the American Psychiatric Association said that either often or very often they thought that social media had influenced their patients' presentation of gender identity.

So I think it's not just me. I think a lot of practicing child psychiatrists believe that.

Q. And the Psychiatric Times, that's not a peer-reviewed scientific publication, right?

A. No, it's not.

Q. You previously testified that --

THE COURT: Let me -- let me tell you for -- just a comment in general.

I've listened to this again and again, and nobody is objecting, and I usually just sit here quietly. If there was a jury in the box, I wouldn't say a word.

If you are going to impeach a witness with what the witness has said previously, first, you have to ask the question. So if he's testifying, and he has not said anything about color the traffic signal is in a case involving a wreck, and he previously told you in a deposition that the light was green, then what you have to do to do this properly is say, what color was the light? And when he says red, you can trot

out the deposition where he said green. The right way to do it is not to say, didn't you previously testify that the light was green?

Now, I bring that up only because I take it you are trying to impress me. You would do much better if you just asked the witness -- and a lot of times he will tell you the same thing today that he told you at the deposition.

MR. GONZALEZ-PAGAN: Understood, Your Honor. I ask for your forgiveness on this.

BY MR. GONZALEZ-PAGAN:

Q. Dr. Kaliebe, would you agree that in particular small populations that tend to be isolated and/or discrete, tend to turn to social media actually as a way to connect and find one another?

A. Yes, I can -- I can definitely concur.

Q. During your direct you discussed a little bit some of the opinions and even during our exchange some of the opinions of -- your discussions with regards to other psychiatrists and their experiences. Do you recall that?

A. Yes.

Q. Would you agree that those conversations are not representative -- are not a representative sample of all childhood adolescent psychiatrists?

A. I believe my interactions with child and adolescent psychiatrists is about as representative as any one could be.

So, yes, there is no one individual whose their social network or those people that they talked to would totally capture all of child psychiatry. I do know people from very different parts of child psychiatry are quite a varied group, so I believe it's somewhat representative.

Q. Dr. Kaliebe, when you were asked:

Your conversations are not a representative sample of all childhood adolescent psychiatrists. Would you agree with that?

You previously answered: *Correct.*

A. Correct, and I still agree with that, but I gave the caveat that I believe that I really know a diverse amount of child psychiatrists. So I'm as representative as you could be kind of. I mean, no one person would be representative of -- their social network could never be representative of the whole.

Q. You previously discussed the breakdown in academic debate, if you will, regarding this condition and the treatment thereof; is that right?

A. Correct.

Q. The Endocrine Society has published letters to the editor that are critical of gender-affirming care.

Am I correct on that?

A. I believe once or twice, yes.

Q. And when asked earlier about your review of the

literature, I believe you mentioned that you have reviewed 50 papers or so, and that you relied your opinions with regards to the scientific evidence for treatment on the systematic reviews that you had reviewed.

Am I understanding your testimony correctly?

A. Yes.

Q. And you cited to the reports from Sweden and Finland and the report from Brignardello-Petersen; is that right?

A. Yes. The systematic reviews are, of course, important.

Q. None of those are published peer-reviewed literature; is that correct?

A. No. That is correct, although they are -- well, I did mention -- well, I didn't mention, but WPATH themselves had commissioned a systematic review which had similar conclusions, and that is published.

Q. But with regard to Sweden and Finland and Brignardello-Petersen, those are not published peer-reviewed literature?

A. Correct.

Q. And in your report, you only cited to four original studies. Am I correct on that?

A. Correct.

Q. So you didn't review or at least discuss in your report any original studies beyond those four?

A. Well, I only cited some studies. I had read many, many

more. So I think I used all of the studies that I know about to help me form my opinion, but I don't have to specifically cite them all, so that's why there was only four.

MR. GONZALEZ-PAGAN: No more questions, Your Honor.

THE COURT: Redirect?

MR. PERKO: No, Your Honor.

THE COURT: Dr. Kaliebe, you talked about therapy. We can probably all use therapy from time to time, and I don't doubt its usefulness. That's not the point of the questions.

I take it that a goal of therapy -- and I'm talking about psychiatric therapy, the kind of thing you do for patients. The goal of therapy or one goal of therapy is to reduce the patient's distress.

THE WITNESS: Correct.

THE COURT: And if the patient has distress over gender identity, a goal would be to reduce the patient's stress over gender identity. True?

THE WITNESS: Correct.

THE COURT: In your view, would a psychiatrist providing that kind of therapy to a person with distress over gender identity have as a goal either, one, reducing the distress by making the person comfortable with a gender identity aligned with sex assigned at birth; or, two, reducing distress by making the person more satisfied, less distressed over identifying as a gender other than the sex assigned at

birth; or, three, one of the other of those depending on the individual and the individual's own individual circumstances.

So which would be the goal, one, two, or three?

THE WITNESS: Well, I don't think the -- I think you could have different goals with different patients, so it may depend on the context of the patient and the person you are seeing.

THE COURT: That's probably answer three.

THE WITNESS: Well, yeah. And a lot of the way I would answer this question is: Are they still a developing individual? Right? Where if you are still developing, and we don't know what type of person you may eventually become, then I think getting you to come to peace with or accept or maybe even learn to love the body that you have while you are still developing is a laudable goal. And that could be a very good goal for most young people most of the time.

And I think you could be explicit about that. I don't think that -- that doesn't necessarily mean to change their gender identity, but more make them comfortable. Many kids are almost disembodied, you know, not in touch with their body.

THE COURT: I got all of that. What I'm trying to find out is: Are you okay with number two or -- look, it's perfectly okay to be morally opposed to trans treatment. You talked about the dysfunctional political debate. I don't

think I'm treading any new grounds when I say there are people engaged in the political debate who just don't believe there are trans people and don't believe that there is any real gender-identity difference.

We had somebody who had joined a brief earlier saying this is false identity. I don't have all the quotes, but they were pretty dramatic. You might have been in the courtroom.

And I'm just trying to find out whether that's your view. Are you in camp two? Is it never the proper therapy for the psychiatrist to assist the person in being comfortable with a gender different from the sex assigned at birth?

THE WITNESS: Well, what I would say is that there's a -- we don't have enough information, so it's not clear because that's just -- we don't have that science right now. And what I think for a developing person, my reading of the evidence, if you -- when we talk about the Dutch studies, I mean, they are not that impressive, honestly, because they don't map on to most of the populations that we are actually treating these days.

So they were like early onset, more male and didn't have a lot of comorbidities, when we're seeing patients with all of these comorbidities and problems. And so I think in an idealized world and in the real world that I live in, it's sort of two different things. The kids I have been seeing, I think really we need to be more --

THE COURT: All four of them.

THE WITNESS: Well, more in depth perhaps.

THE COURT: I'm sorry. I shouldn't have interrupted.

Look, I thought that was an easy answer. Yes, sometimes, number two is appropriate; or no, two is not appropriate. You launched into this long explanation, and I think what you told me is, for a developing adolescent, you don't think two is appropriate.

THE WITNESS: Yes, I do not believe that we should be doing hormones and surgeries for developing adolescents.

THE COURT: My question was therapy. And I think I take it from your answers that you don't think therapy that would make an adolescent comfortable with gender identity different from the sex assigned at birth is ever appropriate. Did I misunderstand it?

THE WITNESS: I would say a little bit. I think that we wouldn't have a goal of trying to change someone's gender identity in therapy. So I'm not trying to get to one particular result. It's more you want to -- so if that's the end result that they have a, you know, a gender identity opposite from their natal sex, I am fine with that. I'm not opposed to that.

I do think that you would have a leaning towards or it is sort of a better outcome for most kids most of the times, considering the comorbidities and everything going on,

that they come to peace with their natal sex because then they don't have all the problems that come from not having that, and the distress from not having that. But I'm okay with -- obviously, there are going to be people that are going to go on and be transgender and not be comfortable with their natal sex, so you could support that.

Is that a better answer? We were on different wavelengths, I'm guessing.

THE COURT: That's more what I was asking, exactly.

Questions to follow up on mine?

MR. PERKO: No, Your Honor.

MR. GONZALEZ-PAGAN: No, Your Honor.

THE COURT: Thank you, Dr. Kaliebe. You may step down.

THE WITNESS: Thank you.

THE COURT: We are probably coming up on the afternoon break. Where do we stand?

MR. JAZIL: Your Honor, we've run out of witnesses. We have Anne Dalton, Matt Brackett, and Dr. Scott left. Dr. Scott was planning on being here. She had a health issue arise, and she'll be available Monday, Your Honor.

THE COURT: My mother used to say once is a habit. You let the kid get chocolate milk one night, you are going to be giving out a lot of chocolate milk.

Remind me what Dr. Scott says.

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023 /s/ Mohammad O. Jazil

No. 23-12159

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME IX OF XIII

Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
(850) 274-1690

Counsel for Defendants-Appellants Florida Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

Ashley Moody
Attorney General of Florida

Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
(850) 414-3300

Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

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Dated: September 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Michael Beato
HOLTZMAN VOGEL BARAN TORCHINSKY & JOSEFIAK PLLC
119 South Monroe Street, Suite 500
Tallahassee, FL 32301
Phone: (850) 391-0503
Facsimile: (850) 741-1023
mjazil@holtzmanvogel.com
mbeato@holtzmanvogel.com
Counsel for Defendants-Appellants Surgeon General, Florida Department of Health, Florida Board of Medicine and Individual Members, and Florida Board of Osteopathic Medicine and Individual Members

/s/Joseph E. Hart
Henry C. Whitaker
Solicitor General
Joseph E. Hart
Counselor to the Attorney General
PL-01 the Capitol
Tallahassee, FL 32399
Phone: (850) 414-3300
henry.whitaker@myfloridalegal.com
joseph.hart@myfloridalegal.com
Counsel for Defendants-Appellants William Gladson, Florida Surgeon General, and Florida Department of Health

MR. JAZIL: Dr. Scott is the neuroscientist from the United Kingdom, Your Honor. She talks about the effects of puberty blockers on the brain. I expect her to be a short witness.

THE COURT: Is she still in the U.K.?

MR. JAZIL: Yes, Your Honor. We are making Zoom arrangements.

THE COURT: All right. Tell me what -- one of the things -- when I let the plaintiffs do this, one of the things I noted was you guys are in town so they are the ones being inconvenienced. Now it's the other way around; they are the ones that travel.

MR. GONZALEZ-PAGAN: Your Honor, we are happy to accommodate restarting tomorrow with the factual witnesses, if it's okay with the Court.

THE COURT: Outstanding. For all the dysfunctional political debate -- and these kind of cases get intense on the two sides, and the fact that all of the parties have been able to deal professionally with one another at the lawyer level is to be commended all the way around. That doesn't mean you should make a habit of not having your witnesses here, but I get it. So she'll be here Monday morning?

MR. JAZIL: Yes, Your Honor. By Zoom most likely. She's trying to figure out if she can travel.

THE COURT: We're going to put her on by Zoom anyway.

Do you need to wait till Monday for the Zoom witness?

MR. JAZIL: Your Honor, she's going through a medical emergency, so she's --

MR. GONZALEZ-PAGAN: Your Honor, just to clarify, my understanding is we would have the fact witnesses tomorrow.

MR. JAZIL: Yes.

THE COURT: You don't have the fact witnesses here now?

MR. JAZIL: Your Honor, one was in the courtroom and I let him go. I didn't think we would get to him.

THE COURT: Okay.

MR. JAZIL: I apologize, Your Honor, bad timing on my part. There are two fact witnesses. One fact witness will be very short, Anne Dalton. The other is Matt Brackett, the author of the GAPMS report.

THE COURT: All right. We can make all that work. Look, if the Monday witness is a Zoom witness, you need to talk with one another on the two sides. Let's don't have people flying back to Tallahassee for a Zoom. Although -- well, let's talk about this. We were going to do closings. We are going to some argument tomorrow morning at the preliminary injunction, but that's not closing in this case. We've got closings coming up, and I really would prefer to do that in person.

I can do this. If we have people on the team that

don't want to return and be here in person, we can probably set it up so that people could monitor the argument. But anybody that's going to argue and participate, it's just better in person. Let's do it in person. If everybody wants to come, that's fine. I'm not suggesting they shouldn't. I'm just giving you the option.

So what we have is two fact witnesses tomorrow, an expert witness Monday maybe in person, maybe by video.

MR. JAZIL: Most likely by video.

THE COURT: Most likely by video. And then closing argument.

MR. JAZIL: Yes, Your Honor.

MR. GONZALEZ-PAGAN: Your Honor, if I may, I believe the only other matter is we filed last night the motion to amend.

THE COURT: Yeah.

MR. GONZALEZ-PAGAN: We were waiting for the official position from --

THE COURT: Right. What do you say about the motion for leave to amend?

MR. JAZIL: I don't oppose the motion, Your Honor.

THE COURT: I'll grant it, and would. Unique circumstances. The rules, of course, allow an amendment right up to and even after trial. I'm not sure I ever let somebody amend other than on some little technical basis during the

trial, but it turned out that during the trial the new statute was signed and so it became a statute.

I have given you a 15-second reaction the other day. Thinking about it a little more, may stressed it incorrectly, I don't think the challenge to the rule is moot. I do think standing to challenge the rule goes hand-in-hand with the challenge to the statute.

If the statute was in place and unchallenged, then the rule wouldn't make any real difference and that would create a standing issue. But with the challenge to the statute, then the standing to challenge of the rule because if the statute got struck down and the rule is still there, you would still have the same adverse situation.

So you got standing to challenge both simultaneously. I don't think nominal damages keeps you in the game, but I don't think any of that matters with the statute now having been -- become effective. It took effect immediately, true?

MR. JAZIL: Yes, Your Honor.

THE COURT: So the statute is in effect. It's properly challenged. We will deal with the preliminary injunction on that in the other case in the morning.

What else can we take care of? Everything lined up? I think we've just got the witnesses and then closing arguments.

MR. JAZIL: Your Honor, in the other case you also

have a TRO now.

THE COURT: Same.

MR. GONZALEZ-PAGAN: Your Honor, I'm not counsel in the other case, but my co-counsel, Ms. Chriss and Ms. Dunn, are counsel in the other case, so they can speak to that.

MS. CHRISS: Yes, we filed the TRO motion.

THE COURT: And let me -- while I am thinking about it, hold the thought and let me --

In the case we're are here trying, the Dekker case, when I wrote the order after the pretrial conference, I gave a specific date as of which the -- it's in the second case, the Doe case.

After the scheduling conference in that case, I wrote an order saying that both sides had agreed to accept the record in the Dekker case as of a specific time. Frankly, I didn't recall whether we said that explicitly on the record when we were talking about it. But as I was putting the order together, it occurred to me that I probably ought to have a set date so we would know exactly what the record was, and the plaintiffs in Doe wouldn't necessarily have seen the evidence that's now come in.

Now we have got a lot of evidence that's been taken in Dekker, and so what I wanted to check on was: In the Doe case, for the preliminary injunction tomorrow morning, do you agree that the testimony that's been taken in the Dekker case

is part of the record in the Doe case for the preliminary injunction?

MS. CHRISS: Yes, Your Honor.

MR. JAZIL: Your Honor, one caveat. Since Dr. Scott hasn't testified, I would simply ask the Court to consider her expert report which we attached to the summary judgment motion, because at the preliminary injunction stage --

THE COURT: And I think that report would already be covered by the scheduling order I did, because that was part of the record already as of whatever that date was. So, yes, I will consider Dr. Scott's report. And for that matter, if I don't rule before the end of the testimony in this case, I would suggest that Dr. Scott's live testimony ought to be included as well and also the two witnesses you put on tomorrow morning.

Does that work?

MR. JAZIL: It works for me, Your Honor.

MS. CHRISS: Yes, Your Honor.

THE COURT: One of the questions I'm going to ask in the morning, and since you are here, you can probably tell me the answer right now:

What's going to happen, if anything, between tomorrow morning and Monday afternoon when we have closing arguments or, for that matter, the rest of the week, if I can get a ruling out next week? Is there any reason why you need a

ruling tomorrow morning as opposed to Monday afternoon as opposed to next Friday?

MS. CHRISS: Are you specifically talking about the preliminary injunction?

THE COURT: Yes.

MS. CHRISS: I mean, the same issues that you are already aware of that we briefed in terms of our plaintiffs are not able to access care that they need right now, two of our plaintiffs have started puberty and need to be prescribed hormones, are currently on blockers and are unable to be prescribed. So the longer they wait, the more harm accrues, but I don't think Friday or Monday is --

THE COURT: You can tell me more in the morning when you check on it. Here's my understanding of meds:

Sometimes you get a prescription, and it's good for the next three months, and then you get it refilled and -- or one month and you get it refilled.

So the question is, are you going to miss a refilling between tomorrow and a week from tomorrow, or is the timing such that that seven days doesn't matter?

MS. CHRISS: With respect to the two plaintiffs who are facing the most imminent harm, it's a new prescription, so they have not yet been prescribed hormones. They have been on blockers, and their physicians have deemed them ready to start hormones. And the only thing precluding that initial

prescription which could be written any time is the rule still being in effect. But then we face the same issue with the statute codifying the rule.

THE COURT: And I take it that the time to start this is a physician's judgment, but it's not an exact science. So whether it's the 19th or the 26th is just kind of a judgment call and probably not going to make all the difference.

MS. CHRISS: I would not disagree with that, Your Honor. I just want to reiterate the harm that these children are facing.

THE COURT: All right. And I ask partly because I've got to do my schedule. I've got a lot of work to do.

MS. CHRISS: Understood.

THE COURT: And the answer is the sooner, the better. Got it.

What else?

MR. JAZIL: Your Honor, should I be prepared to argue the TRO as well?

THE COURT: I don't know that the TRO is any different from the preliminary injunction. I think it's the -- it's the same thing.

MR. JAZIL: Should I be working --

THE COURT: I was on the rules committee in Florida very briefly back decades ago when Florida went back and changed it to only a single temporary injunction instead of a

TRO and preliminary injunction.

TROs are different if they're done without notice but, of course, we are not dealing with that here. There is no reason for a TRO. We are going to have a full extensive evidentiary record, and I'm going to make a ruling on a preliminary injunction. If I called it a temporary restraining order, you'd just have to go fight about whether that made it appealable or whether it had the 14 plus 14 limit.

In all practical respects, it's a preliminary injunction up or down. So I plan to have one ruling, and it won't matter that it's cast both ways.

MR. JAZIL: Your Honor, I haven't gone back and looked at the amended pleadings yet. My understanding is that the criminal liability provision is also being challenged. I just note that I don't speak for the State Attorneys who would be enforcing that position. I hate to add another wrinkle, but --

THE COURT: That's down the list of things to worry about. The biggest thing we need to worry about is whether the plaintiffs have a right to this treatment.

MR. GONZALEZ-PAGAN: Your Honor, if I may, one question, just to clarify, given that there's the amendment that occurred and the TRO has been filed as well, is the Court still intending for trial to begin at ten? We just want to

some clarity.

THE COURT: For the trial what, to begin at ten?

MR. GONZALEZ-PAGAN: Tomorrow.

THE COURT: Is that what I said?

MR. JAZIL: I thought it was nine.

THE COURT: I thought we were going to have the argument at 8:30.

MS. CHRISS: 8:30, yes.

THE COURT: 8:30 is when we said we're going to have the argument.

MR. GONZALEZ-PAGAN: For the Doe case.

THE COURT: Right.

MR. GONZALEZ-PAGAN: So for the trial in this case, are we -- should we just get here at nine and be ready to begin? I'm just trying to get some guidance from the Court on that.

THE COURT: Well, I would think you would be interested, and it's a public hearing. Aside from that, somebody -- I guess the courtroom deputy said should she set a time limit in the notice of hearing. We didn't do that.

My off-the-top-of-my-head thought was half an hour a side ought to be fine. I'll have read the materials but, you know, we will get into this, some exchange.

MR. GONZALEZ-PAGAN: We will be here.

THE COURT: I used to tell people when they were

asking for more time that you've already had more time than you would get if this was argued in the United States Supreme Court. Then the Supreme Court went and started going on for a long time, so that doesn't work as well anymore. But it seems to me half hour a side is what we are talking about.

Mr. Jazil, you raised the question about notice to the state and all those things. I didn't look back at the rule, but I think when you've got an official capacity defendant, you're probably there. They probably have to serve the AG, Attorney General. I don't know if you've done that.

MS. CHRISS: So, Your Honor, we discussed the motion to amend -- for leave to amend the other complaint. But for this complaint, if we have leave to amend, then we can go ahead and issue the summons and serve the new defendants.

THE COURT: Do you even need leave to amend? Can't you just amend?

MS. CHRISS: This is our second amended complaint, Your Honor.

THE COURT: Ah, you do need leave to amend.

Any reason they shouldn't get leave?

MR. JAZIL: In the Doe case, Your Honor, I don't oppose the motion.

THE COURT: So leave is granted. And, yeah, you can proceed to serve it. I don't think that is going to affect anything we are doing in the morning. I assume that Mr. Jazil

will be defending that case as well.

MR. JAZIL: As best I can, Your Honor.

THE COURT: Maybe depends on the ruling, who knows.

Nobody thought that was funny. Obviously it wasn't. When the judge tells a joke and nobody laughs, it's really not funny.

MR. JAZIL: He was just reminded me, Your Honor, to do something which I've already done.

THE COURT: All right. Very good. I'll see you tomorrow morning, same place, 8:30.

(*The proceedings adjourned at 3:10 p.m.*)

(*The proceedings resumed at 3:14 p.m.*)

THE COURT: Please be seated.

I didn't handle, Mr. Jazil, your question as well as I should have, and so I -- because I didn't have the context back.

The Attorney General and the State Attorneys have just been joined. So the TRO, preliminary injunction question becomes more important as to them and who is representing them becomes more important.

We've had various ones of these cases. Sometimes I think you've represented the State, but sometimes the Attorney General has other lawyers, too. And I guess what you are telling me is you're not sure what's going to happen here.

MR. JAZIL: No, Your Honor, I'm not sure. In the

past what's happened is the Attorney General's Office approves that I speak for them, and I just haven't had those conversations yet.

THE COURT: And often somebody in the Attorney General's Office has been on the pleadings.

MR. JAZIL: Yes, Your Honor, like Bill Stafford or others from the complex litigation division.

THE COURT: I'm trying to go back quickly and recall. We have had cases with the State Attorneys or others with -- your Jacobson case now gets everybody sued all over the state. So I've probably had school boards and election cases. You get the supervisors and the canvassing boards, and many times those folks have hired their own lawyers.

MR. JAZIL: Yes, Your Honor.

THE COURT: So part of this is the State Attorneys, and sometimes it gets to be a standing case and sometimes it's just a question of what do you really need to make this happen.

You talked about getting the Attorney General served. You're not going to get -- there must be 20 State Attorneys?

MR. JAZIL: 22, I think.

MS. CHRISS: It's 20, Your Honor, looking at names.

THE COURT: And so tomorrow morning, I mean, do they know? Have you told the people?

MS. CHRISS: Not yet. I was hoping to talk to

Mr. Jazil whether they would accept service or representing them or --

THE COURT: I think in one of these cases -- I'm trying to remember what the issue was because I only had it secondarily. But I know from the Warren case that he was the State Attorney in Hillsborough. He and all the other State Attorneys had been sued for something, and they entered an agreement that they would abide by the result, and they were all dismissed from the case. I think I'm remembering that correctly.

Whether that's something that can be done here or not, what you need to do to simplify this -- I'm not suggesting it, I'm just telling you that I know that at least in one other case underlying -- or discussed in the Warren versus DeSantis case that had come up. It may have been an election case.

Mr. Jazil, do you remember what the underlying case was, where they entered the agreement?

MR. JAZIL: Yes, Your Honor. There are several. In the election cases, the trend has now been there is a subset of the 67 supervisors of elections who entered into an agreement saying we will abide by whatever the Court decides. Just don't come after us for fees under 42 USC 1988.

THE COURT: That's supervisors.

MR. JAZIL: Yes, Your Honor.

THE COURT: How about State Attorneys?

MR. JAZIL: State Attorneys have taken the position in other cases, Your Honor, saying that we will abide by whatever the Court decides. We will serve as nominal defendants and they move on.

I can't recall the State Attorneys being sued in election cases. I think --

THE COURT: That could have been an abortion-related case. Somehow it came up in Warren versus DeSantis. An abortion case in --

Oh, that's what it was. It was the challenge to the abortion statute under the Florida constitution in Florida State Court, and I think the State Attorneys must have been in agreement that they would abide by the ruling, and so they got dismissed from the case.

Different standing issue, of course, in state court than in federal court. Some of that may be down the road, but the question is tomorrow morning we're going to have a hearing. There are going to be parties to the case that will have at most about 16 hours notice of the hearing. And so that brings the TRO back into play.

You can tell me now or you can address it in the morning, but part of the question is: What are we going to accomplish here? You've got doctors in Florida who want to write this prescription, but you may need to find out what

your doctor is willing to do.

MS. CHRISS: So if I may, Your Honor, I will note that part of what we challenged in the TRO, the provision of SP-245, Section 4, there's the ban on providing the care, which basically just codifies the Boards of Medicine and Osteopathic Medicine. And in fact, it gives the authority to the -- the unfortunate authority to the Boards of Medicine and Osteopathic Medicine to create emergency rules implementing SP-254, Section 4.

Then there is a provision that, if the doctor violates that provision, they can be held criminally liable. But I may be wrong and might need to think more about this, but since Mr. Jazil represents the boards and they are responsible for one of the provisions at issue here, if that were enjoined, I don't know that the criminal penalty would come into play.

THE COURT: Do you think the crime is only violated a rule that has not yet been adopted?

MS. CHRISS: I will -- I will think more and opine on that tomorrow, if that's okay.

THE COURT: Okay. You might want to check if it's feasible with your doctor to see what the doctor is going to need; because, frankly, if the doctor is not going to do it anyway, I'm certainly not going to enter an injunction telling the doctor to do anything, and the doctor is not a party to

the case. If the doctor is not going to do it anyway, then that's a whole different problem.

MS. CHRISS: Understood, Your Honor. We can definitely speak with them.

THE COURT: All right. I came back in. I don't think I accomplished anything other than to note the issue that we will need to clean up in the morning.

MR. GONZALEZ-PAGAN: Your Honor, if I might, just for clarity of the record, I believe the entire colloquy pertains to the Doe case and not this case. But I just wanted to clarify that.

THE COURT: It did.

MR. GONZALEZ-PAGAN: We are not adding any new parties.

THE COURT: Well, you need to think through whether you have a standing issue when you don't add additional parties. I don't know if you've looked back at the Jacobson case, but Mr. Jazil was in the case and I was not. It wasn't my case, so I'm not sure I'll describe it perfectly but it does come up again and again.

Here's the brief description: It was a challenge to an election provision, I think the order of the parties on the ballot. So the plaintiffs sued the Secretary of State who is the chief election officer, probably not a precise description, and another district judge in this district

entered an injunction about the order of the candidates on the ballot. The State appealed. The State didn't raise standing in the trial court, didn't raise standing in the brief on appeal. Said in oral argument, oh, there's a standing issue. Issues an opinion vacating the injunction. No standing.

So don't go thinking because I haven't addressed standing or the defense hasn't addressed standing that that means you don't have a standing problem.

MR. GONZALEZ-PAGAN: Yes.

THE COURT: And if what you're asking for in the Dekker case in your amended complaint, and I haven't -- I have been through it but I haven't studied it. But essentially what you are asking for is an injunction that would allow the plaintiffs to get the medical care that they and their parents and their doctor think they need. If it's going to be a crime for a doctor to provide that care, you need to think about whether you have to have somebody with criminal enforcement authority like the State Attorneys as defendants. Because at least if I understand the law of the Circuit, if the injunction wouldn't compel the relevant actors to do what it is you are trying to have done, then you don't have standing.

MR. GONZALEZ-PAGAN: Understood, Your Honor. We are happy to review that Jacobson case, and we did have a motion to amend, but we're happy to review that case and provide further briefing and argument.

THE COURT: And I'll confess, I went through the motion for leave to amend pretty quickly because I anticipated -- correctly, as it turns out -- that the defense probably wasn't going to contest it. And so as I said, I did read through your order, but I'm not sure I can pass the test on your motion.

MR. GONZALEZ-PAGAN: We'll make sure we're here.

THE COURT: Very good. This time I really mean it. We are adjourned for the day. I will see you at 8:30 in the morning.

(*The proceedings adjourned at 3:26 p.m.*)

* * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy are noted within the transcript.

Judy A. Gagnon *5/18/2023*

Judy A. Gagnon, RMR, FCRR Date
Registered Merit Reporter

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DEFENSE EXHIBITS

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Dekker v Weida: 4:22-cv-325

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE, FLORIDA

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
vs.	)	Tallahassee, Florida
	)	May 19, 2023
JASON WEIDA, et al.,	)	10:20 A.M.
	)	
Defendants.	)	
_____	)	

VOLUME VI
(Pages 1152 through 1262)

TRANSCRIPT OF SIXTH DAY OF BENCH TRIAL
BEFORE THE HONORABLE ROBERT L. HINKLE,
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiffs,

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.org
120 Wall Street
19th Floor
New York, New York 10005

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

APPEARANCES: Cont'd

For the Plaintiffs:

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: SHANI RIVAUX
Attorney at Law
shani.rivaux@pillsburylaw.com
600 Brickell Avenue, Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall, Suite 1800
Sacramento, California 95814

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: WILLIAM C. MILLER
GARY J. SHAW
Attorneys at Law
william.c.miller@pillsburylaw.com
gary.shaw@pillsburylaw.com
1200 17th Street NW
Washington, D.C. 20036

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorneys at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DeBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

National Health Law Program
By: CATHERINE ANNE McKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

APPEARANCES: Cont'd

For the Plaintiffs: National Health Law Program
By: ABIGAIL K. COURSOLLE
Attorney at Law
coursolle@healthlaw.org.
3701 Wilshire Boulevard
Suite 315
Los Angeles, California 90010

For the Defendants: Holtzman Vogel Baren,
Torchinsky & Josefiak, PLLC
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(*Call to order; parties present.*)

THE COURT: Please be seated.

Please call your next witness.

MR. BEATO: We call Ann Dalton to the stand, Your Honor.

DEPUTY CLERK: Please raise your right hand.

ANN DALTON, DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: Ann Dalton, D-a-l-t-o-n.

THE COURT: And why don't you spell Ann for us.

THE WITNESS: A-n-n.

DIRECT EXAMINATION

BY MR. BEATO:

Q. Good morning, Ms. Dalton. Just a few questions.

Where are you currently employed?

A. The Agency for Health Care Administration.

Q. And what is your current job at AHCA?

A. Currently I'm the Bureau Chief for the Bureau of Medicaid Policy at the Agency.

Q. What does that job entail?

A. As the Bureau Chief I oversee the Bureau, and the Bureau of Medicaid Policy is responsible for a lot of various

policy-related functions; primarily, the drafting and routing and execution of the Statewide Medicaid Managed Care Plan contracts, the maintenance of the various federal authorities that the State has with our federal partners at the Centers for Medicare and Medicaid Services; as well as drafting and promulgating rule the various coverage policies that really dictate the services that we provide through Medicaid, which includes the GAPMS rule and process; and up until recently, the Canadian Prescription Drug Importation Program.

Q. And we will get back to the program a little bit later on.

How long have you been in this role?

A. I have been Bureau Chief officially since August of 2021.

Q. And did you work for AHCA in any other roles before becoming the Bureau Chief?

A. Yes. I worked in the Bureau, specifically, at AHCA, in two management roles prior to becoming Bureau Chief. Immediately before Bureau Chief, I was an Agency for Health Care administrator, and then before that I was a program administrator in the Bureau.

Q. And so just briefly, what did those two jobs entailed?

A. As an AHCA administrator, I oversaw a unit, the unit specifically responsible for the federal authorities, and then the administrative rulemaking process. And then the program administrator position, I was responsible for a small

unit that primarily worked with the children's health insurance program, the eligibility policies. So working closely with the Department of Children and Families and a few other policy areas.

Q. And when were you in those two positions?

A. I started with the agency in January of 2018 as the program administrator, and had that position until August 2018, which is when I moved into the AHCA administrator role.

Q. So before your time at AHCA, where else did you work?

A. Prior to AHCA I was with the Department of Elder Affairs in various positions working with Medicaid long-term services and support, for a little over five years, since 2012.

Q. Okay. So remind us, what was your position in AHCA in April 2022?

A. In April 2022 I was the Bureau Chief of Medicaid Policy.

Q. And who was your immediate boss?

A. The Assistant Deputy Secretary for Medicaid Policy and Quality, who at the time was Jason Weida.

Q. And so how often did you speak with Mr. Weida when he was the Assistant Deputy Secretary?

A. All the time. I spoke with him daily, sometimes multiple times a day. He was somewhat new to the Agency, so we spent a lot of time kind of catching him up on the different functions that the Bureau was responsible for, and then also

talking about whatever the priority for the day or the week for the Agency was.

Q. Are you familiar with the GAPMS report on treatments for gender dysphoria?

A. Yes.

Q. When did you first become aware of this?

A. I became aware of the direction to do the report in April 2022.

Q. And how did you first become aware of this?

A. I was notified verbally that the Secretary was going to be directing our Medicaid director, who at the time was Tom Wallace, to be -- for the Bureau to undertake the task of the report.

Q. And what happened next?

A. I met with my direct report, Jason -- or my direct supervisor, Jason Weida.

Q. What did you talk with him about?

A. So we talked about the task, what that entailed, and then we talked about how best to move forward with accomplishing the task, and who would be working on the project.

Q. So the last thing you said, who would be working on the project, could you elaborate on that further?

A. Yes. I recommended that the Canadian Prescription Drug Importation team would be available to work on the reports.

Q. Okay. And just to break that answer down, what is the

Canadian Prescription Drug Importation Program?
A. That program was established legislatively in 2019, I believe, to direct the Agency to implement a program working with the federal government to allow us to import prescription drugs from Canada.
Q. Was it a high priority policy for the State?
A. Yes.
Q. And what was the status of that program in 2022?
A. So, in 2022 the Agency had done a lot of work trying to move forward, since it was a high priority, and had really reached the place where we couldn't go much further. We had submitted everything to the federal government, and we were really pending feedback from the federal government on next steps. So it was a little stagnant.
Q. Understood. And you said you recommended that program team. Who was on the team?
A. D.D. Pickle -- Devona Pickle, she goes by D.D. -- Matt Brackett, and Nai Chen.
Q. And why did you recommend Mr. Brackett?
A. I recommended Mr. Brackett specifically in the team for several reasons. Like I was just explaining with the Canadian Prescription Drug Importation Program kind of having a lull, the team had a lot of bandwidth. They had been doing other special projects for the Bureau and kind of stepping in where needed. And Matt Brackett specifically had a lot of

historical knowledge with the GAPMS process. He was previously the GAPMS analyst, he held that position before moving to a supervisory position and then into the role -- his current role. And I had a really strong rapport with the team, specifically Matt and D.D., since they had been with the Agency a pretty long time, and since I had been with the Agency, both in management positions when I first started. So I work closely with them on lots of projects. I knew their work. I knew they both had the historical knowledge, and I trusted that, you know, they could work independently and would deliver a really good product in a short amount of time.

Q. Understood. And sticking with Mr. Brackett, how would you describe Mr. Brackett's GAPMS knowledge?

A. So, my knowledge of GAPMS was somewhat limited when I took the role, and he was the primary source for me at the beginning to kind of get me up to speed with the historical, what GAPMS was, what the process was, you know, just the historical background. And it was my understanding that he worked on GAPMS and completed several GAPMS reports over the years.

Q. And what is Mr. Brackett's work product like?

A. It's very good. His work products come, since I have been his supervisor or in the chain of review, they come polished with very little to no revisions; there are

thoroughly researched; they are well written.
Q. And, generally speaking, what is like to work with Mr. Brackett?
A. My experience with Mr. Brackett has been very positive. I think he's a hard worker, I think he takes his job very seriously. He is kind of a go-to guy in the Bureau. I witnessed my supervisor before me also going to him for special research projects or to review or look at things because he is very knowledgeable and good at what he does.
Q. So abstracting out a little bit, why did you recommend Ms. Pickle?
A. A lot of the same. She had been with the Agency for a long time. She had a lot of -- she's a great manager. She really builds a team like environment, and so her teams have in my experience been very strong and worked well together. And she gives good direction, so she's a good manager, and ability to work with little direct oversight, to really work autonomously.
Q. And why did you recommend Mr. Chen?
A. I don't -- I didn't at the time know Mr. Chen that well. He hadn't been with the Agency that long. He was part of the team. I had witnessed the team working very well together. They had put forward very strong work products related to the Canadian Prescription Drug Importation Program. And he is a pharmacist. So I thought the team, as a whole, would be a

good choice.
Q. Are you familiar with an individual named Jeff English?
A. Yes.
Q. Who is he?
A. He was an employee at the Agency. He had two different positions in the Bureau. He was the analyst for GAPMS on Jesse Bottcher's team, and he was also the analyst or SPA coordinator on Cole Giering's team.
Q. And what was he specifically doing around April 2022?
A. He was the analyst, the GAPMS analyst.
Q. Why didn't you recommend him to draft the 2022 GAPMS report on treatments for gender dysphoria?
A. For the reasons that I stated before why I chose the or recommended the Canada Prescription Drug Importation team, that was the primary driver is knowing that there was a team that had a lot of bandwidth. This was a Secretary request, so it was a high priority. And having a strong team that I had a lot of experience with that I knew the work product was the primary factor in my recommendation.
Q. And does Mr. English, when he worked for the Agency, did he supervise anyone?
A. No.
Q. Who was Mr. English's supervisor?
A. Jesse Bottcher.
Q. And who was Mr. Bottcher's supervisor?

A. Me.
Q. And I would like to show you PX238. You can look on the screen.
Ms. Dalton, are you familiar with this document?
A. Yes.
Q. What's your understanding of this document?
A. My understanding is this document is used by the GAPMS analysts to assist them with completing their work.
Q. Have you ever seen this document filled out before?
A. No.
Q. Most GAPMS employees use this document?
A. It's not a Bureau requirement or an Agency requirement. I think it's -- if it's a helpful tool for the analysts, then I support however the different positions in the Bureau accomplish their work. But it's not a required document.
MR. BEATO: One moment, Your Honor.
No further questions, Your Honor.
THE COURT: Cross-examine?
MS. DUNN: Yes, Your Honor.

CROSS-EXAMINATION

BY MS. DUNN:
Q. Good morning, Ms. Dalton. My name is Chelsea Dunn, and I'm an attorney for the plaintiffs in this case.
You testified that you are the Bureau Chief for the Bureau of Medicaid Policy at the Agency for Health Care

Administration; is that correct?
A. Yes.
Q. And you started AHCA in August of 2018?
A. In January of 2018.
Q. January 2018. Thank you.
You became the Bureau Chief of your division in August of 2021?
A. Yes. I was officially the Bureau Chief in August of 2021.
Q. And your educational background and degrees is in music; is that right?
A. Yes.
Q. You have both a Bachelor's degree and a Master's degree in music?
A. Yes.
Q. Turning to the GAPMS process that we discussed or that you were discussing, Jesse Bottcher supervised the position that's designated to undertake GAPMS analyzes; is that right?
A. Yes.
Q. And Mr. Bottcher was your direct report?
A. Yes.
Q. You met with Mr. Bottcher weekly?
A. Yes. I met with him -- I had a scheduled weekly meeting, but we probably touched base or talked about something in a meeting together daily.

Q. So at least weekly but more likely daily?
A. Yes.
Q. And the GAPMS analyst position was previously held by Jeffrey English; is that right?
A. Yes.
Q. And he was in that position for approximately three years; is that correct?
A. I don't know the exact timeline. When he was hired at the Agency I was in a different capacity, so did not have any direct oversight of that team or the GAPMS process. And then we were home with COVID for a while, and so I don't know exactly when he started.
Q. He started before you became Bureau Chief, though?
A. Yes.
Q. And if he were to say that he had worked in the GAPMS position for three years, do you have anything to believe that that's not correct?
A. No.
Q. And he reported directly to Mr. Bottcher?
A. Yes.
Q. So you testified to making the decision to assign Mr. Brackett, Mr. Chen, and Ms. Pickle to the 2022 GAPMS for gender dysphoria; is that right?
A. Yes.
Q. None of these individuals were assigned to the unit

responsible for conducting GAPMS at the time; is that right?
A. Correct.
Q. At the time Mr. English was in the analyst position responsible for GAPMS determination while the 2022 GAPMS for gender dysphoria was being conducted; is that right?
A. Yes.
Q. And at that time, when you decided to assign this GAPMS determination to Mr. Brackett, Mr. Chen, and Ms. Pickle, you didn't check whether Mr. English had the capacity to complete the GAPMS analysis for gender dysphoria?
A. I didn't check specifically if Mr. English did. I knew that Jesse, his direct report, who would need to be available to oversee work, had an expensive workload at the time. So he overseas three other managers besides the GAPMS position that each had teams, and we had some vacancies. So his team as a whole was very busy.
Q. But Mr. --
THE COURT: I want to interrupt just to make sure the record is clear. When you say -- I think you said Jesse was his direct report, you meant his direct supervisor?
THE WITNESS: Yes. Sorry. I think I said that twice now. I will try to make that clear. Yes, his direct supervisor, Jesse Bottcher.
BY MS. DUNN:
Q. But you didn't check to see if Mr. English himself had

capacity; is that right?
A. No.
Q. And Mr. English would have been the one actually --
THE COURT: Let me make that one clear, too. That's one of those questions that gets asked that way and you say no. What she said was correct, you didn't check to see -- let me ask the question correctly instead of -- I'm sorry.
Did you cheek to see if Mr. English had capacity?
THE WITNESS: No, I did not talk to Mr. English to see what his workload was.
THE COURT: That's what I understood the prior answer to be. I just think the way it was phrased and answered, it wouldn't have been clear.
MS. DUNN: Thank you, Your Honor.
BY MS. DUNN:
Q. And Mr. English would have been the one responsible for writing the report and conducting the research to complete the analysis; is that right?
A. His primary job duty was doing GAPMS reports and research, so, yes. But as Bureau Chief, you know, looking at the Bureau as a whole, at capacity, at trying to manage priorities, manage the various tasks that we were working on, I felt that it is, you know, within my capacity as Bureau Chief to decide if another team would be more appropriate at that point in time to do the work.

Q. You mentioned that Mr. Brackett had previously worked on GAPMS for the Agency?
A. Yes.
Q. And were you aware that he had previously worked on GAPMS for the Agency for under a year?
A. I didn't know the exact time that he was in that position. That was before I started with the Agency. But he always appeared very knowledgeable about the process and was available to answer questions, like I stated before about if I just had general questions about the process and the approach.
Q. You mentioned that he left the GAPMS analyst role to move to a supervisor position. In that supervisor position, he did not supervise the GAPMS analysts; is that correct?
A. Correct. He supervised a different unit within the Bureau.
Q. In the year preceding -- so the year 2020 through 2021 -- Mr. English received a performance evaluation conducted by his manager. Have you seen that performance evaluation?
A. I don't know if I have. I do have to do a secondary review on some, but I don't recall seeing that one specifically.
Q. Would it be helpful if we brought up the report to see if you remember seeing it?
A. Yes. I'll look at whatever you want me to.

MS. DUNN: Let's pull up Exhibit 29 for Ms. Dalton to review.

BY MS. DUNN:

Q. And this has a marking as Plaintiffs' Exhibit 15, which is actually from a deposition, so that's not relevant here.

This performance evaluation was completed in August of 2021. Do you recall seeing it before?

A. No.

Q. Would you have any reason to believe -- strike that. I'm sorry.

Were you in the Bureau Chief role in August of 2021?

A. Depends when in August. I was acting, but I was not officially until I believe it was the end of August.

Q. Mr. English received excellent and above excellent ratings on his performance evaluation. Were you aware of that fact?

A. No.

Q. Did you complete any performance evaluations for Mr. English?

A. No.

Q. During your deposition you testified that Mr. English would be -- Mr. English and Mr. Bottcher would be the two employees with information about the GAPMS process; is that correct?

A. They would have information, but Matt Brackett also had

information, and then there were various other employees I think that had some knowledge of GAPMS.

Q. And often when the Agency is conducting GAPMS, subject matter experts are used; is that correct?

A. I don't know specifically the intricacies of the GAPMS process. Are you asking if the Agency has subject matter experts?

Q. Yes. I'm specifically referring to internal AHCA employees who have specific subject matter expertise.

Are those individuals used during the GAPMS process?

A. I don't know.

Q. When the Agency conducts coverage determinations, are subject matter experts; i.e., internal AHCA employees who have subject matter expertise, used to make those coverage determinations?

A. Yes. The Bureau is organized in away where the different positions or subject matter experts are assigned specific policies, might be one or more policy areas, that it would be the expectation that they become familiar with that policy area. So, if a question came up around coverage in a specific area, there would be a specific employee who would be responsible for answering that question or looking -- researching that coverage.

Q. And would those same individuals be assigned or be consulted with for GAPMS processes, if necessary?

A. I don't know, like I said, the internal process that analyst uses to develop the GAPMS reports. I don't know if it's the same for every report or every request. I'm not that involved or knowledgeable of the actual GAPMS process.
Q. When the Agency makes a determination about whether to cover a certain service, the staff member doing so may consult the chief medical officer of the Agency; is that right?
A. The chief medical officer is available to staff at the Agency if they have questions regarding any policy. He's very nice and very approachable, and so he usually is available if there is a question.
Q. And you know of instances where he has been consulted while the Agency is making coverage determinations, for example, by the pharmacy policy unit; is that right?
A. Yes. I know that they've asked him questions about various components of their different tasks.
Q. And Mr. Bottcher has also drawn on the knowledge of Mr. Cogle in his role for actions of his section?
A. I believe so.
Q. The current chief medical officer for the Agency is Dr. Christopher Cogle; is that right?
A. Yes.
Q. And as you mentioned, he serves as an available resource for your team?

A. Yes.
Q. And you met with him when you first became Bureau Chief; is that right?
A. Yes.
Q. And in that meeting one of the things that was discussed was the GAPMS process?
A. Yes. We met on -- over the years, we have met on lots of things, but when I first took over the role, he was fairly new as well. We didn't have a chief medical officer before him. His role and him personally were somewhat new around the same time. So we met about different processes or functions, I think just try to figure out how we could be most helpful to each other.
Q. And in that conversation you did discuss the GAPMS process?
A. Yes.
Q. You have been the Bureau Chief as we mentioned in the Bureau for Medicaid Policy since August of 2021?
A. Yes.
Q. And in that time you've approved two GAPMS determinations; is that right?
A. Correct.
Q. Turning briefly to the rule promulgation process, when AHCA is promulgating a new rule, there are different public meetings that might be required based on the stage of the

process; is that accurate?
A. Yes.
Q. During the rule development stage a public workshop may be held?
A. Yes.
Q. And before a rule gets promulgated, there may be a public hearing with the final rule text that's considered; is that right?
A. Yes.
Q. These rulemaking hearings are run by Agency staff typically, or always?
A. Typically, there is a specific unit responsible for the administrative side of the process. So helping schedule the meeting, facilitate where the meeting is going to be held, making sure you capture all of the sign-in. And then the subject matter expert or different analysts in the Bureau, sometimes the manager, would also usually participate.
Q. And when you say subject matter expert in this context, you're referring to internal AHCA employees who served on the panel say at the public hearing; is that right?
A. Internal or external. We invite our sister agencies to participate in public meetings often if the rule has to do with a policy that they may oversee; for example, the Agency for Persons with Disabilities participated in the rule hearing that we recently had on the iBudget Waiver handbook,

since they are subject matter experts with the iBudget Waiver.

Q. Typically, the subject matter experts are either from AHCA, the Agency AHCA, or other state agencies; is that right?

A. Yes.

Q. I'm pulling up or I am going to have pulled up what has been marked as Plaintiffs' Exhibit 291, if you can look at your screen.

I understand that you are not on this email, Ms. Dalton, but do you recognize the second part that includes some billing information? And we can zoom in if it's hard for you to read.

A. Yes.

No.

Q. Did you -- when Ms. Pickle has invoices to pay for an expert consultant such as Mr. Van Mol, or Dr. Van Mol -- excuse me -- do you have to approve those invoices?

A. Yes.

Q. And you didn't review these invoices?

A. I don't believe the invoice had this level of detail.

Q. We're pulling up what has been marked as Plaintiffs' Exhibit 321. Do you recognize this document?

A. Yes.

Q. What is it?

A. This is an after the fact request form under $35,000. It's an invoice for consultant services.
Q. And who were these consultant services designed to pay?
A. This one is for Andre Van Mol.
Q. And what was Mr. Van Mol being paid to do?
A. My understanding is as a subject matter expert or consultant for the development of the GAPMS report.
Q. And what was his time being spent on? Do you know?
A. I don't know the specifics. I knew that he was assisting the team.
Q. And we're now pulling up what -- oh, I'm sorry.
We're going to stay on this exhibit, 321, right now. If you will look at the top box, can you just tell us what the date of service for Mr. Van Mol was?
A. 4/15/22 through 6/30/22.
Q. So this would indicate that Mr. Van Mol began consulting with the Agency on April 15th of 2022?
A. I don't know when he began, but that's what the invoice says, yes.
MS. DUNN: We can take this off the screen, and please we will be showing what has been marked as Plaintiffs' Exhibit 320.
BY MS. DUNN:
Q. Do you recognize this document, Ms. Dalton?
A. Yes.

Q. What is it?
A. This is the invoice -- the after the fact request invoice for Quentin Van Meter.
Q. And what was Mr. Van Meter being retained to do for the Agency?
A. The same, consultant for developing the GAPMS report.
Q. And you signed these after the fact request forms for both Mr. Van Meter and Mr. Van Mol?
A. Yes.
Q. You approved payment for these individuals?
A. Yes.
Q. And if you can just look at the dates of service on the request for Mr. Van Meter, what were the dates of service for his services?
A. 4/15/22 through 6/30/22.
Q. So that would indicate that he had started working for the Agency in a consultant capacity on April 15, 2022?
A. That's what the invoice says, yes.
Q. We're now pulling up what has been marked as Plaintiffs' Exhibit 292A. Do you recognize this invoice at all?
A. No.
Q. Do you recognize the person named in the invoice?
A. Can you point out where the name is?
Q. At the very top, it's italicized. I'm sorry.
A. No.

Q. So Ms. Brignardello-Petersen completed one of the attachments to the 2022 GAPMS for gender dysphoria. Have you reviewed those attachments?
A. I did a year ago.
Q. And so this appears to be an invoice for services that she provided to the Agency. Would you have been required to approve this invoice if she was paid?
A. It depends on who was ordering the invoice or who had filled out the form. If I was in the chain of revision or supervision or signing, then, yes.
Q. And when we looked at Mr. Van Meter and Mr. Van Mol's requests, those were done by Ms. Pickle, who was part of the team working on the 2022 GAPMS for gender dysphoria, were they the same individuals who would have been retaining the other authors of the GAPMS reports -- attachments?
A. I don't know.
Q. Do you recall signing an invoice for Ms. Brignardello-Petersen's services?
A. I don't remember.
Q. Do you recall signing an invoice for the services of the other consultants who provided attachments to the GAPMS memo?
A. I don't remember specifically. You just showed me the two. But I don't remember specifically all of the invoices that I signed, no.
Q. We'll pull up Plaintiffs' Exhibit 294. This document is

entitled, "Projected Rulemaking Timeline," and it makes reference to the GAPMS specifically.

Have you ever seen this document?

A. I don't recall if I have or not.

Q. Just from your knowledge as an Agency employee, do you know what some of these acronyms mean, for example, do you know what NORD refers to?

A. Yes.

Q. What does that?

A. Notice of Rule Development.

Q. And what does FAR refer to?

A. Florida Administrative Register.

Q. And are these activities that the Agency undertakes, the Notice of the Rule Development, for example?

A. Yes. Those are required steps in the promulgation process per Chapter 124 of the statutes.

Q. And in the third box, June 17th, there's an acronym NOPR. What does that refer to?

A. Notice of Proposed Rule.

Q. And that's also published in the Florida Administrative Register?

A. Yes.

Q. Under July 12th, there is an acronym JAPC. Do you know what that acronym stands for?

A. Joint Administrative Procedures Committee, I think.

Q. And when it says "Adoption package submitted to JAPC," does the Agency submit rule adoption packages to JAPC?
A. We have to file the rule with the Department of State, but I believe that we submit them for review to JAPC.
Q. And July 19th, where it says, "File for adoption with DoS," that would be Department of State as you just mentioned?
A. Yes.
Q. And on the second row under June 16th, it says, "Send NOPR to OFARR and FAR," I think FAR is Florida Administrative Register, we said. Do you know what OFARR is?
A. I don't know if I can remember off the top of my head. They are an entity.
Q. A state agency entity in the rulemaking process; is that accurate?
A. Yes.
Q. And we are now going to pull up what's been marked Plaintiffs' 295 on the screen.
This is a flowchart entitled, "Gender Dysphoria/Transgender Health Care Non-Legislative Pathway."
Have you ever seen this particular document?
A. I don't remember seeing this before.
Q. Does this document seem to reflect the process by which AHCA completed the GAPMS process for gender dysphoria and promulgated the rule that's being challenged today?

A. Yes.
Q. And one more document that we'll pull up, Plaintiffs' Exhibit 296. This document is another flowchart this is entitled, "Gender Dysphoria/Transgender Health Care Policy Pathway."
Do you recognize this document?
A. No.
MS. DUNN: Just one second. This might just take a minute. I'm sorry.
BY MS. DUNN:
Q. We are pulling up what has been marked as 297. Do you recognize this document?
A. Yes.
Q. What is this document? Oh, I'm sorry. This is not the version of the document that I intended.
This is what has been marked as 297A. Do you recognize this document?
A. Yes.
Q. And what is it?
A. This is an internal form that we use to track routing and approval of documents through the Agency.
Q. And what is this particular routing and tracking form referencing?
A. The GAPMS report assignment.
Q. And this would have been what was completed when

Mr. Brackett, Ms. Pickle, and Mr. Chen had finished the GAPMS for gender dysphoria and submitted it to the management team?

A. Yes.

Q. And they completed or they submitted that form for review on June 1st, 2022; is that right?

A. Yes.

Q. So Ms. Pickle signed it on June 1st, 2022?

A. Looks like Matt Brackett for D.D.

Q. Oh, that's what the "MB for DVP," means, Matt Brackett signed it for her?

A. Yes.

Q. And you signed it on that same date, June 1st, 2022?

A. Yes.

Q. Mr. Weida, your direct supervisor, also signed it on June 1st, 2022?

A. Yes.

Q. And then it was sent to Tom Wallace, who is the Deputy Secretary for Medicaid, and he signed it the next day, June 2nd, 2022?

A. Yes.

MS. DUNN: I have no further questions. Thank you.

THE COURT: Redirect?

MR. BEATO: No, Your Honor.

THE COURT: Ms. Dalton, I want to make sure I understood this, and I have a follow-up question, too.

Let me start by saying, I get it, when you give special attention to a request that came from the boss as opposed to something that was routine or came some other way. So I take it this process was a request essentially that came from the boss, and I think you said Tom Wallace, as you understood it, at the very beginning of the GAPMS process.

THE WITNESS: Yes. It was a request from the Secretary essentially directing the Medicaid Director, Tom Wallace, to assign it to his team; and, because of the assignment, that would come to my Bureau.

THE COURT: So it came actually from the Secretary.

THE WITNESS: Yes.

THE COURT: Did you understand at that point that the Executive Office of the Governor had some involvement with this, too?

THE WITNESS: I don't -- I wasn't really involved in any of that. I was taking direction from my supervisor.

THE COURT: You're keeping your head down and doing your job.

THE WITNESS: Yes.

THE COURT: So, as you understood it, this is a request from the Secretary. And so it's a request from the Secretary so you want it done well, and you know the Canadian team has time on its hands, and you have confidence in them, and you give it to them.

THE WITNESS: Yes.

THE COURT: I understood all of that.

I think I understood you to say that you didn't remember those flowcharts that they were showing you on cross a minute ago.

THE WITNESS: Yes. I don't recall ever seeing them.

THE COURT: Nobody quite asked you what they really care about, and so I'm going to ask you about it.

Over on the right side at the very end of that flowchart, it said, "Care Effectively Banned."

Now, I have to tell you that it seems to me that, if somebody was starting out at the beginning and wanted to describe the process that we're going to use to evaluate some kind of medical care, we would set out all of those steps, and then at the end it might say, "Rule adopted or result reached"; but, if you're really trying to figure out what the policy ought to be, and you adopted this flowchart in the beginning to show where you were going, the last thing it said wouldn't already have the results.

When you got this assignment, did you know what the result was supposed to be?

THE WITNESS: No. I mean, I was aware of the Department of Health and what had been going on there. I wasn't intimately aware of it, but being part of a government worker, I was aware. But my direction from my supervisor was

always, approach this following the standard process, thoroughly review of the research, and this is a GAPMS report following the rules.

THE COURT: So you knew what was going on, which is to say trans individuals were in the crosshairs. Is that -- that's probably a colloquial way to say it, but, look, I live in this town, too, and read the papers. Trans individuals were targeted. Is that a fair description?

THE WITNESS: As a person living in the town, I agree that I was aware of the political -- I mean, the things that were going on politically or some of the other -- with some of the other agencies.

THE COURT: Nobody ever gave you a wink and a nod and said, "Where this is supposed to come out is that care is supposed to be effectively banned"?

THE WITNESS: No.

THE COURT: And when you picked the Canadian team, it wasn't because you thought these people will understand what they are supposed to do, you picked them because they had time and you thought they would do a good product.

THE WITNESS: Correct. It was not -- yes, it was because I thought that they had time and would do a good product and could accomplish the task.

THE COURT: We saw while you were being cross-examined three invoices, I suppose, one was for $6100,

and I didn't make a note of what the second one was for. The third one was for $34,800. This is money out the door to people that don't work for the State. And I understand that's not a whole lot of money in a state budget. Can you think of other things where your Bureau approved that kind of money to outside consultants?

THE WITNESS: I believe there had been a consultant for the Canadian Importation Drug Program when the legislation first passed. I don't know the amounts associated with that. So I personally have not had much experience with outside consultants.

THE COURT: Fair enough. Thank you.

Questions just to follow up on mine?

MR. BEATO: No, Your Honor.

MS. DUNN: Yes, Your Honor, just one or two.

RECROSS-EXAMINATION

BY MS. DUNN:

Q. Ms. Dalton, did you select the Canadian Drug Importation Program team on your own?

A. I initially recommended it, but I believe it was a discussion with my supervisor at the time, and I think he agreed that that was like, okay, let's move forward that way.

Q. And do you know why the particular consultants that were used in this process were chosen?

A. I don't.

Q. Do you know how the particular consultants used in this process were contacted or selected?
A. No.
Q. To your knowledge, has the Agency ever used seven outside consultants on a GAPMS process prior to this?
A. My personal experience with GAPMS is limited, and I have not had any experience prior with consultants on a GAPMS.
MS. DUNN: Thank you. No further questions.
THE COURT: I think the record already shows this. When you said you may have talked about it with your supervisor, that was Mr. Weida?
THE WITNESS: Yes, Jason Weida.
THE COURT: Thank you. You may step down.
Please call your next witness.
MR. JAZIL: Your Honor, Mr. Brackett is the next witness.
May I ask for five minutes to use the restroom?
THE COURT: Let's take five minutes. We'll start back at 11:20.
(*A recess was taken at 11:16 a.m.*)
(*The proceedings resumed at 11:20 a.m.; plaintiffs counsel not present.*)
THE COURT: Please be seated. We'll be at ease for a minute.
You're welcome to have a seat. We'll make you stand

up in just a minute, but you can sit down right now.

MS. DUNN: We can start.

THE COURT: Good to go?

MS. DUNN: Yes.

THE COURT: Please call your next witness.

MR. JAZIL: Thank you, Your Honor. Matt Brackett is our next witness.

DEPUTY CLERK: Please raise your right hand.

JOHN MATTHEW BRACKETT, DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: My full name is John Matthew Brackett; my last name is spelled B-r-a-c-k-e-t-t.

DIRECT EXAMINATION

BY MR. JAZIL:

Q. Good morning, Mr. Brackett.

Where do you work?

A. I work for the Florida Agency for Health Care Administration.

Q. And if I refer to it as AHCA, will you know what I mean?

A. Yes, I will.

Q. When did you start working at AHCA, sir?

A. I started working at AHCA in October 2015.

Q. Where did you work before October 2015?

A. I worked for the Florida Department of Health as a medical disability adjudicator.
Q. How long did you have that job?
A. I had that job for 15 months, from July 2014 to October 2015.
Q. And what did you do in that job?
A. So that job was responsible for handling the medical aspect of social security disability claims, reviewing medical records, and determining whether or not those records and the medical evidence, determine whether or not somebody met the criteria for social security disability.
Q. What did you do before that?
A. I was a school teacher.
Q. How long were you a school teacher for?
A. I was a school teacher for six years.
Q. So you joined AHCA in October 2015, what was your first job?
A. So my first job at AHCA was a medical health care program analyst under the deputy secretary for health quality assurance.
Q. How long did you have that job?
A. I had that job for 15 months.
Q. And what did you do in those 15 months?
A. So that job, I worked on coordinating the completion of bill analyses; tracking legislation; completing monthly,

quarterly and annual reports; and I also worked on the Agency's online licensing program.

Q. What was your next job at the Agency?

A. My next job with the Agency was a Government Analyst II. That was in the Bureau of Medicaid Policy.

Q. And what did you do as a Government Analyst II?

A. That role, was responsible for completion of Generally Accepted Professional Medical Standards reports.

Q. What was your next job?

A. My next job was a program administrator over the specialized and behavioral health services coverage policy section.

Q. And how long did you have that job for?

A. I held that job for three and a half years.

Q. Next job at the Agency, sir?

A. My next and current position is a program consultant for the State's Canadian Prescription Drug Importation program.

Q. Were you a political appointee in any of those jobs at the two agencies you've mentioned?

A. No, I was not.

Q. Now, you mentioned Generally Accepted Medical Standards, GAPMS. Is it okay if I refer to it as that, would you know what I mean?

A. Absolutely.

Q. I'm pretty sure I just butchered the acronym, so I

apologize.

You talked about GAPMS, and you told us what it stands for. Do you know that a GAPMS report is?

A. Yes.

Q. What is it, sir?

A. So a GAPMS report is a document that is prepared in accordance with Rule 59G-1.035, Florida Administrative Code. So that report takes a comprehensive look at evidence as required by that rule to determine whether or not a medical service conforms to Generally Accepted Professional Medical Standards.

Q. Are there different kinds of GAPMS reports?

A. We have a couple.

Q. And what are they?

A. So we have a traditional GAPMS and then we have an expedited GAPMS.

Q. What's the difference between the two?

A. So an expedited GAPMS, this is a GAPMS that is usually done by request from one of our managed care plans. It is usually specific to one recipient. And because it's one recipient who is awaiting a service or a determination needs to be done quickly, that GAPMS has to be done kind of individualized, looking at that recipient's condition and whether or not that service will benefit that recipient.

Q. And the other kind of GAPMS, the traditional GAPMS, can

you tell us what that is?
A. A traditional GAPMS is much more comprehensive. So because there's not an urgent request for it, it provides a comprehensive report looking at like multiple medical conditions if they are applicable, and looking it through the guise of recipients who might benefit from that particular service that's being evaluated.
Q. Mr. Brackett, you testified earlier that you held a Government Analyst II job, and as part of that you wrote GAPMS reports. Can you remind us how long you held that job for?
A. I held that position for ten months.
Q. And how many traditional GAPMS reports did you write in those ten months?
A. During that role, I drafted nine.
Q. Mr. Brackett, you mentioned Rule 59G-1.035.
MR. JAZIL: Can we bring up Plaintiffs' Exhibit 23, please.
Your Honor, may I approach the witness with a copy as well?
THE COURT: You may.
BY MR. JAZIL:
Q. Mr. Brackett, as I understood your testimony just now, you said that this rule guides your work. What specific provision in this rule do you look to when you're working on

your GAPMS reports?
A. In particular, subsection (4).
Q. I would like to work through the subsections so we get an understanding of what these factors mean to you.
What's your understanding of what subsection (4)(a) requires of you as you're working through a GAPMS report?
A. So subsection (a) applies to evidence-based clinical practice guidelines. That does require us to look at what's available, evidence-based clinical practice guidelines are available pertaining to the medical service under consideration.
Q. Okay. And what about the subsection (b)?
A. Subsection (b) is referring published reports and articles in authoritative medical, research journals -- peer-reviewed articles to be short. So that's going to require an exhaustive search for what peer-reviewed literature is available on the subject.
Q. And subsection (c)?
A. Subsection (c) is requires the evaluation of the effectiveness of the health service in improving the individual's health conditions.
Q. What about (d), sir?
A. That is in reference to utilization trends.
Q. What does that mean to you?
A. How is the service being used at the time of its

evaluation.
Q. What about subsection (e), sir?
A. (E) is looking at coverage by other credible insurance payors.
Q. And what would those other credible insurance payors be?
A. Those could be first and foremost other states' Medicaid programs, Medicare, other payors, such as TriCare, Veterans Administration. It can also include private insurers.
Q. And what's your understanding of subsection (f), sir?
A. Recommendations or assessments by clinical or technical experts on the subject or field. This is to take a look at what the authorities out there are saying about this particular service under consideration.
Q. And based on your experience, sir, which of the factors in subsection (4) dictates the results of your GAPMS decisions?
A. There isn't really one in particular. It's all taken as a whole.
Q. So, sir, you mentioned that you wrote GAPMS reports. What happens after you finish your draft of your GAPMS report? What's the next step?
A. So after I've prepared a finalized version of that draft, and it's ready to go, I give that draft to my immediate supervisor.
Q. What happens after that?

A. Either my immediate supervisor signs off and gives it to their immediate supervisor, or it comes back to me with questions or edits.

Q. If it moves up the chain from your immediate supervisor to their supervisor, what happens after that?

A. It eventually makes its way up to the Deputy Secretary of Florida Medicaid.

Q. And do you know what the Deputy Secretary's role is in this process?

A. The Deputy Secretary of Medicaid gets the final say in agreeing or disagreeing with the conclusions and findings of the report.

Q. And where in Rule 59G-1.035 does it say that?

A. That is in subsection (5).

MR. JAZIL: We can take that down.

BY MR. JAZIL:

Q. Mr. Brackett, I would like to move on to the June 2022 GAPMS report on gender dysphoria, which is Defendants' Exhibit 6.

MR. JAZIL: Your Honor, may I approach with a copy?

THE COURT: You may.

BY MR. JAZIL:

Q. Mr. Brackett, please take a look at the report and let me know when you're done, and you can look back at me.

Are you familiar with this document, sir?

A. Yes, I am.
Q. How so?
A. It's -- well, it's our complete GAPMS report from June 2022, on treatment for gender dysphoria. It contains my report as well as all of our attachments.
Q. And when you say "your report," what are you referring to, sir?
A. I'm referring to the first part, the General Accepted Professional Medical Standards Determination. That's the part that I wrote.
Q. And who asked you to write this GAPMS report, sir?
A. I was asked to write this report by our Bureau Chief, Ann Dalton.
Q. What's your understanding of why you were asked to write this report?
A. My understanding of why I was asked to write this report was that I had extensive experience not only just working on GAPMS reports, but also executing special projects for the Bureau of Policy over my time there. And also the time because our proposal had been submitted to the Food and Drug Administration related to the drug importation program, we were still awaiting feedback, that we had the bandwidth -- I had the bandwidth to do this project.
Q. When were you asked to work on the report, stir?
A. Around mid April 2022.

Q. So mid April 2022, you get asked to work on the report, what's your first step?
A. My first stop was to start combing the literature, to start finding articles, anything that pertained to the subject, anything in a peer-reviewed journal, and to start gathering the materials and start reading them, and kind of letting the research -- letting the research guide me.
Q. And where did you go to gather these materials?
A. Primarily went to PubMed. That's the National Institutes of Health's database for peer-reviewed medical literature.
Q. What was your next step?
A. My next step, of course, as I gathered more and more materials, reading the articles, kind of understanding what the literature was saying, kind of trying to get a complete picture of -- kind of cumulatively what the literature said about these services. And then kind of began kind of making a mental outline of how to structure the report.
Q. So you've done your mental outline. What comes next?
A. Once the mental outline is done, that's when I began drafting.
Q. Okay. And how long did it take you to draft your first draft of the report?
A. My first draft, which was a polished first draft, took me about three weeks.
Q. I'm bad with math so remind me, approximately when in

2022 would that put us?
A. That would put us in early May 2022.
Q. Did anyone at the Agency help you with your draft of the report?
A. As far as the actual writing goes, no. But when it came down to gathering information on other insurance payors, I did have some support with that.
Q. Who helped you with gathering information on other insurance payors?
A. D.D. Pickle and Nai Chen.
Q. Can you tell me what specifically D.D. Pickle did for this report?
A. So D.D. Pickle's role in this was to go out there and find what other State Medicaid programs were doing in terms of coverage of these treatments.
Q. Anyone else help you with this report?
A. Nai Chen.
Q. What was Nai Chen's role?
A. His role was to take a look at Western European countries and to take a look at what they were also doing regarding these treatments.
Q. Now, you said Ms. Pickle went and looked at other Medicaid agencies around the country and what they were doing. Why didn't Ms. Pickle work with you, look at private insurance companies and what they were doing?

A. So, since Florida Medicaid, since we are a public payor, when we do the section of the GAPMS, we are primarily interested in other Medicaid programs first and foremost. And since she was taking an exhaustive search, far more exhaustive than we have done for other reports, and we got a nice breakdown of what the 50 states said, considering that we had a very complete picture of Medicaid and other public payors, and we just for this one we did not emphasize -- we did not emphasize private insurers, but also this is not a unique situation with that GAPMS. We have done other GAPMS where we did not look at private payors.

Q. I think you mentioned this earlier, but I just want to make sure this is clear.

Did Mr. Chen or Ms. Pickle write any portion of the report?

A. No.

Q. And in the report on pages 31 and 32, if you wouldn't mind turning to them, it discusses the coverage policies. What did y'all conclude?

A. So, for Medicaid, we concluded that there was disagreement among the states regarding coverage. Some states covered it, other states said they would not cover it. A lot of states said they didn't have a policy one way or the other.

Q. It does say that other Medicaid perspectives were

considered. How exactly did you and your team go about checking to see what other states were doing?

A. So as part of the research we do in the Bureau of Policy is scouring other state Medicaid programs for research, D.D. took the same approach, scoured the 50 state Medicaid program published policies, their handbooks, their coverage statements, and, of course, recorded the findings.

Q. Y'all also looked at what Western European countries. Why did you do that?

A. Because Western European countries, since they are generally almost all utilize some kind of universal health care system, we also considered them to be public payors, and we also were curious to see what their input was.

Q. What did you find when y'all started looking at the Western European countries?

A. We found that they had put in place prohibitions regarding these services.

Q. Mr. Brackett, you testified earlier that the rule for GAPMS requires you to look at utilization trends. Did y'all do that here?

A. Yes, we did.

Q. What did you find?

A. So we found that the utilization of these services had been increasing; that it had been increasing in almost a reverse manner. We had a lot more young women transitioning

to males as opposed to the other way around where you had more young men who wanted to transition into females. And we found that the number of cases, of course, had been rising steadily in recent years.

Q. Mr. Brackett, the rule says that you should look at evidence-based clinical practice guidelines. Did you look at evidence-based clinical practice guidelines?

A. I did.

Q. Which ones, sir?

A. I looked at the guidelines from the World Professional Association for Transgender Health, more colloquial known as WPATH; and the Endocrine Society, as well as guidelines from the University of California at San Francisco.

Q. Let's take those one at a time, sir.

Based on your review of WPATH's guidelines, what did you conclude for purposes of your GAPMS report?

A. For the purpose of the GAPMS report, after having read all of the literature, I kind of concluded that the WPATH guidelines were founded on low to very low quality evidence.

Q. What about the Endocrine Society guidelines, sir?

A. The Endocrine Society guidelines, while they were more transparent in sayings that these recommendations were based on low to very low quality evidence, their recommendations didn't really mesh with what their evidence was saying, in addition, to the grade that their evidence had been given.

Q. And what about the University of California, San Francisco, guidelines, sir?
A. So I found their guidelines to be more -- a little bit more I guess basic, but also found they conflicted with some of what WPATH and what Endocrine Society said.
Q. Understood. The rule requires a review of published reports, articles, authoritative medical literature. You said you looked at those. Where in your report do you provide a list of the articles that you reviewed?
A. Starting on page 39 through page, I think, 46.
Q. Is this an exhaustive list of the papers that you reviewed?
A. This is an exhaustive list, yes.
Q. And which of these articles did you review in their entirety, sir?
A. I reviewed all of the articles in their entirety.
Q. Did you review papers that contradicted the findings ultimately reached in your GAPMS report?
A. Yes. I reviewed numerous articles in peer-reviewed literature that asserted that these treatments were beneficial to mental health.
Q. Sir, can you take a minute to just take a look at your works cited and point me to one or two articles that ultimately disagreed with the findings that you reached?
A. Sure. On page 43.

Q. Okay. Can you read off the author?
A. Sure. One was by Tordoff and a group of other scholars, talked about mental health outcomes in transgender and nonbinary youths.
Another one was by I think Olson-Kennedy, and I think it was about gender identity five years after social transition.
Q. Sir, after your report there are attachments. Are you familiar with those attachments to the GAPMS report?
A. Yes, I am.
Q. How, if at all, do they influence the report itself?
A. Considering that we didn't receive those reports until after I had already drafted mine, they didn't.
Q. Mr. Brackett, do you know Andre Van Mol?
A. Yes.
Q. How do you know him, sir?
A. I do know him through collaborations with this project.
Q. What role did he play in this project?
A. He served in an advisory capacity. We had a few conference calls with him.
Q. What did you discuss on those conference calls?
A. Resources, articles.
Q. Anything else?
A. He did give us -- I think in one of the calls he gave us some suggestions for edits when we were polishing the draft.
Q. I would like to show you what has been admitted into

evidence as PX329.

MR. JAZIL: Your Honor, may I approach?

THE COURT: You may.

BY MR. JAZIL:

Q. Mr. Brackett, just look up at me when you are done taking a look at it.

Do you recognize this document, sir?

A. Yes, I do.

Q. What is it?

A. So, Dr. Van Mol had supplied us with a bibliography to help guide our research.

Q. How did this document guide your work specifically?

A. It was a resource to take a look to see if there are articles out there. By the time we had already received this, I had already pulled numerous studies. This helped make sure that, if there was anything else that was valid or current or could contribute to our own analysis, this helped served as a resource for that.

Q. And based on this document and based on the conversations that you had with Mr. Van Mol, the charge has been made that Mr. Van Mol was the one who actually wrote this GAPMS report. What is your response to that, sir?

A. Well, to that one, I am actually personally offended to that allegation.

Q. Why?

A. Because this was my work product. I am an experienced researcher. I have written a lot of reports. I have peer-reviewed publications. I did the research for this report. I also structured it. I determined how best to approach writing it, and I also -- that was my analysis on the literature; that they didn't conform to GAPMS. That was my assessment.

Q. Mr. Brackett, do you know Miriam Grossman?

A. Yes, I do.

Q. How do you know her?

A. Through collaboration on this project.

Q. Again, tell me what that means, sir.

A. So, we had, like with Dr. Van Mol, we did have some conference calls with Dr. Grossman. She provided the -- gave us some historical background on gender dysphoria treatments, talked to us a little bit about Dr. John Money. She also provided us some background on studies and some background information in general.

Q. I want to make sure the record is clear on this.

Did either Dr. Van Mol or Dr. Grossman write any part of the GAPMS report?

A. Neither one of them wrote any part of it.

MR. JAZIL: I would like to bring up Plaintiffs' Exhibit 297A, please.

BY MR. JAZIL:

Q. Do you recognize this document, sir?
A. Yes, I do recognize this.
Q. What is it?
A. This is our signed routing form for the June 2022 GAPMS.
Q. Looking at this form, it looks like everyone on the review list signed off on the GAPMS report within a day.
A. Uh-huh, yes.
Q. How did that happen?
A. So, during the drafting process, and especially after we had our initial drafts complete, there were numerous briefings held with leadership. In the week before that this was signed, there was a large briefing with everybody on there, including Secretary Marstiller. They had all been provided copies and drafts of the report. They all had a chance to look through it, and they also had a chance to ask questions while I was briefing them on how the report was done, how I reached the conclusions, what research I used.

So by the time we printed up the routing sheet, every person who had signed off on it had already had an opportunity to review, ask questions, had been briefed on it. So they were well aware what they were signing and approving.
Q. In these briefings did anyone tell you to arrive at a particular result?
A. No.
Q. Now, you mentioned there were briefings, the Secretary

was there, et cetera.

What is your understanding of why it was that this project was being pursued on such an expedited basis?

A. My understanding behind the urgency for this project was that the Department of Health and Human Services of the United States, on the federal level, had released guidance citing that these -- that the treatments for gender dysphoria, that these were evidence-based, should be, you know, should be utilized in treating gender dysphoria, and also there had been a Department of Justice document that had been sent out, I think, advising people that they can contact DOJ if they felt they had been discriminated against.

Q. I would like to show you some of those documents.

MR. JAZIL: Your Honor, may I approach?

THE COURT: You may.

MR. JAZIL: I'm going to show the witness Defendants' Exhibit 1, 2, and 3.

BY MR. JAZIL:

Q. Mr. Brackett, look at me when you are done reviewing them.

Are these the documents that you are referring to, sir?

A. Yes, these are.

Q. If you take a look at documents 1 and 2, they lay out citations to the federal government's position.

A. Yes.

Q. Why weren't you persuaded by the position in the citations that were listed there?
A. So, well, I mean, these are -- like I consider these like one-pagers. I'm generally not persuaded by a one-pager in general. I always want to go see what the sources say. My training as a researcher kind of instilled that in me. So it's like, okay, well, this is what it says, but what does the evidence say?
Q. Mr. Brackett, does the GAPMS memo, which is the first part of DX6 accurately capture your conclusions?
A. Yes, it does.
Q. Did anyone anywhere tell you to arrive at those conclusions?
A. No, they did not.
Q. I would like to move on to a few other GAPMS reports.
At the time you were drafting the June 2022 GAPMS report, did you know whether AHCA had any other GAPMS reports related to the treatment of gender dysphoria?
A. I was aware that a couple of drafts had been done prior to my time to the Bureau. I think one was started while I was in the Bureau.
Q. At the time that you were asked to do this job, did you know whether any of them had been finalized?
A. I was not aware if any had gotten through the process, no.

Q. Did you review any of those reports before you started work on your GAPMS report?
A. I did not.
Q. Why not, sir?
A. So I wanted to take a look at the evidence with fresh eyes. I didn't want to see what any other analyst had come up with as far as conclusions went. I just wanted to go into it with a clean slate, not having reviewed really anything else other than what I kind of already had in my head, which wasn't much of anything on the subject.
Q. Have you since reviewed those prior GAPMS reports?
A. After we had gotten this report finalized, I did look at those.

MR. JAZIL: Your Honor, if I may approach with three exhibits for the witness?

THE COURT: You may.

MR. JAZIL: For the record, they are Plaintiffs' Exhibits 240, 242 and 244.

BY MR. JAZIL:
Q. Mr. Brackett, what is 240, sir?
A. 240, that is our GAPMS memo on puberty suppression therapy.
Q. That is a finalized memo, right?
A. Yes, that one is finalized.
Q. And what about Plaintiff's Exhibit 242?

A. That one is on cross-sex hormone therapy, and that's also a GAPMS memo.

Q. Is that a draft or a finalized one?

A. This was a draft.

Q. Explain to me the discrepancy --

MR. JAZIL: If we can pull up 242, please.

BY MR. JAZIL:

Q. There's a date here April 19, 2022, and the top right shows Rick Scott, Governor; Justin Senior, Interim Secretary. Explain that discrepancy to me, sir.

A. So, the GAPMS template that we use was a -- it was a Word document, and when the GAPMS template was created, it -- the date autopopulated whenever you open the document. If you were to open up these three documents today in our share drive, you're going to get today's date in that field.

MR. JAZIL: Can we pull up 244, please, Plaintiffs' Exhibit 244.

BY MR. JAZIL:

Q. Sir, can you tell me whether or not this gender confirmation surgery GAPMS was a finalized one?

A. No, this one was not finalized.

Q. You now have testified that you reviewed these GAPMS reports after writing your own. Having reviewed these three, is there anything in these three reports that would change your mind about the GAPMS report you wrote in June of 2022?

A. No, there wasn't anything in these three.
Q. Why not?
A. So to kind of take them piecemeal, we will start with the one from 2017 on the surgery, I did take a look at that. What I found when I reviewed it was that the conclusions of all the studies that were evaluated were taken more or less at face value. There wasn't any probing of the methodology used, whether or not the subject -- whether or not the studies were low or high quality. It was mostly like, here's the conclusion, and it just moved on. So because I felt like it was missing that aspect of -- that analytical critical aspect that can determine whether or not the evidence was, you know, really truly supported the conclusions, I couldn't be swayed by that one.

For the cross-sex hormone therapy, similar. Literature review is very thin. I think that one did acknowledge that the evidence was low quality, but it was also very thin. It didn't really go into depth onto those subjects. Given that I had also read the evidence for myself, I didn't see how that conclusion could match with what I had read.

And the similar goes to the one from 2016, as well.

I think one other -- one other thought that I had was, when I was reading them, was that we have a process for off-label usage, and I thought that the way the literature reads and the way these were written, I thought the evidence

in the narrative concluded -- conflicted with the findings.
Q. Sir, after the June 2022 GAPMS report was finalized, what did the Agency do next?
A. After the report was finalized, the Agency went to rulemaking.
Q. Did you play a role in that rulemaking?
A. Yes.
Q. What was your role, sir?
A. My role was to help provide feedback on the rule language. I also participated in the July 8th hearing, and I also prepared a comment summary afterwards.
Q. What is your understanding of why the Agency went to rulemaking after finalizing the report?
A. So, since we had determined these services to be experimental and investigational, we moved to go ahead and codify that to rule to demonstrate that, because we had determined them to be investigational and experimental, that we wanted to have them codified as excluded services under the Medicaid program.
Q. Was there a comment period under that rulemaking?
A. Yes, there was.
Q. When did that comment period open?
A. I think somewhere around mid June, maybe late June. It went through shortly after the end of the hearing on July 8th.

Q. Sir, do you know how many comments approximately the Agency received?
A. Oh, I think at least 600.
Q. Are these written comments or are you including the oral comments provided for --
A. Oh, these were the written comments that we received.
Q. And you mentioned a rulemaking hearing. When was that hearing, sir?
A. That was July 8, 2022.
Q. Where was it held, sir?
A. That was held at the Florida Department of Transaction's auditorium at its headquarters downtown.
Q. Why was it held at the Department of Transportation's auditorium and not at AHCA?
A. So DOT's auditorium had a large capacity. Also, it -- so it could accommodate a large crowd. We also anticipated that the Florida channel would probably also want to broadcast the hearing. That venue made for a much better setting to allow videography. And also because of the proximity of DOT's location to downtown and its accessibility compared to AHCA's.
Q. Why did you think there would be a large crowd?
A. Well, because we did receive a substantial number of written comments, and that -- because there had been a fair amount of media coverage behind our GAPMS report, we

anticipated a large crowd.
Q. Who from the Agency was at attendance at that hearing?
A. So serving on the panel, myself, at the time Assistant Deputy Secretary Jason Weida, Shena Grantham, and Cole Giering.
Q. Did the Agency invite others to attend?
A. Yes, we did.
Q. Who?
A. So to participate on our panel, we invited Drs. Andre Van Mol, Quentin Van Meter, and Miriam Grossman.
Q. Why did y'all invite those three doctors?
A. Since we anticipated a lot of comments, and we did anticipate some -- a fairly high quantity that would be in opposition to the rule, to be able to provide responses and feedback to those comments directly, we thought it would be best to have a few outside experts participate on the panel.
Q. Now, during the comment period at the hearing and the comment period for written comment, did the Agency receive comments that opposed its perspective?
A. Yes, it did.
Q. Who reviewed those comments?
A. Myself, our rules unit as well as Nai Chen.
Q. Do you recall the names of some of the prominent folks who commented against the rule?
A. Yes. So most notably, as far as written substantive

comments went, there was a group of faculty from Yale University as well as a couple of other universities that had written us a lengthy comment.

We also received comments from the Endocrine Society.

In addition we had also received comments from the American Academy of Pediatrics.

Q. When you received those comments from those prominent institutions and people, what did you do with them?

A. I read them very carefully.

Q. Did you do anything else beyond reading them very carefully?

A. Because they were very lengthy and very much based on scientific literature, research, and since I actually had been the one who had gone through and did the research for the report, I went ahead and started putting together analyses of each one.

MR. JAZIL: Your Honor, may I approach the witness with Plaintiffs' Exhibit 326?

THE COURT: You may.

BY MR. JAZIL:

Q. Do you recognize this document, Mr. Brackett?

A. Very much I do.

Q. What is it, sir?

A. That is our comment summary from the rule hearing from July 8, 2022.

Q. You testified a bit about why it is you prepared this document. Is there anything you would like to add to the why you prepared this document after having seen it just now?
A. So, because the Agency, I mean, because we did do exhaustive work on this project, we had gone through -- did a report, did a lot of research for that report, we had gone through the rulemaking process, that we do take outside comments very seriously. And we wanted to review them to determine whether or not they introduced anything that could particularly truly conflict where our GAPMS report, with our conclusions or our actions. So, it was -- this is part of what the Agency's responsibilities are, is to take into account comments from the public.
Q. If someone had as part of that comment process, provided you a high quality study, showing the efficacy and safety of puberty blockers, for example, to treat gender dysphoria, what would you have done with that comment?
A. It would have made me rethink my position.
Q. Now, Mr. Brackett, are you familiar with the tag line, "Let Kids Be Kids"?
A. Yes, I'm familiar with it.
Q. What is it, sir?
A. So that's the slogan that went on the web page that accompanied the GAPMS release.
Q. Are you aware of other instances where the Agency has

used slogans with policy initiatives?
A. Yes.
Q. Mr. Brackett, we've some heard testimony before about how the Agency has not used outside consulting experts as part of the GAPMS process.
Do you know whether the Agency has used outside consultant experts as part of other work the Agency has done?
A. Oh, yes, we have.
Q. Can you give me a couple of examples, sir?
A. Well, as our Bureau Chief testified earlier, we did use an outside consultant for the Canadian Prescription Drug Importation Program. We've also used outside consultants when working on behavior analysis and other policies on that treatment service.
THE COURT: Before we go beyond that, let me make sure I understood the premise of the question. The premise of the prior question was that the Agency had not used outside consultants in the GAPMS process. Is that correct?
THE WITNESS: That's correct, sir.
MR. JAZIL: Your Honor, I believe there was some earlier testimony from Mr. English that the --
THE COURT: Right. I knew there was prior testimony, but sometimes people disagree with prior testimony. I was just trying to make sure there wasn't any doubt about it.
MR. JAZIL: Understood, Your Honor.

BY MR. JAZIL:

Q. You gave us a couple examples of instances where outside consultants were hired. I asked you about the tag line, "Let Kids Be Kids," you said the Agency had used tag lines before. Do you have a couple examples for us of instances where the Agency --

A. Since I do work on the Canadian Prescription Drug Importation Program, there have been a couple of slogans associated with that, and the Agency initiatives on lowering prescription drug prices.

Q. Understood.

Mr. Brackett, do you know Jeffrey English?

A. Yes, I do.

Q. How do you know him, sir?

A. He was a co-worker of mine in the Bureau Medicaid policy.

Q. Are you familiar with his work, sir?

A. Yes, I am.

Q. How so?

A. There have been times I had to review it. I have also been his acting supervisor, but always because of my experience on GAPMSes, I have been periodically asked to review his work product.

Q. Were you asked to review a GAPMS report of his on computer-assisted musculoskeletal surgical navigational orthopedic procedures for total knee arthroplasty, sir?

A. Yes. I remember in March of 2022 being asked to take a look at that draft.
Q. What did you find based on your review?
A. I had found that he had plagiarized parts of it.
Q. Now, Mr. English has testified before in this case that he did not include citations for a draft document. So how then can you say that he plagiarized something when he just didn't cite something in the draft?
A. Because according to the Bureau of Medicaid Policy Procedures, when you have completed a draft of something and you have routed it to your supervisor for approval, and your supervisor signs off on it as having approved it and sends it to the Bureau Chief, that's a finalized draft. That's not a draft for review and feedback prior to routing. That's a finalized draft.
MR. JAZIL: Your Honor, I have no further questions.
THE COURT: Cross-examine?

CROSS-EXAMINATION

BY MS. DeBRIERE:
Q. Good morning, Mr. Brackett. I've been taking some notes, so I'm going to get myself organized. It will take just a second.
A. No problem.
Q. Thank you.
Okay. Let's start by talking about your education a

little bit.

You have an Associate in Arts from Tallahassee Community College; is that correct?

A. Yes.

Q. And you have undergraduate degree in history from Florida State University?

A. Yes.

Q. You have a Masters of Arts also from Florida State University; is that right?

A. That's correct.

Q. I think your thesis for your Masters was called, "Pensacola, Florida, During the Civil War and Reconstruction"?

A. That's right.

Q. Do you have a science degree?

A. I do not have a science degree.

Q. Do you have a medical degree?

A. I do not.

Q. Are you or have you ever been a health care provider?

A. I have not personally worked as a health care provider.

Q. Have you published in any scientific journals?

A. No, I have not.

Q. Have you published in any medical journals?

A. No, I have not.

Q. And you mentioned you were peer-reviewed. What was that

in?
A. So my peer-reviewed articles, those were historical. One was in the Florida Historical Quarterly, and the other one was in Southern Studies, which is an Interdisciplinary Journal of the South. That one actually was a public-health-history-related project.
Q. What was the title of that article?
A. "Cutting Costs by Cutting Lives."
Q. And what was it about?
A. It was about prisoner health and how it led to the abolition of Florida's penal labor system.
Q. And the other article you published in Florida Historical Quarterly, I believe the name of that article was "Wrongful Defeat: The 1934 Florida Senatorial Democratic Primary between Claude Pepper and Park Trammell"; is that correct?
A. That's correct.
Q. Do you have any experience conducting clinical research?
A. Can you please rephrase that?
Q. I can try asking it again. Does that work?
Do you have any experience conducting clinical research?
A. So are you referring to reading clinical-reviewed articles or are you talking about actually preparing research for clinical journals?
Q. Actually preparing research for clinical journals.
A. No.

Q. Do you have any education or training related to the evaluation of clinical or medical research?
A. So, when I did work at the Department of Health as a medical disabilities examiner, that job, in order to execute it correctly, you do have to have a degree of medical literacy. So you do spend a lot of time reading medical literature, going through medical science. You are collaborating with doctors. That job requires a high degree of medical literacy. If you don't have it, you can't execute it.
Q. When did you work in that position?
A. I worked in this position in 2014 and 2015.
Q. Did you go straight from being a teacher to going into being an adjudicator?
A. Yes.
Q. And what kind of teacher were you?
A. So I have caught a little bit of everything. I taught just about every social science thread, middle school, high school, I also taught college and university. When I --
Q. I'm sorry, Mr. Brackett. I was just speaking if the teaching position you held directly before becoming an adjudicator. What teaching position was that?
A. So I taught math and science at a school in Sweden.
Q. What type of school?
A. It was an international school, English speaking.

Q. What grades?
A. So I taught around ninth grade.
Q. Okay. And then the adjudicator position, did that require a degree in science to work at?
A. No. So the Department of Health brought in people with different backgrounds, and the Social Security Administration does have a program for people to go through to train to become one.
Q. So you received some training with the Social Security Administration regarding medical reviews; is that correct?
A. That is correct.
Q. How long was that training for?
A. That training was really ongoing for about a year. Of course, your first couple of months are just spent doing nothing but training, and then they start giving small numbers of cases. And as you train on those, you steadily get more and more well versed in medical literacy, policy. It takes about a full year before they work you up to a full caseload. So you train for a year.
Q. Okay. Turning to the case at hand, Mr. Brackett, the task given to AHCA by the governor's office in this matter was to take a detailed look at the available medical evidence or at least the peer-reviewed literature and see what it says. Is that an accurate statement?
A. Yes.

Q. And it's my understanding that Ann Dalton and Secretary Weida selected you and the Canadian Prescription Drug Importation Program team for that task; is that right?
A. That's right.
Q. You testified just a second ago you were chosen for that task in part because of your experience in special projects as well as your experience I think for ten months, you said, in GAPMS. Why was this a special project?
A. Well, for me, I considered this a special project, it was just a GAPMS, but since it was a job that was outside the Canadian Prescription Drug Importation. Special projects is kind of a term that I've used personally for myself, since it was a -- I just considered it a special project, considering it was a little outside what my position description required.
Q. So, it was something you defined yourself, but it was criteria that Ms. Dalton used to select you to draft the GAPMS, right?
A. Yes.
Q. Nai Chen, a pharmacist, was also on the Canadian Prescription Drug Importation Program team; is that right?
A. That's correct.
Q. And Mr. Chen is a pharmacist; is that right?
A. Yes.
Q. Mr. Chen's assistance with the June 2022 GAPMS report,

would you describe it as fairly limited?
A. As far as the work that contributed, that would be limited, but he and I discussed stuff every day.
Q. Okay. So his role my understanding was two parts: He created the map that you discussed earlier, and then he also occasionally sent you -- found and sent you an article. Is that accurate?
A. Yes, he did that as well.
Q. It's my understanding that the process you used to draft the June 2022 GAPMS was to collect and review the literature that you deemed relevant in determining whether gender-affirming care was experimental. Is that an accurate representation of your process?
A. So my assessment going through, determine whether or not -- finding sources that were relevant to the topic, that would be accurate, yes.
Q. Did you rely on all relevant medical literature regarding gender-affirming care when drafting the June 2022 GAPMS?
A. I relied on everything that I found and include on my works cited page.
Q. So everything you relied on is contained in that works cited page; is that correct?
A. That's correct.
MS. DeBRIERE: So, Your Honor, I would like to show what has been marked as Plaintiffs' Exhibit 141. It will take

just a second to appear on the screen. Bear with me.
BY MS. DeBRIERE:
Q. Mr. Brackett, this is a 2011 study from de Vries. The study pertains to puberty suppression in adolescents with gender identity disorder and published in the Journal of Sexual Medicine.
Did you rely on this study in your report?
A. I believe I did cite study. Yeah, this is one of the studies that we considered.
Q. And this is contained in your works cited?
A. I think that one is, yes.
MS. DeBRIERE: Can we bring up Plaintiffs' Trial Exhibit 18. Can we go to page 40, please.
BY MS. DeBRIERE:
Q. Mr. Brackett, what I would like you to do is review that. I believe it's in alphabetical order, so we can scroll down to page 40. Is that correct, it's in alphabetical order?
A. Yes, it's in alphabetical order.
Q. Right now we are talking about de Vries, the 2011 study. I do see --
MS. DeBRIERE: Go to page 40, please.
BY MS. DeBRIERE:
Q. I do see a study here 2014 de Vries, but I was asking about a 2011 study.
A. So in response to that question, is that there are 88

articles cited. Many of these I have not laid eyes on in a year.

Q. That's fine. I was trying to confirm: Did you rely on the 2011 de Vries study?

A. What's cited in the works cited is what I relied on --

Q. Okay.

MS. DeBRIERE: Can we bring up Plaintiffs' Exhibit 166, please.

BY MS. DeBRIERE:

Q. This is a 2013 Colizzi study. It's entitled, "Hormonal Treatment Reduces Psychobiological Distress in Gender Identity Disorder," and it was published in the Journal of Sexual Medicine. And I would just like to look at the study's conclusion at PLAINTIFFS6574. It states:

Our results suggested that untreated patients suffer from a higher degree of stress and that attachment insecurity negatively impacts the stress management. Initiating the hormonal treatment seemed to have a positive effect in reducing stress levels, whatever the attachment style may be.

Mr. Brackett, I can tell you this is not contained in your works cited page. Did you rely on this study in drafting the June 22nd GAPMS report?

A. No, I did not.

MS. DeBRIERE: Can we go to Plaintiffs' Trial Exhibit 176.

BY MS. DeBRIERE:

Q. This is 2021 Green study that discusses the association of gender-affirming hormone therapy with depression, thoughts of suicide and attempted suicide among transgender and nonbinary youth. It was published in the Journal of Adolescent Health. And looking at the conclusions of the study in PLAINTIFFS6676, it states:

Findings support a relationship between access to gender-affirming hormone therapy -- that's what "GAHT" stands for -- *and lower rates of depression and suicidality among transgender and nonbinary youth.*

So, again, Mr. Brackett, I can tell you this article is not contained in your works cited page. Did you rely on it in the June 2022 GAPMS report? We're happy to bring up the works cited page.

A. I've got it right here in front of me.

No, we did not look at this one, but we did look at studies similar to that.

Q. What study was that?

A. So I think that one would be -- because we did look at surveys. I think we used as an example of a study we used Geffen.

Q. I'm sorry?

A. On page 40, the Geffen study.

Q. And what was the name of that study?

A. Wait. No. I want to backtrack on that one.

No, we didn't. In our quality of evidence section -- I think I had the authors mixed up -- we did rely on -- we did do an analysis of a study that we relied on a large survey.

Q. Okay. But you did not rely on this particular study?

A. I did not.

Q. And the topic of this particular study?

A. Are you talking about the topic?

Q. The study that you evaluated, yes.

A. So I would not use this study -- as far as the topic on suicide, I would actually need to go back and look at some of the content in the GAPMS report to confirm for you whether we did or not.

Q. Okay. I'll move on.

I would like to show what's marked as Plaintiffs' Exhibit 151. This is 2020 study by Achille. This is a study on the longitudinal impact of gender-affirming endocrine intervention on the mental health and wellbeing of transgender youth. It was published in the International Journal of Pediatric Endocrinology.

Looking at the study's conclusion at PLAINTIFFS6284, it states:

Our preliminary results show negative associations between depression scores/suicidal ideation and endocrine intervention, while quality of life scores showed positive

associations with intervention, in transgender youths over time in the U.S.

Again, Mr. Brackett, I can represent to you that this was not contained in your works cited page. Did you rely on this study in drafting the June 2022 GAPMS?

A. I did not.

Q. Bringing up Plaintiffs Trial Exhibit 154. This is a 2021 Almazan study which reviewed association between gender-affirming surgeries and mental health outcomes. It was published in JAMA Surgery. Looking at the study's conclusion at PLAINTIFFS6320, this study's results -- excuse me -- the study's results demonstrate that undergoing gender-affirming surgery is associated with improved past-month severe psychological distress, past-year smoking, and past-year suicidal ideation.

Same question, Mr. Brackett.

A. We did not use this one in our study.

MS. DeBRIERE: I'm going to ask for Plaintiffs' Exhibit Trail Exhibit 155.

BY MS. DeBRIERE:

Q. This is a 2022 Ascha study. It evaluates top surgery and chest dysphoria among transmasculine and nonbinary adolescents and young adults, published in JAMA Pediatrics.

I have the same question for you, Mr. Brackett.

A. If it's not in our works cited, we did not use it.

Q. Okay. Just one more.

Looking at one final study, Plaintiffs Trial Exhibit 192, this study is entitled, "Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth." It's authored by Mehringer in 2021.

Looking at the study's conclusion at PLAINTIFFS6858, it states that, quote:

We *observed consensus that chest dysphoria is a major source of distress and can be functionally disabling to transmasculine youth. Masculinizing chest surgery performed during adolescence, including before age 18, can alleviate suffering and improve functioning.*

Last time, Mr. Brackett, was this a study you relied in the June 2022 GAPMS report?

A. We did not rely on this study.

Q. So you stated during your earlier testimony that your review was exhaustive. Do you maintain that your review of those medical literature was exhaustive as to gender-affirming medical care?

A. I still maintain that position, yes.

Q. So turning back to Plaintiffs' Trial Exhibit 18, in the June 2022 GAPMS report, you concluded that because the cause of -- excuse me. Let's get to the page first so you can read it. It would be page 14.

A. Okay.

Q. So in the report you conclude that because the cause of gender dysphoria has not been established, treatments that pose irreparable effects should not be utilized to address what is still categorized as a mental health issue.

There is no citation next to that statement, is there, Mr. Brackett?

A. No, there is not.

Q. So that's your independent conclusion?

A. Yes, that's my independent conclusion.

Q. Also, in the June 2022 GAPMS report, on page 21, you discuss the positions of the American Academy of Pediatrics and the American Psychological Association regarding gender-affirming care, and you conclude that stances like these can substantially influence practitioners in their treatment recommendations.

And, again, Mr. Brackett, there is no citation next to this statement; is that right?

A. That's correct.

Q. So this is your independent conclusion?

A. That's my independent conclusion.

Q. Are you a member of any professional medical organizations?

A. No, I'm not.

Q. In a couple of the sections of the June 2022 GAPMS report you discuss watchful waiting. If high percentages of

children diagnosed with gender dysphoria.

THE COURT: Give me the exhibit number of this again. I thought you said Plaintiffs 18, and --

MS. DeBRIERE: That's correct, Your Honor, it's Plaintiffs' Trial Exhibit 18. It's the June 2022 GAPMS report.

THE COURT: I got it.

MS. DeBRIERE: Page 12.

MR. JAZIL: Your Honor, if I may, it's also DX6. DX6 is the exhibit with all of the attachments.

THE COURT: I was just pulling up the wrong document on my machine. I'll figure that out at some point, but thank you.

BY MS. DeBRIERE:

Q. So as I stated, in a couple of other sections of the June 2022 GAPMS, you mention watchful waiting; for example, you state:

If high percentages of children diagnosed with gender dysphoria also have histories of trauma and attachment issues, should conventional behavioral health services be utilized without proposing treatments that pose irreversible effects? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects.

And then you say, *For example, one of those approaches*

would be the watchful waiting approach.

Is that an accurate representation of your report?

A. I'm seeing the whole screen. I'm trying to follow you from where you were reading.

Q. Take your time to locate it. It's in the second full paragraph.

A. Okay. Can you scroll down so I can see the exact page number?

Okay. There we are.

Q. I apologize. There is --

A. I was reviewing the wrong page.

Q. It was my fault, Mr. Brackett. I apologize. I confuse things.

So, once again let me ask the question, because I'm sure at this point it's been lost.

There is a couple of times in this report that you refer to watchful waiting. This is an example of referring to watchful waiting.

When you were referring to watchful waiting, were you referring to the Dutch model?

A. Yes.

Q. And under the Dutch model, it's my understanding that after the waiting period the studies suggest that care should be started at some point for those who persist. Is that accurate?

A. According to those individuals, I think they do make recommendations for that, yes.
Q. Okay. Based on your report it seems like you're endorsing watchful waiting. Is that a correct characterization?
A. No. I can see how that paragraph can be read, though, when taken out of context, but no.
Q. Okay. Because, just to be clear, the watchful waiting approach at some point does recommend that care be started; is that right?
A. At some point, yeah, following the Dutch model.
Q. Okay. Thank you.
MS. DeBRIERE: Can we pull up Plaintiffs' Trial Exhibit 23, which is Rule 59G-1.035.
Your Honor, my co-counsel was asking if we would like to stop for lunch. I think I only have probably 20 minutes left. It's 12:30.
THE COURT: If we can finish, let's do. We can make it till 1:00 before we eat.
BY MS. DeBRIERE:
Q. Okay. So as my friend reviewed earlier, part of the Agency's standard process in assessing whether health services fall with Generally Accepted Professional Medical Standards is to determine whether the services are supported by evidence-based clinical guidelines. Is that a correct

characterization?
A. So, subsection 4(a), yes.
Q. Having read your report, I take it that you do not think WPATH guidelines are evidence-based. Is that a correct statement?
A. Well, I can -- when you take into account evidence at-large, well, yes, they are evidence-based, but that evidence is low, low, very low quality. So it's very weak evidence, and you can't build a solid foundation for guidelines on weak evidence.
Q. So that's why you didn't use WPATH as a determining factor under 4(a); is that right?
A. No, that's not correct. I did use WPATH. I took WPATH's guidelines extensively into my considerations. I read, re-read, and probably re-read again their guidelines. I did take them into high consideration, maybe more so than some of the other sources.
Q. Okay. Does WPATH maintain that gender-affirming medical care is experimental?
A. No, that's not WPATH's stance.
Q. Okay. So you did not adopt that portion of WPATH; is that right?
A. My findings didn't agree with theirs.
Q. Okay. Thank you.
And your findings -- so it's my understanding that your

finding did not agree with theirs because your determination of the low quality of the evidence; is that correct?

A. Right. My assessment of the evidence did not align with the strength of their recommendations.

Q. Okay. Last week plaintiffs' expert, Dr. Dan Karasic, testified that a 2016 study found that there was a high degree of certainty to support the provision of care in only 13 and a half percent of the time when a systematic review of all medical interventions was conducted.

Did you take that particular finding into consideration when you decided not to follow the WPATH's guidelines in your opinion?

A. Since I don't think we included that in our works cited, I don't think we took that position into account, no.

Q. Okay. Dr. Karasic further testified about another study, also a systematic review of a variety of medical interventions, not just gender-affirming care, which was done to determine the percentage of interventions that satisfied the high quality criteria of GRADE, dividing those interventions into simple and complex.

Dr. Karasic testified that the study found that, when looking at complex interventions which would include gender-affirming medical care, none had high certainty under GRADE, and the most common result was the medical intervention demonstrated was very low certainty.

Again, Mr. Brackett, did you consider that when you were adopting your conclusions in the June 2022 GAPMS report?

A. I did not consider that, but based on what you've read, that seems to mirror my findings upon my reading of the evidence.

Q. Okay. I was saying as to all medical interventions, not just gender-affirming medical care.

A. No. I understand where you are going with that, yes.

Q. You also just mentioned in your earlier testimony that, after learning that the 2017 surgery GAPMS -- GAPMS on gender-affirming surgery, was not, as you mentioned, probed and the studies relied on, guidelines cited, were taken at face value.

Did you decide at that point, seeing that that GAPMS was weak, that you would go back and review all GAPMSes to make sure there were similar weaknesses regardless of the type of care it was assessing?

A. No. That's not a job I would undertake.

Q. Looking at another factor under 59G-1.035, the criteria used to determine whether -- another factor under 59G-1.035 is evaluating whether there is other credible health coverage of the health service. That would be (4)(e).

So in reviewing the June 2022 GAPMS you assess coverage under Medicare, TriCare, the VA, and state Medicaid programs; is that correct?

A. That's correct.
Q. Did you include an assessment of whether gender-affirming care was covered by commercial or private insurers?
A. No, we did not.
Q. So, looking at this rule, where in this rule does it state to limit assessment to only government insurance programs?
A. It doesn't actually specify what insurance programs to look at. It just says other credible insurance payors.
Q. So the ruling does not contain the limitation as to only government insurance programs; is that right?
A. It's not a requirement, but it's -- this is also not the only GAPMS where did not look at private payors. It's a totally different business model.
Q. Fair enough. So in undertaking GAPMS, prior to the June 2022 GAPMS, was there ever a time AHCA did rely on private or commercial insurance coverage as part of the assessment?
A. There have been times with GAPMS reports in the past that we've taken a look at private payors. That's usually to supplement if we are having problems getting enough information from other Medicaid payors, but first and foremost it's always what do the other state Medicaid programs cover.
MS. DeBRIERE: I would like to pull up at Plaintiffs'

Trial Exhibit 331, this is a GAPMS on scleral contact lens in its final draft form. On page 7 -- scroll down a little bit, a little bit more. There we go.

BY MS. DeBRIERE:

Q. So here, consideration, yes, of commercial insurance coverage, AEtna, Blue Cross/Blue Shield, I think it continues on to the other page. So in this GAPMS you did decide to rely on commercial insurers?

A. I did not actually author the one on scleral lens, but this mirrors some of the GAPMS reports I did. I mean, when we don't have an exhaustive perspective of other state Medicaid programs or to strengthen that section, often we can add private insurance payors.

Q. Okay.

MS. DeBRIERE: Can you scroll up just a little bit, probably the page above.

BY MS. DeBRIERE:

Q. So here it says state Medicaid programs, 30 Medicaid programs include coverage for scleral contact lens. So here it looks like there was strong evidence within the state Medicaid programs, but you also decided to do an analysis of the commercial insurance; is that right?

A. Well, 30 states, yes. That's often at the analyst's discretion. It's not necessarily required.

Q. Okay. A final factor, under 59G-1.035 calls for the view

by -- excuse me. Let's start by saying:

Just reviewing through some of your earlier testimony about coverage not here in the U.S., but in European countries, you mentioned some European countries that have recently placed restrictions on gender-affirming care for minors. Is that an accurate representation of your testimony?

A. Yes.

Q. Have any of those countries barred provision of coverage of gender-affirming care to adolescents under all circumstances?

A. I don't -- as I recollect, I don't think so, but I think it's very, very extenuating circumstances if it's used.

Q. How would you define "extenuating"?

A. I don't know. You would have to -- I mean, given -- I'm basing that statement based on the guidelines that I read from the other countries, it would be up to like House of Lords in Sweden to make that determination.

Q. So touching on one final factor under 59G-1.035, which calls for the views by clinical or technical experts on the subject or field. Did AHCA contract with Dr. Andre Van Mol to assist with the June 2022 GAPMS report?

A. Yes, we did contract with him.

Q. At the time AHCA decided to contract with Dr. Van Mol, were they aware that he was affiliated with the American

College of Pediatricians?

A. I do not know if they were aware.

MS. DeBRIERE: Can we pull up Plaintiffs' Trial Exhibit 284.

BY MS. DeBRIERE:

Q. You see here some articles that Dr. Van Mol shared with Secretary Weida while working on the June 2022 GAPMS report. Some of these articles are about "Financing the Transgender Movement and Its Tactics," another title is "Who are the rich, White Men Institutionalizing Transgender Ideology." Do you see those there?

A. Yes.

Q. Are these the kind of articles that AHCA might take under consideration when they're deciding whether to contract with consultants to provide information about care for people who are transgender?

A. I can't speak to that.

Q. Would it have affected your personal decision to contract with Dr. Van Mol?

A. I don't know. Because this is an email, I don't know how it would apply to the large context of the discussions.

MS. DeBRIERE: Can we pull up Plaintiffs' Trial Exhibit 285.

BY MS. DeBRIERE:

Q. Here Dr. Van Mol writes to you: *I've read through*

several more. These four are the best of the lot that establish the connection to big pharma, biotech, philanthropy profiteering in the clothes of being rights advocates.

Including an article, you'll see in the attachments called, "A Founding Father of the Transgender Empire," as well as, "The ACLU Gets Fat on Pharma and Tax Funding."

So these articles were sent to you. Did they have any impact on your decision as to whether to rely on Dr. Van Mol's information provided?

A. Well, I never actually read anything that he sent us, so as far as those goes because they didn't really pertain to the subject I was evaluating. I was looking at the medical evidence. So the input that I got from Dr. Van Mol that helped were mostly more getting citations and some feedback or suggestions for peer-reviewed literature that were in academic journals.

Q. Did these articles that he shared with you, did it indicate he might be biased?

A. I mean, it indicated that I think he disagreed with the conclusions of a lot of medical evidence.

Q. Okay. So you did know that he disagreed with gender-affirming medical care when you were consulting with him; is that right?

A. As we worked with him, yes, I was aware of that position.

Q. Okay. Turning to the rule adoption process a little bit,

why did you -- you earlier testified. Why did you expect such a large opposition to the rule at the public hearing?
A. Well, as far as my experience and my role in the process since we had gotten so many comments -- I mean, we had like 600 comments -- hundreds before the hearing even took place, so we expected there to be a large turnout of people there; and just the fact that the report, when it was released, I mean, it was in the news. So this was a hot topic.
Q. Did that extensive opposition affect your decision to adopt the final rule?
A. No, it did not.
Q. Did AHCA confer with the GAPMS consultants about any questions they might receive from those testifying at the public hearing prior to the hearing?
A. There were a couple, I think, Zoom calls. Generally the ones I was on were just more basically on how the arrangements for the hearing would go. I don't think so there was an extensive Q and A prep with the experts. I think it was just mostly more, here's what's going to happen, here's what you can expect.
Q. Okay. So AHCA didn't suggest that the consultants provide specific answers to questions for the public hearing?
A. I don't recall them providing specific answers.
Q. Okay. Did the consultants ask if they should say anything in particular at the public hearing?

A. No, I don't think there was anything like that, no.

MS. DeBRIERE: Can we look at Plaintiffs' Trial Exhibit 303.

BY MS. DeBRIERE:

Q. Here you see an email from Miriam Grossman to Secretary Weida and it says:

Quick question: Is it okay if while answering a question at the hearing, I say something like, this rule will protect young people in Florida the same way similar kids are now protected in Sweden, Finland, et cetera. I applaud the State of Florida and hope many others will follow.

So that does seem like asking if she should respond in a certain way at the hearing. Is that your interpretation?

A. Yeah.

MS. DeBRIERE: Can we look at Plaintiffs' Trial Exhibit 292. Can you scroll down just a little bit, please. I'm looking specifically for --

THE COURT: Voices up where we can all hear.

MS. DeBRIERE: I apologize, Your Honor.

Actually, can you pull up 286. Again, my mistake. Thank you. Can we scroll down. We talked about this exhibit quite a bit. Keep scrolling, please. This is not the right one. Can you go to 286A, please, A as in apple.

BY MS. DeBRIERE:

Q. So you had previously testified that Dr. Van Mol had put

together a bibliography for you, and this is the document you were referring to; is that correct?

A. Yes.

Q. Okay.

MS. DeBRIERE: And I just want to note for the Court, this document is both at 286 -- if you can scroll down, please, Ms. Gonzalez, keep scrolling through the whole document just very quickly so we can all see.

BY MS. DeBRIERE:

Q. You know, as I'm looking at this, Mr. Brackett, there's actually a 286B, as in boy, as well. This looks like more than a bibliography to me. Do you disagree with that contention?

A. There are some summaries in there. I actually didn't really look at the summaries. I just looked at the sources.

Q. Okay. It's my understanding you paid someone -- Dr. Van Mol close to $35,000 to write a document, a pretty extensive document, that you then decided not to consult while drafting the June 2022 GAPMS report; is that right?

A. Can you repeat the question?

Q. I absolutely can.

So it's AHCA's decision to pay Dr. Van Mol several thousand dollars to draft this document; is that right?

A. My awareness was that he already had this document composed before he contracted with us, or at least most of it

composed. I don't think, given the time that we had spent between getting an agreement done and him sending this to us, he would have had enough time to do this project on his own.

THE COURT: Here's the question: This man got hired for a lot of money to work for the State. He sends you this long document talking about the very subject you're working on, and your testimony is you didn't read it or take it into account. Is that --

THE WITNESS: No, Your Honor, I'm not testifying to that.

THE COURT: All right. Then tell us the truth. Did you read this document? Did you consider it?

THE WITNESS: So, I read the document, but I was primarily interested in the articles. That was really what I was looking at, or the articles and the citations. The content summaries, I wanted to look at -- I look everything for my own eyes.

THE COURT: So he read it. There you go. Next question.

MS. DeBRIERE: Thank you, Your Honor.

Plaintiffs' Exhibit 291. Scroll down, please.

BY MS. DeBRIERE:

Q. I think you had just testified that Dr. Van Mol had already prepared the document and simply shared it with AHCA.

What I just showed, that was the master background

document; is that correct?
A. That was the document that he had sent to us. I mean, I don't -- no one has ever referred to it as a master background document. I'm not sure what's meant by that.
Q. Well, what is this master background document then that he refers to in his invoice?
A. I guess that would probably be what he sent us. I didn't see his invoice, so --
Q. So Dr. Van Mol may have charged you guys nine hours for completing a master background document that he had already drafting previously?
A. No. I think, given how long it is, it would strain fragility to say that he composed a 55-page document in nine hours.
Q. I just have a few more questions.
MS. DeBRIERE: Can we pull up Plaintiffs' Trial Exhibit -- what we have marked as Plaintiffs Trial Exhibit 365.
Your Honor, if I may turn to counsel, this, Mr. Jazil, is an exhibit that we shared with you last night and asked if there were any objections. It's a press release regarding Senate Bill 254. I'm gathering from your face that you did not see my email.
MR. JAZIL: Your Honor, I haven't seen the exhibit. Perhaps we can put it up and I can --

If my friend is going to represent this is from the governor's website, then I think the Court can take judicial notice of it. I think it's a press release. Are you --

THE COURT: Are you offering the document in evidence?

MS. DeBRIERE: I would like to, Your Honor, yes, please.

THE COURT: It probably doesn't have a number, yet. I don't know what the last number is. Give it the next number.

MS. DeBRIERE: We premarked it, Your Honor.

THE COURT: 365?

MS. DeBRIERE: Yes, Your Honor.

THE COURT: Is there an objection to 365?

MR. JAZIL: Your Honor, a quick question. Are we using it to attribute statements to the governor or to --

MS. DeBRIERE: So, Your Honor, I --

THE COURT: Look, let me just tell you. I'm sure you all have read my *Warren* opinion. One of the things I said is, look, when an official makes a decision, the official is welcome to put it out however they want; and, if you put some statement out for political reasons, that doesn't tell you why you made the decision. And so, if you made a decision for legitimate reasons and you issued a press release to maximize the political benefit, well, that's what people who run for

office do. Maybe that tells you something about how it got done, but not very much. So this isn't going to tell us very much. It's too small for me to read it, but --

MR. JAZIL: Your Honor, just a word of caution, I guess; that is, statements in press releases that are attributed to people ordinarily aren't said by those people, they are written by someone in the press shop, et cetera. So with that --

THE COURT: Well, I get it; but, if it got issued in his name, it's --

I'll admit it. Plaintiffs' 365 is admitted.

(PLAINTIFFS' EXHIBIT NO. 365: Received in evidence.)

MR. JAZIL: Thank you, Your Honor.

MS. DeBRIERE: Scroll down, Ms. Gonzalez, the second page please.

THE COURT: And go ahead at some point and file 365 on the CM/ECF system so that it's part of the record.

BY MS. DeBRIERE:

Q. Mr. Brackett, as we just discussed, the governor's office issued a press release yesterday about Senate Bill 254, which in part prohibits the use of State funds like Medicaid to pay for gender-affirming care. Are you at all familiar with that bill?

A. Only what I have seen in local news.

Q. Are you familiar with the press release other than seeing

it here today in front of you?
A. I am now. No, I had not seen the press release.
Q. I just want to point out that in this press release it does use the slogan "Let Kids Be Kids."
Did AHCA solely develop the "Let Kids Be Kids" slogan?
A. You mean when we did the --
Q. Yes, for the --
A. -- GAPMS?
Q. -- June 2022 GAPMS.
A. I'm under the impression that AHCA created that, yes.
Q. Okay. And so the AHCA-created slogan has now been adopted by the governor's office regarding Senate Bill 254?
A. That appears to be the case.
Q. And you had mentioned that AHCA had developed other slogans for programs; is that right?
A. Yes.
Q. Okay. What were those slogans?
A. I think "lower Prescription Drug Prices." I think that's the one I can think of off the top of my head. Our website, I think, we have like one for visitation rights. I mean, our website has lots and lots of slogans and banners for various programs we do.
Q. Okay. So we would be able to find those slogans on AHCA's website?
A. You should. We definitely have archive versions of

these. I mean, we come up with new slogans every quarter, so --

Q. Okay. Thank you. Just one last set of questions.

It's my understanding that you were in the GAPMS position for 11 months; is that correct?

A. Ten months.

Q. Ten months. Thank you.

Jeff English, it's my position, was in that position for three years?

A. Yes.

Q. And he left that position voluntarily?

A. To my knowledge, yes.

MS. DeBRIERE: Thank you, Your Honor. That's all I have.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. JAZIL:

Q. Mr. Brackett, my friend asked you about studies that were not included in your GAPMS report. Do you recall that testimony, sir?

A. I do.

Q. One of the studies that my friend brought to your attention was a study called, "Top Surgery and Chest Dysphoria Among Transmasculine and Nonbinary Adolescents and Young Adults," from JAMA Pediatrics.

Do you recall questions about that?
A. I do recall her questions.
Q. If you go to page 43 of DX6, your GAPMS report, the third one down, sir.
A. Yes.
Q. Was that an article concerning top surgeries and dysphoria?
A. Yes, it was.
Q. My friend mentioned the de Vries article, but your -- does your works cited include an article by the same author, just from a different year?
A. It does. And that was the reason why I was little confused when that one was put on the screen versus what we had actually cited. Titles can be kind of combobulated sometimes.
MR. JAZIL: Can we pull up Plaintiffs' Exhibit 176, please.
BY MR. JAZIL:
Q. Do you recall my friend asking questions about this article, sir?
A. I do.
MR. JAZIL: If we can go to the next page. Can we blow up the procedures section.
BY MR. JAZIL:
Q. Take a look at that, Mr. Brackett, and look up at me when

you're done.
A. Okay.
Q. Did you in your GAPMS report look at other articles that used the survey method to obtain information?
A. We did.
Q. And did you find them -- why -- did you find them persuasive?
A. No, I did not.
Q. Why not, sir?
A. While it's a survey, it does have a very large, large sample size. I mean, I think the citation I was looking for was on page 41, and it was by Herman. So, you have 34,700 plus sample size. They recruited through various social media means, Snapchat, et cetera, so they are looking through online communities. But regardless of how they are sampled, it's a momentary snapshot. It's how these youths are feeling at any given moment. It's just a momentary snapshot. We don't have longitudinal histories. We don't know the participants' backgrounds. We don't know their profiles.

So -- and I think these surveys, most of them are usually anonymous. So we don't really know who they are even. So that makes it quite problematic. But it's a snapshot, okay, this is interesting, but there's a lot more information that's needed.

MR. JAZIL: No further questions, Your Honor.

THE COURT: Mr. Brackett, they asked you a lot of questions about your background. I want to fill it in a little bit.

You were a teacher in Sweden immediately before you came to AHCA. Where else have you taught?

THE WITNESS: Your Honor, I also spent four years teaching in Jacksonville, Florida.

THE COURT: Where did you teach in Jacksonville?

THE WITNESS: So I taught at a charter school called River City Science Academy.

THE COURT: Say again.

THE WITNESS: Oh, it was a charter school called River City Science Academy. It was kind of like south side, Beach Boulevard area, if you're familiar with Jacksonville.

THE COURT: Some kind of science emphasis?

THE WITNESS: The school had a science emphasis, yes.

THE COURT: Where else? Sweden and that school in Jacksonville. Anywhere else?

THE WITNESS: I've also taught at Florida State University, Tallahassee Community College, and I also taught at St. Johns River State College.

THE COURT: What did you teach at FSU?

THE WITNESS: History.

THE COURT: Were you on the facility at FSU teaching history?

THE WITNESS: No. I was a TA.

THE COURT: So you were a student, and you were a TA, helping out -- I was an undergraduate at Florida State, so I had back then we called them graduate assistants. That's what you were, a graduate assistant?

THE WITNESS: Well, I was not assisting a professor. I was the teacher of record. So I prepared all of the lectures, exams, grade all the content. I was the teacher of record for those courses, sir.

THE COURT: And you were a student at the same time?

THE WITNESS: I was a student at the same time.

THE COURT: When you got involved in this GAPMS project, what did you understand about where the assignment came from; why it was that the Agency was doing a GAPMS study on the subject?

THE WITNESS: So, initially, when I got the assignment, when I was asked to do it, I figured there were some other factors at play. I wasn't really aware of those. I also knew it had been a long time since we looked at it. So I figured it was probably coming from Agency leadership.

THE COURT: Ms. Dalton gave you the assignment?

THE WITNESS: Yes, Your Honor.

THE COURT: She didn't tell you where the assignment came from? She left that for you to figure out on your own?

THE WITNESS: I don't -- often we ask these

questions, and we don't always get the answer. I figured it definitely came from like senior leadership.

THE COURT: But Ms. Dalton didn't tell you that?

THE WITNESS: It just didn't come up, Your Honor.

THE COURT: Did you have any reason to think it came from the governor's office?

THE WITNESS: I suspected that it probably did.

THE COURT: You live here in town, I'm going to guess you read the newspaper.

THE WITNESS: Yes, Your Honor.

THE COURT: You must have known that trans issues were a hot topic with this administration. True?

THE WITNESS: I was aware of that, yes, Your Honor.

THE COURT: Did you know when you got the assignment what result the administration would prefer?

THE WITNESS: I had an idea, I mean --

THE COURT: I haven't gone back and tracked the chronology, but people who took a position that didn't match up with what the administration wanted, haven't fared very well in the State. Were you aware of that at that time?

THE WITNESS: No, I was not.

THE COURT: Is it your understanding that being trans is a mental health issue?

THE WITNESS: Based on the DSM-5 diagnosis, being trans by itself, according to the definition, that's not.

THE COURT: I want to know what you believe.

Do you believe that there are people who are, in fact, trans people who have one native sex, biologic sex, sex assigned at birth as it's sometimes referred to, but who, in fact, identify as the opposite gender?

THE WITNESS: I do, Your Honor.

THE COURT: I've been involved and reviewed a number of public hearings. I don't think I have ever seen one that seemed to be so orchestrated in advance as this one.

First, have you been involved in any other public hearings that were as orchestrated as this one?

THE WITNESS: No, I haven't been involved in a public hearing that large or anything like that, no.

THE COURT: Who orchestrated this, or choreographed it? Who decided the order in which people were going to speak?

THE WITNESS: I don't know, Your Honor.

THE COURT: One of the questions on cross was about the -- I think they were Zoom meetings you said -- the discussions with the experts, and you said something that frankly struck me as curious. I want to follow up on it.

You said, "I don't think there was extensive Q and A prep with the experts." If there wasn't any Q and A prep with the experts, that's an odd way to phrase it. If there wasn't any extensive Q and A prep with the experts, was there at

least some Q and A prep with the experts?

THE WITNESS: So I wasn't present for all of the calls, all of the Zoom meetings, so I would be speaking to events for which I wasn't present for. The calls I participated on were not Q and A prep sessions. There were just more logistics, getting to and from the venue, how things would transpire.

THE COURT: How things would transpire, that we're going to have a long list of speakers in favor or what was that?

THE WITNESS: No, Your Honor. It would be more how we go into the building, where we'd sit, things like that.

THE COURT: And this has nothing to do with the merits, but DOT, where is DOT? I'm not sure I know where DOT is.

THE WITNESS: Your Honor, it's right there by Cascade Park.

THE COURT: In one of those that used to be Caldwell.

THE WITNESS: I think it might be the Caldwell building. I don't know. It's definitely one of the historic ones.

THE COURT: One of those --

THE WITNESS: 1950s, it's very nice.

THE COURT: When I used to go to the Public Service Commission over there, I'm not sure anybody described it as

very nice, but I'm with you. All right. Thank you.

Questions just to follow up on mine?

MR. JAZIL: Your Honor, just one.

REDIRECT EXAMINATION

BY MR. JAZIL:

Q. Mr. Brackett, if you had come to the opposite conclusion in your GAPMS report, in other words, supporting the use of puberty blockers, cross-sex hormones, gender reassignment surgeries, do you think you were going to get fired from your job?

A. No, definitely not.

Q. Why not?

A. So, I'm a career civil servant. My position is classified as such. I was performing a task as I was assigned, which was to do a GAPMS report on treatments for gender dysphoria.

MR. JAZIL: Nothing further, Your Honor.

THE COURT: Thank you, Mr. Brackett. You may step down.

MS. DeBRIERE: I have one follow up.

THE COURT: Sure.

RECROSS-EXAMINATION

BY MS. DeBRIERE:

Q. Mr. Brackett, just for the clarity of the record, do you know if the request to undertake the GAPMS came from the

governor's office?
A. To undertake to do the GAPMS specifically?
Q. To do the review of gender-affirming care -- Medicaid coverage of a gender-affirming care.
A. I think it did. I'm not certain.
MS. DeBRIERE: If we can bring just up -- hold on.
BY MS. DeBRIERE:
Q. So you say you are not sure.
A. I mean, I think from my understanding was that the governor's office asked us to also take a review as the Department of Health did. As far as to do a GAPMS specifically, they are not that familiar with our processes.
Q. But it is your understanding that the initial request for Medicaid to undertake a review of gender-affirming care came from the governor's office; is that right?
A. I think so.
MS. DeBRIERE: Thank you. That's all I have.
THE COURT: Now, thank you, Mr. Brackett. You may step down.
We are going to take a lunch break. Where do we stand? We're done for the day?
MR. JAZIL: Your Honor, we just have Dr. Scott left who is going to appear by Zoom Monday morning.
THE COURT: So we don't need a lunch break. We just need to quit for the day.

Anything else we need to discuss?

MR. GONZALEZ-PAGAN: Not from the plaintiffs, Your Honor.

THE COURT: Do we have time? Nine in the morning probably works in England.

MR. JAZIL: Yes, Your Honor.

THE COURT: All right. I will see you back at 9:00, Monday morning.

(*The proceedings adjourned at 1:11 p.m.*)

* * * * * * * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy are noted within the transcript.

Judy A. Gagnon *5/20/2023*

Judy A. Gagnon, RMR, FCRR
Registered Merit Reporter

Date

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
v.	)	Tallahassee, Florida
	)	May 22, 2023
JASON WEIDA, et al.,	)	
	)	9:00 AM
Defendants.	)	Volume VII
_____	)	

TRANSCRIPT OF BENCH TRIAL PROCEEDINGS
BEFORE THE HONORABLE ROBERT L. HINKLE
UNITED STATES CHIEF DISTRICT JUDGE
(Pages 1263 through)

Court Reporter: MEGAN A. HAGUE, RPR, FCRR, CSR
111 North Adams Street
Tallahassee, Florida 32301
megan.a.hague@gmail.com

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APPEARANCES:

For Plaintiffs:

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.com
120 Wall Street
19th Floor
New York, New York 10005

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JENNIFER ALTMAN
Attorney at Law
jennifer.altman@pillsburylaw.com
600 Brickell Avenue
Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall
Suite 1800
Sacramento, California 95814

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

Southern Legal Counsel Inc
By: SIMONE M. CHRISS
CHELSEA LEE DUNN
Attorney at Law
simone.chriss@southernlegal.org
chelsea.dunn@southernlegal.org
1229 NW 12th Avenue
Gainesville, Florida 32601

Florida Health Justice Project
By: KATHERINE JEAN ANN DEBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

APPEARANCES (continued):

For Plaintiffs (continued):

National Health Law Program
By: CATHERINE ANNE MCKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

National Health Law Program
By: ABIGAIL K. COURSOLLE
Attorney at Law
coursolle@healthlaw.org
3701 Wilshire Boulevard
Los Angeles, California 90010

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: GARY JOSEPH SHAW
Attorney at Law
gary.shaw@pillsburylaw.com
1200 17th Street NW
Suite 1800
Washington, DC 20036

For Defendants:

Holtzman Vogel Baren, et al.
By: MOHAMMAD OMAR JAZIL
GARY VERGIL PERKO
MICHAEL BEATO
Attorneys at Law
mjazil@holtzmanvogel.com
garyp@holtzmanvogel.com
michaelb@holtzmanvogel.com
119 South Monroe Street
Suite 500
Tallahassee, Florida 32301

P R O C E E D I N G S

(Call to Order of the Court at 9:00 AM on Monday, May 22, 2023.)

THE COURT: Good morning. Please be seated.

Mr. Jazil, please call your next witness.

MR. JAZIL: Thank you, Your Honor. The defense's next witness is Dr. Sophie Scott.

THE COURT: Dr. Scott, good morning.

THE WITNESS: Good morning.

THE COURT: I'm Judge Hinkle. Before the lawyers start asking you questions, let me ask you this: Are you there in a room all by yourself?

THE WITNESS: I am, yes. I'm in my office. I'm on my own.

THE COURT: If somebody comes in, we'll deal with that. Otherwise, we'll assume you're there by yourself.

If you would, please, raise your right hand.

DR. SOPHIE SCOTT, DEFENDANTS WITNESS, DULY SWORN

THE COURT: Please tell us your full name and spell your last name for the record.

THE WITNESS: My name is Sophie Kerttu Scott, and my surname is Scott, S-c-o-t-t.

THE COURT: And tell me again -- maybe spell the middle name.

THE WITNESS: K-e-r-t-t-u.

THE COURT: Mr. Jazil, you may proceed.

MR. JAZIL: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. JAZIL:

Q. Dr. Scott, what do you do?

A. I'm a cognitive neuroscientist at University College London.

Q. Dr. Scott, what does a cognitive neuroscientist do?

A. A cognitive neuroscientist works in the area of brains and brain structure and brain function and relating that to human experience and human behavior. So it's an area of neuroscience, and we work with brains. But we're sort of a -- analogous to psychologists.

Q. Dr. Scott, you said that you work at University College London.

MR. JAZIL: I'd like to pull up what's been admitted into evidence as Defendants' Exhibit 33.

BY MR. JAZIL:

Q. Dr. Scott, this was a CV attached to your expert report. Was that CV a fair and accurate summary of what you've done to date?

A. Yes.

Q. Now, Doctor, you mentioned that you work at the Institute of Cognitive Neuroscience at University College London. On your CV, it says that you are the director of that.

What does the director of the Institute of Cognitive Neuroscience do?

A. I'm responsible for the day-to-day running of the building. So, you know, if there is a problem with staff or an issue with safety, then that's my responsibility, and I'm also responsible for the scientific direction of the research and the teaching that's carried out here. So I have a broad scientific perspective. In addition to that, I'm also running my own lab here at the institute.

Q. Do you also do your own teaching at the university?

A. Yes, yes, I teach a couple of modules.

Q. I understand.

Doctor, just going through your résumé, it says that you were previously the Wellcome trustee or fellow for several years --

A. Yeah.

Q. -- at the Institute of Cognitive Neuroscience.

What is that?

A. The Wellcome Trust is a big biomedical charity that funds biomedical research, and they fund people at different points in their careers as what they call research fellows.

What that means is if you apply for one of these grants and you are awarded it, it pays for your salary. So you are an independent research fellow at the university. It also pays for other staff working on your grant and also for all your research

expenses, so, you know, the cost of brain scanning, for example, and all your other costs, like travel and publications.

So they are very competitive grants to get, and they're fantastic grants to get because it really lets you build up your lab and build up your research profile.

Q. And, Doctor, is it correct that you've been a professor since 2006 at University College London in neuroscience?

A. Yes.

Q. Doctor, just going down, you've got a list of prizes and recognitions.

Doctor, what is the Michael Faraday Prize by the Royal Society?

A. The Michael Faraday Prize is one of the prizes given by the Royal Society for excellence in scientific research, but also excellence in communicating science. So it's for my work both scientifically and also my work communicating research.

Q. And was the work related to neuroscience or something else?

A. Yes, it's all neuroscientific research.

Q. Doctor, it also says that in 2020, you were appointed Commander of the Most Excellent Order of the British Empire for services to neuroscience.

Do you see that?

A. Yes.

Q. Who appointed you Commander of the Most Excellent Order of the British Empire for services to neuroscience?

A. It's awarded by the monarch. So my -- I was appointed commander of this -- CBE, it's called -- on the Queen's birthday in 2020.

Q. Understood.

It says that in 2016, you were elected a fellow of the British Academy.

First, can you tell us what the British Academy is?

A. The British Academy is one of a number of learned societies in the UK which are there to promote academic research and also researchers. So the British Academy is broadly covering research into the humanities, so it includes psychologists and people at the -- sort of the humanity end, if you like, social end of the sort of research I do, and it goes across linguistics and also historians and philosophers.

Q. And what were you elected as a fellow for?

A. I was elected for my research into -- yeah, into human communication.

MR. JAZIL: Can we go on to the next page?

BY MR. JAZIL:

Q. It says that in 2012 you were elected a fellow of the Academy of Medical Sciences.

Doctor, what's the Academy of Medical Sciences?

A. The Academy of Medical Sciences is another learned society. It's a more recently developed one, and it's people doing research and working in the fields of medicine and also related

disciplines. So there are a lot of medics who are members of the Academy of Medical Sciences but also lots of people like neuroscientists or epidemiologists who do research which relates to biomedical science, like me.

Q. Doctor, there is a section in your CV that talks about supervision of graduate students. It says that you've supervised 14 Ph.D. students at University College London and 35 master students at University College London and two students at City University and one at the University of Reading.

Was the subject that all these students were studying neuroscience?

A. Yes.

Q. And later on in your CV, it lists where some of your students went. They went on to work at Oxford, the University of Amsterdam, and the Max Planck Institute; correct?

A. Yes, I'm very proud that everybody who has worked on my lab has gone on to a good job in academia or a related discipline.

Q. Understood.

Doctor, there's section in here about editorial work. It lists five journals.

First, can you tell us what editorial work means?

A. Editorial work for a peer-reviewed journal, and four of those journals are peer-reviewed journals. So *The Psychologist* at the top, that's a -- that's a journal for people who are members of the British Psychological Society.

All the other journals, my work there as an editor was to oversee the peer-review process. So people would submit papers to the journal; I would read the paper; I would decide whether or not it was appropriate to send out to review; I would select the reviewers and invite them. When they reviewed the paper, I would get those together, read the paper, read their reviews, and then come to a decision about whether the paper could be accepted, whether it should be rejected, or whether changes were needed. And then I'd oversee that whole process, and that is the peer-review process.

Q. Understood.

Doctor, have you ever done work for the U.S. National Institutes of Health and the National Science Foundation?

A. I have. I've been on panels overseeing the grant review process for a couple of ad hoc grants for the NIH, and I was on the -- an NSF panel for several years looking at psychology according to neuroscience grant applications.

And what you're effectively doing on those panels is people have written grants and submitted them to these different grant causes, and what your job is to do is to read the grants that have been submitted. Some of those will have been allocated to you to represent to the panel. So you read them in more detail, and you have to present them to the panel for discussion. And it's very -- in effect, what you're letting -- what you're doing is you're helping the funding body, NSF or NIH, decide how to

spend their money, what is the research that we should be funding.

It's an extremely interesting job to do because what you have to do is, of course, read in great detail, a bit like when you're an editor of a journal -- you have to read papers and these grant submissions in great detail. It might not necessarily be precisely in your own area of research. So it gives you a very useful, much wider view over the sorts of research going on in what discipline that you're a part of.

Q. And you've done the same work for the Royal Society?

A. I have, up until last year. For six years I was on the Dorothy Hodgkin Fellowship panel, and that's actually a panel that goes across all of science. So we're seeing grants submitted about computer science or oceanography or physics or genetics, and the panel reflects that. And for the six years, I was the person representing sort of behavioral neuroscience, cognitive neuroscience, psychology, anything to do with behavior and organisms.

And you're doing the same thing. You have to read the grant applications, and you have to represent them to the panel, and you have to interview the person who has come -- in this case, who actually is there to be -- who has submitted the work, who is going for this fellowship.

And that's extremely interesting because it's even broader than those NSF panels I was on, because any -- all possible

areas of science are being represented, and you have to be able to discuss different areas of science across a wide range of disciplines.

Q. Understood.

And, Doctor, looking at your CV, you've got approximately 150 refereed articles in there.

Can you tell what you say the term "refereed articles" mean?

A. Refereed articles, it's the same as a peer-reviewed article. So it's been through a formal process. You've submitted it to a journal, and it has been edited and sent out for peer review, and it's gone through some, potentially, period of revisions before being accepted.

Q. Were all those articles in the field of neuroscience?

A. I think all of them are in psychology and cognitive neuroscience with the exception of one, which is in poetry.

MR. JAZIL: You can take that down.

BY MR. JAZIL:

Q. Doctor, what were you asked to do in this case?

A. I was asked to provide some expert testimony about the -- the use of puberty blockers, gonadotropin-releasing hormone, agonists, and antagonists in teenagers -- four teenagers both in terms of the possibility of teenagers to be able to engage with what was -- understand the possibilities of what this kind of medication could mean, but also in terms of what the effects

could be on the developing teenage brain of GnRH agonists.
Q. Were you also asked to look at Dr. Edmiston's trial testimony in this case?
A. I was.
Q. Were you asked to review Florida law concerning the treatment of gender dysphoria?
A. I was not.
Q. Were you asked to review any clinical guidelines or best practices on the treatment of gender dysphoria?
A. I was not.

MR. JAZIL: Your Honor, I'd like to ask Dr. Scott her opinions in the field of neuroscience, brain development, brain structures, and neurochemistry, not poetry.

THE COURT: Questions at this time?

MR. SHAW: Yes, sir.

VOIR DIRE EXAMINATION

BY MR. SHAW:
Q. Good morning, Professor Scott. Good to see you again.
A. Morning. Nice to see you.
Q. Professor Scott, you're not a medical doctor; right?
A. I'm not.
Q. And you don't have any training in adolescent healthcare?
A. No.
Q. You've never treated a patient with gender dysphoria?
A. No.

Q. And you've never conducted any clinical research on gender dysphoria?
A. No.
Q. You've never published any peer-reviewed articles on gender dysphoria?
A. No.
Q. Your main area of research looks at the effects of speech, laughter, and sound on the brain; right?
A. Yes.
Q. And none of that --
A. And to do that, what I have to -- sorry.
Q. No, no. Please.
A. So what I have to do to study that is both understand the physics and the acoustics and the linguistic aspects of speech, but also I have to understand brain structure, brain function, brain neurochemistry, and brain development to be able to look -- looking at how speech is processed, for example, in the human brain.
Q. And none of that -- none of the things that you study -- speech, laughter, and sound, none of that relates to gender dysphoria; correct?
A. No.
Q. About puberty blockers, you testified that you're not a doctor. So is it safe to say that you've never prescribed puberty blockers?

A. I'm not a medical doctor, and I have not prescribed puberty blockers.
Q. And you've never conducted any clinical research on the effects of puberty blockers on the brain?
A. Other than reading the literature, which is, of course, research, I haven't conducted any basic science in that area, no.
Q. But never any clinical research yourself?
A. I've applied the research. I haven't done the research, no.
Q. And you've never conducted any clinical research on the effectiveness of puberty blockers in treating gender dysphoria?
A. Other than reviewing the literature, no.
Q. So is it fair to say that your knowledge of puberty blockers is based on your review of the literature?
A. Yes.
Q. And you submitted a report in this case; right?
A. Yes.
Q. Did you -- in your report, did you discuss any of the literature that looked at the effects of puberty blockers in treating -- in treating gender dysphoria?
A. No. I was looking at the animal research and what little human research there is on the actual brain effects of the puberty blockers.
Q. So, no, you did not discuss any human research in your

report related to gender dysphoria?

A. In the report, no. No.

Q. Are you aware of the Staphorsius 2015 study on executive functioning?

A. I am. Would you like me to talk about it?

Q. You didn't put that in your report, though?

A. I didn't, because if you look at the mice research -- I'm sorry; it wasn't research -- the mice study that was looking at -- it was conducted, I think, in 2018, 2019, as part of the case review looking at the evidence for the benefit of puberty blockers in treating gender dysphoria, which concluded that there were no benefits, partly because the evidence was very poor, and the Staphorsius paper was an example of very bad evidence for showing, for example, no difference in the effect of puberty blockers.

So it was a study using the Tower of London test where you are asking people to move -- it's a test. It's like a problem-solving test. And they were doing a functional imaging study of teenagers with or without gender dysphoria, and within gender dysphoria, some of them were on puberty blockers and some were not, and what they found was no overall difference.

But this was a study of functional imaging, which is hard to find robust differences in different populations, whoever they are, because it's quite noisy data. So it's not strong data either way. I wouldn't -- with that bit of functional

imaging study, I wouldn't choose to say whether or not that was something that was showing positively that there are no differences or definitely that there are differences. It's not a good dataset, and that's -- I'm quoting the mice study on that.

Q. Thank you.

You did not mention any of that in your report; correct?

A. Because of its poor evidential value, I did not.

Q. Right.

Well, you did not mention Staphorsius at all?

A. I did not for its poor evidential value.

MR. SHAW: Your Honor, in light of the fact that Professor Scott has no experience with gender dysphoria, no experience treating patients with gender dysphoria, no experience administering or clinically studying puberty blockers in any setting, we would move to exclude Dr. Scott's testimony.

THE COURT: Mr. Jazil.

Part of what I'm interested in in that exchange is she's now given testimony that was not in her report. Why does she get to come to trial and discuss something that's not in her report?

MR. JAZIL: Your Honor, a couple of points there.

One, the study that my friend mentioned, that is a study that she is -- that was not included in her expert report. It's a study that, I believe, was referenced in Dr. Edmiston's

testimony.

THE COURT: Why does that matter? If it's not in her report, why isn't it excluded on the ground -- I don't care how good a report it is, and I don't -- why does it matter if her testimony is true and relevant and helpful? If it's not in her report, isn't the answer it should be excluded?

MR. JAZIL: Your Honor, testimony regarding that one specific report, yes, but her testimony will be more than about just that one specific report.

THE COURT: Got it. We'll double back to that.

But if I understand what she just said, her report does not discuss studies on humans.

MR. JAZIL: No, Your Honor, that was incorrect. Her report does not discuss studies on humans for the treatment of gender dysphoria. Her report does discuss studies on humans for -- pardon me, Your Honor. Her report does discuss studies that talk about the use of puberty blockers for other things like precocious puberty, et cetera. So she looked at the available --

THE COURT: Point taken.

So, plainly, she can't give medical testimony about treating patients, and certainly not trans patients for gender dysphoria, but she can give testimony within her area, and -- and some of that testimony is certainly relevant to the issues here.

So she can testify about cognitive neuroscience within the scope of her report, and if particular questions come up that the plaintiffs think aren't within her expertise, object and I'll deal with it then. But the motion to exclude her testimony entirely is denied.

MR. JAZIL: Thank you, Your Honor.

THE COURT: And I'm not going to consider the testimony she gave in response to the voir dire question on subjects she did not include in her report. She -- her testimony should be received only as consistent and addressed in her report.

MR. JAZIL: Your Honor, clarification on that. At the end of Dr. Edmiston's testimony, there was a colloquy with the Court on some issues related to transgender identifiers in the brain. There was a question asked by one of my colleagues that elicited a response from Dr. Edmiston.

Would it be appropriate for her to comment on that exchange, which was, frankly, outside the scope of both sets of expert reports, but --

THE COURT: Maybe, and we'll deal with it when we get to it.

There is a difference between testimony offered by the proponent, by the party that hired the expert, when that testimony is outside the scope of the report on the one hand and testimony elicited on cross-examination by the adverse party on

the other hand.

And there is a difference between testimony elicited by the party that hired the expert on the one hand and an answer volunteered on the -- during the voir dire examination by the opponent on the other hand.

I don't recall the exchange involving Dr. Edmiston, but if it was something that your side asked, then your side certainly doesn't have an objection that it's beyond his report. If it's something he volunteered in response to a question that didn't call for it, that's different.

I also don't want to give the impression that I'm unduly strict in the application of the requirement to tender a full 26(a)(2) report. It's a dynamic process. Things come up during a trial. They certainly know that Dr. Scott is a cognitive neuroscientist, and they know generally what it is she's here to testify about.

So whether you can ask the question about the subject that Dr. Edmiston dealt with really depends on what it is and how close it is to what she's already disclosed, but I do understand how a lawyer would not come to court expecting to cross-examine her about this particular study when she didn't discuss that study or anything like it in her report, just comes up on voir dire. And so Mr. Shaw is not ready to cross-examine on that subject because he had no reason to think that's what we were going to be talking about.

MR. JAZIL: Understood. And, Your Honor, just so the Court's clear, Dr. Scott, in her expert report, talked about animal studies, human studies. The human studies were about giving -- as I explained earlier. So, I mean, to the extent that we're talking about animal studies and human studies, it's a broad category.

THE COURT: I get it, and I -- this is probably a longer discussion than Dr. Scott wanted to sit through or maybe than we needed to have. Let's get to the actual questions, and it may turn out none of this makes any real difference. I'll hear what Dr. Scott has to say.

MR. JAZIL: Thank you for the indulgence, Your Honor.

BY MR. JAZIL:

Q. Dr. Scott, I'd like to start with brain development.

A. Uh-huh.

Q. What are the phases to brain development?

A. There's three broad phases over life span of big changes in development of the brain. The first is during gestation and through to the end of being a child up to puberty, and that's when you get really big changes in the structure of the brain.

There's then another period during -- from puberty through to the end of adolescence, and then that takes you through to about the early 20s and then you have basically an adult brain, which is still a work in progress. That's still a flexible organism, but it then doesn't go through any big changes until

the end of life.

Q. And can you walk us through how brain structures evolve during those three phases?

A. So to think about this, you have to let me just very briefly touch on what we -- what we talked about when we're talking about brain structure. We're talking about neural tissue which is made up of brain cells called neurons, and all living things are made up of cells, and cells can be very different in different animals and different parts of the body, but brain cells are particularly unusual.

They have a cell body, which is containing the cell nucleus, and they're often surrounded by lots of little projections, some of them big, some of them small. And then there's normally one very long, slender projection that goes from that cell body that can go off and make connections elsewhere in the brain, and this is how your brain can make connections over relatively long distances, because the cell bodies have got these long axonal projections.

Now, if you look at the brain, these brain cells aren't just mushed in there. What they do is they form distinct layers. So the cell bodies sit in what's called grey matter, and that's the cortical mantle that sits on the surface of your brain is one big layer of grey matter, and then there are little nuclear grey matter sitting underneath that.

The cell connections, these long axons, form sort of

information superhighways, which are connecting different brain areas and sit underneath that cortical mantle. And that looks white, and it gets called white matter for this reason, whereas the cell body layers look grey, and they're called grey matter.

And if we look at the structure of the brain, what you're seeing is something that when you're born you have almost all the brain cells that you're ever going to have. You have nearly 90 billion brain cells, and you're born with almost all of them.

And what you see between sort of birth to about the age of 6 is that brain gets four times bigger, not because you're growing new brain cells, but because the brain structure is very rapidly growing and those brain cells are growing. They're growing longer, and they're starting to make many more connections.

So between birth and puberty, what you see is quite a dynamically changing brain with the relative size of the grey matter and the white matter areas changing quite a lot. And then as you go into puberty, you have this remarked change in the way that the brain structure's starting to evolve where you start to see a consistent thinning of the grey matter layer in the cortex and a relative deceleration in the growth of the white matter. So you're picking that up as an overall change.

If we think about what's actually underpinning that juvenile period and that change through adolescence, that's being driven by two very main ways that the brain is changing,

the relationship of the brain cells are changing.

So, first of all, the brain is changing in terms of the number of connections that the brain cells can make with each other. That varies a lot through adolescence, and it continues to change -- so through childhood, it continues to change through adolescence.

And you're also seeing a change in the myelination of those long axonal projections. What myelination means is that the brain cells -- these long projections start to get coated in a thin, fatty sheath called myelin. And what that lets the brain cells do is send signals much more efficiently and much more quickly.

So if you track this profile going through childhood and then on through adolescence, what you see is a change in these connections moving towards an adult-like brain and also a change in myelination, and both of these features progress through the brain very roughly in the back, different direction, such as the part of the brain that shows an adult-like pattern of connections, and an adult-like pattern of myelination is the front of the brain that comes in last.

Then in your early 20s, you're starting to see something that has this more adult-like profile, but, as I say, that's not fixed; that's still dynamic. Your brain is changing throughout your whole life span because anything that changes in your brain -- anything that you learn will affect the kind of

connections that your brain has. Anything you remember from the conversations you'll have today is because your brain has changed yet again. But you don't get these huge changes, both in size and growth pattern, that you're seeing in the period from birth to puberty and then from puberty to adulthood.

Q. Doctor, as puberty is affecting the brain during the phase that you just described from the beginning of puberty -- to I'll call it the end of adolescence, your 20s, as you said, how, if at all, does that period affect decision-making in the human being?

A. There was a recent review in nature of neuroscience that described sort of decision-making as being distinctly different in adolescents in a way that's a sort of critical defining feature of adolescents. So adolescents are amazing humans. They are creative; they're intelligent; they are full of fantastical ideas of things to do.

The challenge that the adolescent brain has is that the decisions that adolescents can make can be, in some circumstances, more impulsive, but more generally more risky. And the problem here seems to be not that there are some risky things that attract adolescents more. It's more that teenagers and adolescents can struggle to understand or engage with what potential outcomes of behavior could be.

Now, that might be something trivial like not taking an umbrella with you when it might rain, or it might be something

really serious that might affect your health. And that's something that is associated with not necessarily a one-to-one way, but it seems to be linked to the fact that, as I say, these changes in the brain go from back to front in terms of connectivity and in terms of myelination. And the frontal lobes, which is the last to show this pattern of adult connectivity, and myelination are the brain areas which are strongly involved in decision-making, in emotion regulation, in managing behavior.

Q. Understood. And, Doctor, you say that you looked at Dr. Edmiston's testimony in this case. Now, Dr. Edmiston discusses decision-making in a hot context, in a cold context, and seemingly disagrees with your assessment of risk-taking.

What's your response, Doctor?

A. I think my response is twofold. First of all, Dr. Edmiston is, I mean, correct in that you can identify tasks that are more hot where decisions can be more driven by emotion, and you can identify tasks that are more cold, more rational.

In the real world, I've certainly worked in areas of cognitive psychology, but are strongly influenced by the idea that actually, in the real world, all decisions involve emotional aspects. You can't not have an emotional contribution to how you reason about the world, how you decide what to do in the world.

And I think the second point of our disagreement with

Dr. Edmiston is that he is framing risky decisions as impulsive decisions, and decisions don't have to be impulsive to still be risky. Decisions could be very well thought through and thought through for a considerable amount of time and still be very risky in their potential outcomes.

Q. Understood.

Now, Doctor, are you familiar with gonadotropin-releasing hormone agonists?

A. Yes. Yes.

Q. And if I just call them "puberty blockers," will you know what I mean?

A. Yes.

Q. All right. Walk us through the effects of these chemicals on the human brain. How do they impact the brain?

A. There -- so the gonadotropin-releasing hormone is something that's released, I think, in the pituitary gland, and it has its effect on the hypothalamus. And this is triggering cascading effects, that they can give you an increased release of sex hormones from the ovaries and the testis. So both estrogen and testosterone start to be increased as a result of this.

The GnRH analogues, which can be agonist and sometimes antagonist, they are sitting on the receptors and stopping, blocking, literally, that hormone having its effect. The GnRH --

MR. SHAW: Objection, Your Honor.

Professor Scott -- objection. Professor Scott doesn't have any expertise, has never clinically studied puberty blockers or studied how they affect the brain.

THE COURT: Well, Dr. Scott, tell me how you know about what GnRHa does.

THE WITNESS: Because I have to, as part of my job, understand brain structure, brain function, and brain neurochemistry. GnRH acts as a neurotransmitter, and the -- so any neurotransmitter is picked up by receptors that -- there's no other way for neurotransmitters to have their effects on the brain.

And there are different ways that you can disturb the uptake of a neurotransmitter by its receptors. And in the case of the GnRH agonist, what they're doing is they're blocking the -- they're sitting on the receptors and stopping the hormone from getting in there.

So I understand this because I understand how neurochemistry works and how neurotransmitters work.

THE COURT: Well, I guess two responses: First, it seems to me that this isn't the doctor's area and, second, do you even disagree with that?

MR. SHAW: I'm sorry?

THE COURT: Do you even disagree with what she just said?

MR. SHAW: I -- we would disagree to the extent that

she does not have the -- the expertise to understand. She gave a very general explanation of --

THE COURT: I get it. I'm going to overrule the objection.

But, look, I guess here's part of my response that probably doesn't affect the ruling, but it's as if the witness just said, I know the light was green, and the question -- the question whether the light was green is really not debated. Everybody -- it's just clear the light was green, and you object, Well, she doesn't have any reason to know the light was green. Well, if she doesn't have a reason to know the light was green, that's a good objection, and I would sustain it.

But it's a bench trial, and I'm trying to figure out where we're going. And if everybody agrees the light's green, I'm not sure what we're worrying about.

MR. SHAW: Understood.

THE COURT: The objection is overruled.

BY MR. JAZIL:

Q. Doctor, would you like to add anything to what you've already said about how the GnRHa agonists affect the brain?

A. No. Other than the original hormone, the GnRH hormone, has a very short half-life. It's made, and it has its effects that disappear very quickly, and the blockers seem to work by having a longer half-life. They are around in the system for longer, so they're able to have this effect. They have this blocking

effect for longer.

Q. Understood.

Doctor, are there any animal studies that look at the long-term effects of using the GnRH agonist on the human brain?

A. On the human brain?

Q. I'm sorry. Pardon me. On the brain?

A. Yes, there are -- the majority of the studies that we have -- and there still aren't many -- looking at the effects of puberty blockers on brain development during the peripubertal period going into adolescence is on nonhuman models, because you can do experiments with nonhuman models that you can't do with humans. For example, you can do post-mortem analyses.

So there are, I think, five studies on sheep, there is a study on yaks, and there is a study on mice.

Q. Okay. Let's take those five sheep studies, Doctor.

What do those five sheep studies show?

A. I think the first three studies are basically on the same sheep. So there was a study showing that administering puberty blockers around puberty in male and female sheep, male sheep go into puberty earlier than female sheep, which is the opposite with humans, so they have to treat them actually at different points, slightly early for the male sheep.

And then it was looking at effects on behavior, and it found that there are effects on sort of emotional behavior, emotional reactivity in the sheep. And it goes in the opposite

direction. So the male sheep become more reactive, and the female sheep become less reactive.

There are two follow-up studies, I think, on that same -- my impression is that it's the same population of sheep. One was looking at gene expression in brain areas that seem to be a delaying and finding differences in the amygdala caused by administering the GnRH analogues. And this, if I remember correctly, had a greater effect on the female sheep than the male sheep.

And then if you look at the anatomy -- and this was done with structural magnetic resonance imaging -- a brain area that was very important in terms of social processing, learning, and emotional behavior is the amygdala. It sits in the middle of the temporal lobes and in front of the hippocampus. And administering the puberty blockers led to an increased size in the amygdala for both the male sheep and the female sheep. The effect was more exaggerated for the female sheep possibly because there is already a sex difference in the size of the amygdala, and the sheep male amygdala are larger than female amygdala. So you are seeing a growth in this area in all the treated sheep, and it's more exaggerated in the female sheep.

Q. Why do we care about the changes in the size of the amygdala, Doctor?

A. Because it's leading to a difference. It's leading to a change. This is not having no effect on the brain. If puberty

blockers were a pause button that led to, like, kind of a neutral period where you could sort of -- things are changing, there should not be these alterations in brain structure. There is an effect happening there.

Q. And what does the amygdala control?

A. The amygdala -- it's not very big, but it's a very important area in terms of behavior. I used to work a lot with people who had damaged their amygdala. They do have very affected behavior. You don't want to damage your amygdala. It can lead to big changes in your ability to deal with social situations. But it's actually comprised of a lot of tiny little nuclei.

So all we have from the study on the sheep is a measure that is bigger. What we don't have is a very clear study of actually saying which components of the amygdala, which are tiny, whether they're actually changing that's driving that. So we don't actually know what's underlying this.

Q. Doctor, did the sheep studies deal with spatial cognition at all?

A. There are a couple of other sheep studies, these ones just in rams, so just in male sheep. And what they did was they administered puberty blockers in half of the sheep around puberty, and then they looked at the sheep's ability to learn spatial navigation in mazes. And they were looking at this because spatial navigation in mammals really relies on the

structure that sits just behind the amygdala called the hippocampus, and it's very important in spatial navigation. So they are taking spatial navigation as a proxy for potential effects on the hippocampus.

And what they found when the sheep were being treated with the puberty blockers was that the sheep who were treated had difficulties with spatial navigation. They took longer to learn their way through mazes.

And there was some suggestion that they also showed emotional reactivity, but what they did is they then applied testosterone to those sheeps, and they were replacing the testosterone that their bodies aren't making. And when they did that, it improved their emotional reactivity, but it didn't affect their ability to learn the mazes.

So then you sort of start to pull out, What's the effect of the puberty blockers? What's the effect of lacking testosterone?

Significantly, this lab also went back -- because this is missing from the rest of the literature in a way that's quite frustrating. They went back and they asked questions about what happened to those sheep when they got older, because they only applied the puberty blockers for an amount of time. They didn't keep the sheep on this.

So the studies in the first paper were all done around sort of 40, 50 weeks. They went back at 80, 90 weeks when the sheep

who had been treated are no longer on puberty blockers, and they looked at their spatial cognition. And what they found there was that the sheep had problems with their long-term spatial memory. They were taking longer to solve mazes that they had previously learned, even though they're no longer on puberty blockers. And they interpreted from that that there was a longer term effect on the brain caused by the puberty blockers even after the puberty blockers had ceased.

Q. Understood.

And, Doctor, again, you reviewed Dr. Edmiston's testimony in this case; right?

And she commented on the sheep studies, and my understanding of her testimony is that she found no differences in spatial cognition.

How do you respond?

A. I didn't agree with Dr. Edmiston's interpretation of that study. He had argued that the first study showed no difference in spatial ability, and that's not what the paper shows, and it's not what is argued. And it's certainly not what the data show. He also didn't pick up on the follow-up study at all.

MR. JAZIL: And, Your Honor, I apologize. I believe I referred to Dr. Edmiston by the wrong pronoun. It was unintentional.

MR. GONZALEZ-PAGAN: Thank you.

THE COURT: Before we're done, I assure you, I'll call

people by the wrong name. I do it almost in every case I preside over, so this case probably wouldn't be any different.

MR. JAZIL: And I meant no ill by it. It was just a slip of the tongue.

BY MR. JAZIL:

Q. Doctor, moving on to studies in other animals, were there any mice studies?

A. Yes, there's a study by Anacker and colleagues. And what they did with the mice is they had, again, male and female mice, and they administered puberty blockers, I think, by daily injections. And they studied what was elicited in terms of the mice's behavior, and they also looked at elements of brain function in the mice, the postmortem.

And what they found was that, A, there were effects of the puberty blockers on the treated mice. The brain and the behavior measures were different. What was clear was that for every difference that they found, you either found it in the male mice or the female mice. None of the effects they reported were showing you something where both the males and the females were affected or anything that looked like the males were becoming masculinized or the females were becoming -- I'm sorry -- the males were becoming more feminized or the females were becoming more masculinized.

So, for example, they found that the male treated mice were more likely to want to spend time with an unfamiliar male mouse

than unfamiliar female mouse, and that's unusual in adult male mice. They tend to prefer to be around female mice.

So there is a difference, which, in fact, in the paper they attribute to aggression, because male mice are quite aggressive towards other mice, and that seems to be -- a perception that seems to be reduced in the treated mice.

The female mice show different patterns of behavior around anxiety and what is used in mice as now like a despairing behavior. So they were more likely to be nervous about eating food in a novel environment. And if you place them in water in what's called a forced swim task, they were more likely to stop swimming altogether and just float, which is used as a measure of the mouse feeling hopeless.

So you see this pattern through all the behavioral measures that they had an effect on male mice or female mice. And at the brain level, they looked at the dentate gyrus, which is part of the hippocampus. And what they were looking at was gene expression that is associated with recent activities in those areas, and they did find differences, that is, increased activity in the hippocampus, for the treated female mice, but, again, no difference for the male mice.

Q. Understood.

MR. SHAW: Objection, Your Honor. There was no discussion of any mice study in her report.

THE COURT: Is that so?

MR. JAZIL: That is, Your Honor.

THE COURT: The testimony about the mice study is struck.

BY MR. JAZIL:

Q. Doctor, we did talk about the sheep studies.

Let me ask you this question: Why should we give any credence to these sheep studies when we are talking about the human brain?

A. Because we are able to do wholly controlled studies with the sheep that are able to illustrate aspects of behavior change or brain change. We can do analyses with the sheep that we can't do with humans. We can do postmortem analyses, for example, gene-expression analyses.

It's tempting to imagine that because sheep are animals that we farm that they are uninteresting -- the sheep are highly social mammals. Like all mammals, they go through puberty. They have an extended period of being juveniles, and they go to sexual maturity, which involves changes in behavior. And that gives us a good model for looking at puberty. And although it is a completely different area, they studied evidence that, in terms of sexual orientation, male sheep are somewhat more complex than human males.

So sheep are definitely not -- I'm not claiming that sheep have anything like gender identity, but it is certainly not the case that sheep are sort of boring robots.

Q. Understood.

And, Doctor, in your report you also looked at some human studies.

Can you tell us what those studies were and what conclusions you draw from them?

A. There is a study of precocious puberty, and precocious puberty is more -- puberty itself has a range, so it's not like everybody goes into puberty at the age of 12. So some people go into it early and some people later. Some people go in very young. And so precocious puberty is defined as girls or boys going into Tanner Stage 2, which is the appearance of breast tissue, around the ages of 6 or 7. And it can be associated with quite serious outcomes. For example, your height can be very badly effected if you go through puberty too young. So it's very commonly treated with puberty blockers.

There is only one study that I'm aware of that has gone in and asked questions about the effects of these puberty blockers that wound up being used to delay puberty in -- normally going into puberty, but puberty was happening early, the effect of that on behavior and on measures of cognition.

And this study showed that on many measures -- so, I should say, in this study, you've got two groups of girls. So it's all girls. They've got girls who are going through precocious puberty and are being treated with puberty blockers as a result, and then you've got a group of controlled girls who have no

problems at all, so they are just a group of average girls.

They were tested on a measure of emotional processing and sort of distractibility. And on one aspect of that, the girls with precocious puberty did show a different response. They seemed more distractable under certain circumstances with emotional faces.

They also did measures of IQ, and the girls in the control group had an average IQ of 101, which you would expect to see. Average IQ should be around 100. The girls with precocious puberty who were being treated with puberty blockers had an IQ -- an average IQ of 94.

Now, that did not come out as being statistically significant in this study when they compared the two, although statistical significance is hard when you have small groups, as they had there. And, also, statistically significant is just a measure of how lucky something is to have happened by chance. It doesn't mean to say it couldn't be meaningful.

But I think it is striking that IQ isn't just relevant in terms of is it different between two groups, because IQ is a scaled score. What your IQ is also matters.

And the girls with precocious puberty had an average IQ of 94. That's seven points lower than the controlled group of girls. And, also, in the subtests of the intelligence test that they used, none of those girls with precocious puberty who were on puberty blockers scored higher on average than the controlled

group of girls.

I'm not the person to point this out. Somebody -- Dr. Hayes wrote a commentary on this paper, pointing out that there was no reason for being complacent around an IQ difference of seven points. I think if somebody told you you were going to take medication that would knock seven points off your IQ, you might think twice about it.

And the study itself is also not ideal, because in the way that it's designed, you can't determine the effects of the puberty blockers. Or are you looking at the effects of precocious puberty because you can't -- the girls have both? So we don't have another condition where there are untreated girls who have precocious puberty.

So it's -- you know, as you tend to find with human studies, it's not perfect, but it's certainly -- there is enough evidence to make at least one other person say, This is slightly concerning.

Q. So, Doctor, based on your knowledge and experience of brain development, brain structures, neurochemistry, and your review of literature that you've described, what, if any, opinions have you formed regarding the effects of puberty blockers on the human brain?

A. I think, first of all, what we can't do is be complacent and assume that there's nothing happening here. All the evidence that we have from human studies is that there are

effects on brain development if puberty blockers are administered around puberty, and that's already concerning.

From my reading of the literature around the use of puberty blockers in gender dysphoria, it's initially -- was certainly suggested in the UK at Tavistock Clinic, just up the road from here, to be something that was going to be brought in at the age of 16, because after puberty had happened --

MR. SHAW: Objection, Your Honor. None of this was in her report.

THE COURT: Are we off the report again?

MR. JAZIL: Your Honor, we are off the report on the Tavistock discussion, so --

THE WITNESS: Okay. Okay. I am to leave that bit out, but I'm going to go back to what's in my report, yep.

BY MR. JAZIL:

Q. So, Doctor, based on your review of the studies we discussed, the sheep studies --

A. Yep.

Q. -- and based on your review of the human studies that you just discussed with the Court, and based on just your general knowledge of how neurochemistry works, what conclusions have you reached about the use of puberty blockers on the human brain?

A. They are not a pause button. They are having changes on the brain, and we are seeing this in the mammal models. We've got no reason to imagine that this would be different in the

human brain. There is nothing in the literature that would suggest that.

So I think the problem is twofold. It's having an effect, and we don't know what the effect means. All I can say is that I can't think of another situation in which you would be complacent about the potential effects of drugs on brain development, particularly occurring at a very critical point in development.

Q. And are these changes reversible or are they irreversible, the effects that you're seeing on the brain?

A. From the studies that we've seen on sheep, they are -- there's at least some evidence that it's irreversible. The brain -- remember, you're born with all the brain cells you're ever going to have, and changes in your brain are due to growth in those brain cells and changes in how they're myelinated and changes in how they talk to other brain areas. That's all there is.

So by the time you're an adult, the brain that you were -- we've all got different brains. Part of the reason for that is the different experiences and the different things we've done with those brains. You can't just go back to some default state. The brain is changed by experiences and by these sort of things that can affect the brain, and they don't -- it doesn't just snap back like an elastic band.

Q. Understood.

MR. JAZIL: No further questions, Your Honor.

THE COURT: Cross-exam?

CROSS-EXAMINATION

BY MR. SHAW:

Q. Professor, you mentioned that puberty blockers have the potential to cause a decrease in IQ; is that correct?

A. Yeah.

Q. And you cited a number of studies in your report on that, and one of them was the Mul study from 2001?

A. Sorry. How is that spelt?

Q. M-u-l.

A. Sorry. I don't have my report.

Is it okay for me to open my report up? I've closed everything on my computer.

Q. Do you not recall citing that in your report?

A. I don't remember the name. Is it possible for me to open up my report?

Q. Sure. We can bring it up.

A. That would be great. Thank you.

MR. SHAW: Ms. Gonzales, if you could bring up the Mul study.

If you'd go to the first page, please.

BY MR. SHAW:

Q. This is the --

A. Oh, yes, I do remember. So this was cited by Hayes, wasn't

it?
Q. And for the record the study is called "Psychological assessments before and after treatment of early puberty in adopted children."
Do you see that?
A. Yes, I do. Thank you.
Q. And this is a human -- this is a study on humans?
A. Yes.
Q. Yes?
And it looks at the effects of puberty blockers in children with precocious puberty.
Do you recall that?
A. Yeah.
Q. And you reviewed this study before you cited it?
A. I did look at it because Hayes had mentioned it, yep.
Q. Did you review this study before you cited it?
A. As I said, I looked at it because Hayes had mentioned it.
Q. Because -- okay.
The study explicitly says that there is no relevant decrease in IQ among the treated children; correct?
A. It says: *Intelligence quotient levels decreased significantly during treatment*.
Q. Right.
MR. SHAW: If we could go to the PDF, page 4.

BY MR. SHAW:

Q. Second column, under *Intelligence*, it says --

A. Yeah.

Q. -- *the IQ levels for the whole group decreased significantly, but this was not clinically relevant. A comparable significant decrease was present in both groups. There was no significant differences between Groups A and B.*

Did I read that correctly?

A. You did.

Q. Did you mention this finding in your report?

A. No, because it's within the same range as the change in the paper by Wojniusz with the -- the one we were talking about just before.

So when you're talking about a clinical change in intelligence tests, what you're normally talking about is something that's starting to go in units of ten. So something that went under 90, under 80, that would be starting to become clinically relevant, or in the opposite direction.

Q. You didn't mention any of that in your report?

A. No, because, as I said in the report -- and it's the same case with the study with Wojniusz -- that's -- just because it's not falling outside of the parameters of something that would be clinically relevant. So, for example, if you have a head injury, then you probably will have a much larger decrease in IQ, but it doesn't necessarily mean, as Hayes was arguing in

their article, that this is something about what you should be complacent.

Q. You've just mentioned Hayes, and you're referring to the Hayes commentary of Wojniusz's 2016 study; correct?

A. Yeah.

Q. I want to talk about Wojniusz's study.

But, first, did you know Hayes was a political scientist?

A. No.

Q. No.

Do you often rely on the expertise of political scientists in your research on the brain?

A. If I don't know who's a political scientist, then how could I know that?

Q. I'm sorry?

A. If I don't know if someone is a political scientist, how could I know -- how could it be having a view on what I'm taking to be data about the brain?

Q. And you didn't know he was a political scientist?

A. I think I said that.

Q. Okay. Let's talk about the 2016 Wojniusz study that Hayes comments on.

MR. SHAW: Ms. Gonzales, can you bring up that study?

And for the record, Wojniusz is W-o-j-n-i-u-s-z.

BY MR. SHAW:

Q. This study is called "Cognitive, Emotional, and

Psychosocial Functioning of Girls Treated with Pharmacological Puberty Blockage for Idiopathic Central Precocious Puberty"; right?

A. Yes.

Q. And this is another study of humans?

A. It's the only study of humans, other than the Mul one.

Q. And it looked at the effects of puberty blockers in girls with precocious puberty --

A. Yeah.

Q. -- right?

Just as an aside, you would agree that puberty blockers are standard treatment for precocious puberty?

A. They are, yes. As I say, the effects of precocious puberty are not trivial.

Q. And you would agree that puberty blockers have been used for decades to treat precocious puberty?

A. It doesn't go back that far. We've only known about these hormones since the '70s. But, yes, they've been used for a while.

Q. Do you think we should stop using puberty blockers to treat precocious puberty?

A. I suspect that what you'd be looking at here is weighing up the different risks, because, as I say, the precocious puberty in and of itself is -- it's a risky condition for the girls. It can have serious outcomes. So I'm not aware of any other

studies, other than these two, looking at issues around common side effects of this. It might be interesting to have a conversation about what would be the different risk factors that are involved here using them or not using them.

Q. But my question was: Do you think we should stop using puberty blockers to treat precocious puberty?

A. As I said, I don't think that's something that is -- it's certainly -- the question is should you stop it now, or you should start doing that. If it's going to be considered, then it would have to be considered in the light of what are the problems of precocious puberty.

Q. Okay. I'll move on.

A. You'd be weighing up the options.

Q. On Wojniusz's 2016 study, Wojniusz concluded that the puberty blockers had no effect on cognitive functioning; correct?

A. Other than they described it as interesting; that there were these differences on one of the emotional measures.

MR. SHAW: Ms. Gonzales, can you go to PDF page 7? And blow it up. Yep, there.

BY MR. SHAW:

Q. So the last paragraph, it says: *No significant differences between the CPP and the control group were seen with regard to cognitive performance neither on paper and pencil nor in computer-based tests concerning memory, spatial ability,*

attention, and executive functions.

Did I read that right?

A. Yes. You'll notice there is also a difference in the next sentence about the Trail Making Test, so there is a difference there.

Q. Yeah, I'll read the next sentence. It says: *Only in the Trail Making Test-Number Sequencing, assessing --*

MR. SHAW: If you could go down, Ms. Gonzales.

Keep going.

BY MR. SHAW:

Q. *-- processing speed, the CPP group showed a significantly poorer performance. This finding is difficult to explain since neither the very similar Trail Making Test-Letter Sequencing nor any other of the processing speed tests showed significant differences between the groups. Taking into account that the p-values were not corrected for multiple testing, it is possible that this finding is accidental.*

Did I read that right?

A. You did.

Q. Okay. Thank you.

MR. SHAW: Ms. Gonzales, if you could go up, please, back up to the previous page.

BY MR. SHAW:

Q. And on IQ specifically, the second-to-the-last paragraph in the right column, it says: *The puberty-blocker-treated CPP*

girls estimated IQ in the current study was within the normal range and somewhat lower, although not significantly than that of the controls; correct?

A. Yes, as I said before.

Q. Okay. And I just want to stay on this study for one more point.

You mentioned in your testimony something about puberty blockers affecting emotional reactivity; isn't that correct?

A. Yes, yeah.

MR. SHAW: Ms. Gonzales, if you could go to page 9.

BY MR. SHAW:

Q. And it's not highlighted, but it's on the screen. The last sentence above the "Cardiac function and emotional regulation" section, it says: *In summary, although part of the findings suggest differences in emotional reactivity between the groups, the results are not conclusive.*

Did I read that right?

A. Yes.

Q. And I misspoke. I want to stay on this study for one more point.

You mentioned something about -- did you -- you mentioned in your report that puberty blockers may cause a decrease in heart rate. Do you recall mentioning that in your report?

A. Yes, yeah.

Q. And you mentioned this study for that --

A. Yes.
Q. -- correct?
A. Yeah.
Q. A lower heart rate can mean that a person is more relaxed; right?
A. Yes, or healthier.
Q. So a lower heart rate is a good thing?
A. Well, as you'll notice towards the bottom of that paragraph, like they say, through interpretation of the puberty blockers as being something that's actually changing the emotional regulation capacity as you're measuring by heart rate. What you have to do is rule out a direct role for the puberty blocker itself on heart rhythm, and they point out that you can't do that if you bear in mind that the original GnRH is a neurotransmitter and it's having its effect on the hypothalamus.

But, actually, you find GnRH receptors in a much wider area of the brain. It's not only found in areas that are directly controlling the things that are happening in the ovaries and the testes. It is working as a neurotransmitter. When you block that, you could be also changing other aspects of how the body is going to start working, because we don't know what this is.

That's precisely what they're saying here. You can't tell whether this is something to do with the precocious puberty, the actions of the blocker, or the actual direct action of that drug.

Q. But you'll agree that the study says it's the -- in the last paragraph: *Consequently, the lower heart rate and higher heart rate variability would suggest that treated CPP girls have better emotion regulation capacity and higher adaptability to changing contexts than controls.*

A. I wouldn't agree with that --

Q. I read that right; right?

A. -- without the context of the next sentence, and the fact they say "could." Then they are definitely saying that this is one mechanism, but you cannot be certain.

Q. Do you have any training in puberty blockers that makes you certain either way?

A. No, but I have a little bit of expertise in how emotion effects the brain and the body, and that's one of things you're measuring here with the heart rate variability. So I'm commenting on this as something that's affecting the brain and the body.

Q. So you're familiar with heart rate variability?

A. Yeah.

Q. And heart rate variability is a measure of emotional control; right?

A. It can certainly be linked to that. It can -- there are a lot -- the heart is unbelievably reactive in terms of its moment-to-moment changes, but also it's -- how it's influenced by longer scale phenomena that can affect you. So, for example,

if you are in a fight-or-flight state of extreme fear, then your heart rate will be high, but your heart rate will also be less variable. So you are in a different emotionally reactive state and at some ball points in between. So it's not -- it's like a world of complexity starting to understand heart rate and heart rate variability.

Q. Heart rate variability is associated with lower levels -- excuse me. Let me rephrase. A higher heart rate variability is associated with lower levels of anxiety; correct?

A. When you hold other things constant, yes, and that's because what you're seeing is the heart rate is becoming -- is being more reactive. That's why it is being more variable.

Q. And the first sentence -- it's still on the screen. The first sentence under "Cardiac function and emotional regulation": *GnRHa-treated CPP girls had significantly lower resting heart rates and significantly higher heart rate variabilities than controls.*

Did I read that right?

A. Yes.

Q. Moving away from puberty blockers, you made some comments in your testimony about adolescent behavior; correct?

A. Yeah.

Q. And you made the point in your report, and I believe in your testimony, that teenagers are more prone to impulsive behavior?

A. I think the bigger emphasis I was making was on risk and risky behaviors. So their behavior can be impulsive, but the bigger problems are when it's associated with the riskiness of things whether or not they are impulsively decided.

Q. Would you agree that teenagers are able to assess -- to properly assess those risks when in the company of other adults?

A. No. If you think about the overall differences between how everything we understand about the adolescent brain differs from the adult brain, one of the cardinal features is that it can be extremely difficult for adolescents to engage with the potential consequences of actions whether or not they are being impulsive, whether or not they're being guided by adults. The meaning of those consequences can simply be less salient and less engaging to them.

Q. Would you agree that teenagers are able to properly assess the risks when speaking or working with medical doctors?

A. No, I think the same problem would still be there. If you -- if you can't understand what the import and the valence and the severity or the potential severity of outcomes could be, then it doesn't matter how well you are being supported by a medic or not. It's still going to be very difficult for teenagers to fully engage with that.

Q. So would you recommend that teenagers should not take any advice from a medical doctor?

A. No, I'm not saying that. I think you've got a situation

where the outcomes are potentially extremely serious and, actually, the medical doctors don't necessarily have the best advice. Then you -- and the outcomes could really be something that could have life-altering possibilities. Then I don't think that that's something that a teenager -- in most of the situations, we would protect teenagers from the consequences of their decisions because of that.

MR. SHAW: Pardon me one moment.

(Discussion between the attorneys.)

BY MR. SHAW:

Q. Professor, one final question. Do you know, in the United States, that it's the parents' responsibility to consent to medical treatment?

A. Yes. But I would imagine, in this situation, parents aren't going to be trying to get their children on puberty blockers without the child agreeing to it.

MR. SHAW: No further questions.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. JAZIL:

Q. Doctor, you discussed with my friends some issues concerning neurotransmitters and the effects on the hypothalamus. I'll confess I got a little lost in that discussion.

Are you saying that puberty blockers are a mechanism to

block neurotransmitters, and the neurotransmitters that could be blocked are in places other than the hypothalamus? Help me understand that --

A. Yeah.

Q. -- exchange there.

A. So from when they were first discovered, GnRH, gonadotropin-releasing hormone, was assumed to be having a very precise role in the hypothalamus because that's triggering, you know, these sex-hormone changes and the way that they behave.

But it turns out that, certainly in primates, if you look for the receptors that are sensitive to gonadotropin-releasing hormone, you don't only find them in the hypothalamus. You find them in basal ganglia. You find them in the basal forebrain. So you're finding them in a more distributive network. We still don't know what that means.

For example, several of the sheep studies that were looking at the effects of puberty blockers onto the brains and behavior in the sheep were doing that precisely, because there is the potential for these neurotransmitters -- so for the blocking of the function of this neurotransmitter to have an effect on cognition and behavior in a way that's more widespread than the effect it's having on -- in a direct way on sex hormones.

Q. So just to make sure I understood this, When we started studying puberty blockers, we were concerned about the effects on the hypothalamus. But since then, we've come to see that the

effects would be more widespread on the brain.

Did I get that right?

A. Exactly, exactly. There is the potential of it actually having an effect on a wider network of behavior and cognition.

Q. And, Doctor, my friend showed you some excerpts from the Wojniusz study.

Did any of those excerpts change your perspective on your testimony earlier about the conclusions you drew from the Wojniusz study?

A. No. It is interesting. If you read all the papers that I've mentioned, every one of them, including Wojniusz, says, We don't know what this means; we need to have more data, particularly because these drugs are being used in adolescent populations at a time when the brain is changing. So it's not changing my thoughts about this. The effects are not big, but they are there, and they are there in a direction that is worrying.

Q. Understood.

MR. JAZIL: No further questions, Your Honor.

THE COURT: Dr. Scott, one probably insignificant question to start with: Have you ever done any studies using sheep?

THE WITNESS: No. I've done some studies with horses, but not sheep.

THE COURT: One thing you noted in your testimony was

that precocious puberty is not trivial, and so I think you said, in response to Mr. Shaw's question about whether we should stop using GnRHa on patients with precocious puberty, that we should evaluate the risks -- the patient should evaluate the risks; true?

THE WITNESS: Well, ideally, I think the medical profession would be the best place to be gathering evidence and evaluating the risks so that they can then present to the families and the children concerned. But, yes, it is certainly, at least potentially, the case that there are things to think about here, and it may be that the severity of precocious puberty is so great that it is worth taking those risks.

THE COURT: Certainly for the patient and the patient's parents to evaluate the risk, they need the input of the doctor, and the doctor needs to know what the medical profession as a whole knows.

You're nodding your head yes, and I think that's what you just told me.

So precocious puberty is not trivial, and I suspect everyone would agree with that.

Is gender dysphoria trivial?

THE WITNESS: No. No, that's not trivial. However, at the moment -- and this is in my report -- we have no way of knowing. We have no biomarkers. We have no behavioral measures. We have no way of telling which adolescents

presenting with gender dysphoria are going to be the ones who benefit from treatment with puberty blockers.

So mental health is at risk in untreated gender dysphoria, but it's also significantly worse in treated gender dysphoria. So it really is the case that we're dealing with people who are in a very dire situation, and they deserve much better health care than they are receiving, absolutely.

But there's no clear evidence -- sorry.

THE COURT: Go ahead.

THE WITNESS: I was just going to say, there's no clear evidence that puberty blockers help, other than anecdotal evidence that there are some people for whom it does help, and that's still a level of anecdote. So at the moment we really don't know who are the people who are going to benefit from this for whom the risks really probably are worth going through for this treatment.

I recently read a book by Hannah Barnes with people absolutely making that case who are now in their 20s who are very happy they went down this path, and there are also the case that the vast majority of people with gender dysphoria are not going to have their symptoms improved by this treatment.

THE COURT: My question is this: If patients and their parents and doctors should evaluate the risk and make a decision whether to use this drug when the patient has precocious puberty, why isn't it the patient and parent and

doctor who should evaluate the risks and benefits and make the decision whether to use this drug when the person has gender dysphoria?

THE WITNESS: I think that's probably because we know that in precocious puberty it works. What that does is it delays the progression from Tanner Stage 2 all the way through puberty, and it delays it for long enough that you can then take the girls or the boys off it, and they go into puberty at a more normal age, and you've delayed the changes in height that can be associated with that.

We do not know this with the treatment of gender dysphoria with puberty blockers. What we do know is that the evidence we do have suggests that it does not work. It is not effective, so I think --

THE COURT: Let me see if I understand this.

You think -- you've never treated a gender dysphoria patient. I've heard evidence of many hundreds of gender dysphoria patients who are substantially better off after having had this drug, but what you're going to testify under oath is that none of them are better off?

THE WITNESS: No. That's not what I said. I said we know that there are some people for whom this is beneficial. What we cannot tell, and what the evidence is not there for, is who those children are going to be. So we don't know, in advance of it working, whether or not this is going to be

somebody for whom this will work. And for the people whom it doesn't work, it does not improve anything. It doesn't improve mental health. It doesn't improve a quality of life --

THE COURT: Fair enough.

THE WITNESS: -- so --

THE COURT: If it doesn't work --

THE WITNESS: (Indiscernible crosstalk.)

THE COURT: If it doesn't work, it doesn't work; I get it.

THE WITNESS: And we can't tell in advance.

Sorry.

THE COURT: Well, you can't. I've heard from doctors who think they can, but I don't want to get in a debate with you. I know you're not the treating doctor.

THE WITNESS: Absolute --

THE COURT: Questions just to follow up on that?

MR. SHAW: No.

MR. JAZIL: No, Your Honor.

THE COURT: Thank you, Dr. Scott.

THE WITNESS: Thank you.

THE COURT: I appreciate your availability, and we're going to disconnect you now.

That testimony is completed.

THE WITNESS: Thank you.

(Dr. Scott exited the Zoom conference.)

THE COURT: Please call your next witness.

MR. JAZIL: Your Honor, the defense rests.

THE COURT: Rebuttal case for the plaintiffs?

MR. GONZALEZ-PAGAN: No more witnesses, Your Honor.

THE COURT: All right. Let's take a 15-minute break, and we'll do closing arguments.

10:40 we'll start back.

(Recess taken at 10:25 AM.)

(Resumed at 10:40 AM.)

THE COURT: Please be seated.

Closing argument for the plaintiffs.

MR. GONZALEZ-PAGAN: Briefly, Your Honor, before closing arguments, if it's okay, my colleague, Ms. Dunn, would like to correct something.

MS. DUNN: Ms. Dunn, Chelsea Dunn.

Your Honor, when we submitted the deposition designations, we neglected to include the completed errata sheets. We were notified by Mr. Beato, so we refiled those deposition designations, but we also have copies for the Court to include with the binders that we submitted.

THE COURT: Got it. Okay.

MR. GONZALEZ-PAGAN: Good morning, Your Honor.

THE COURT: Before you -- good morning.

But before you start -- before I forget it -- let me tell you one thing.

We've had discussions before about the relationship between this case and the Doe case that's pending on a submitted motion for preliminary injunction. My tentative plan, at least, is to rule on both of these at the same time. There will be a lot of overlap between the decision in this case and decision in that case. There are obviously some differences, but there's a lot of overlap.

Here's my suggestion to both sides: If you appeal -- and it certainly seems likely to me that one side or the other or both will appeal -- I'm not sure the procedures at the circuit for notifying the circuit that there are these related cases.

I recently sat with the circuit. We had a case. We prepared. We heard oral argument. It turned out the exact same issue with the exact same lawyers had already been argued to another panel and nobody told us. So they -- they may not have the same rule that we have here that require you to notify us of related cases -- or if they do have that rule, the lawyers in that case just missed it -- but that was a lot of unnecessary work.

So if these cases both wind up going up, figure out what you need to do to let the circuit know that both cases are pending so that they can deal with it, however it is appropriate for them to deal with it, but somebody there needs to decide how to do it.

MR. GONZALEZ-PAGAN: Understood, Your Honor.

Thank you very much.

May it please the Court, Omar Gonzalez-Pagan for the plaintiffs. Your Honor, over the past two weeks we have been building a trial record demonstrating that subsection 7 of Rule 59G-1.050 of the Florida Administrative Code, or what we will call the AHCA rule, and section 3 of the recently enacted Senate Bill 254, which prohibits state funding for medical care that affirms a person's gender identity if inconsistent with their sex assigned at birth, are unlawful.

Both of these provisions independently serve to prohibit the Florida Agency for Health Care Administration from providing Medicaid coverage for gender-affirming medical care, care that only transgender people need as treatment for gender dysphoria.

In building this record we have shown that gender-affirming medical care is not only safe and effective but that it is not in any sense of the word experimental. This is so because under *Rush v. Parham*, based on current medical knowledge, the State's determination that gender-affirming medical care is experimental is not reasonable.

As previewed at the beginning of this trial, AHCA's overt -- very own regulation to determine whether a treatment is experimental, that which dictates Generally Accepted Professional Medical Standards, shows that the only conclusion

one can reach is that the State's conclusion in this instance is grossly unreasonable.

We have provided extensive and, in many instances, uncontroverted evidence that under the six factors of subsection 4 of Rule 59G-1.035, gender-affirming medical care, meaning puberty-delaying medications, hormone therapy, and surgery as treatment for gender dysphoria meets Generally Accepted Professional Medical Standards. And, again, while those factors are not binding on this Court, we do think they're instructive, and they emphatically illustrate that gender-affirming medical care is safe, effective, and not experimental.

Factor one, which the Court is very familiar with already, the existence of evidence-based Clinical Practice Guidelines. It is uncontroverted that there are primarily two evidence-based Clinical Practice Guidelines for the medical treatment of gender dysphoria.

These are the WPATH standards of care, specifically Version 8 published in 2022, and the Endocrine Society guidelines published in 2017. Plaintiffs' eight experts -- two psychiatrists, a pediatric endocrinologist, a clinical researcher and adolescent medicine physician, a surgeon, a bioethicist, a neuroscientist, and a public health researcher -- all testified to this fact.

These evidence based guidelines set forth that gender-affirming medical care, which is only provided after the

onset of puberty, is appropriate and indeed necessary when medically indicated.

In making such a determination, one looks to the patient, the particular needs of the patients after conducting an individualized assessment and for which the guidelines provide detailed guidance on how to conduct that assessment.

The State's experts, and AHCA's employee responsible for the June 2022 GAPMS report, Mr. Brackett, all acknowledge that the WPATH Standards of Care and Endocrine Society guidelines are already applicable clinical practice guidelines. They point to no competing guidelines in the United States, let alone guidelines that are widely accepted.

As outlined in trial Exhibits 36 through 43 and 45 through 49 and the testimony of plaintiffs' experts, these guidelines are viewed as authoritative and have been endorsed by the American Medical Association, the American Psychiatrist Association, American Psychological Association, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatrists, the Endocrine Society, the Pediatric Endocrine Society, and many more.

While defendants point to no recognized competing guidelines in the United States, they point to three reports from three different countries; namely, Finland, Sweden, and the UK. But these reports have no weight, Your Honor. For one, each of the reports only apply to medical care for adolescents

and not adults, and each provides for the medical treatment of gender dysphoria based on an adolescent patient's individual needs.

In this sense, as the U.S. Court of Appeals for the Eighth Circuit recognized in *Brandt v. Rutledge*, the reports really do not differ significantly from the WPATH Standards of Care.

For another, even if the reports were contradictory, they are in opposite. That's because, unlike the WPATH Standards of Care and Endocrine Society guidelines, each of the reports is unpublished, it's not peer-reviewed, and it's incomplete. Defendants have not identified or provided full copies of each of these reports. They've provided summaries, interim reports and, with regards to Finland, a summary -- a translated summary of an unknown origin. Maybe it is because they have no bearing.

In addition, the three reports were drafted by government bureaucrats in these other countries and not medical professionals. And as the State's own expert, Dr. Stephen Levine, testified, standards of care and Clinical Practice Guidelines are, quote, to be constructed by people in the field, closed quote.

He gave the example of the standard of care for low-grade prostate cancer and said that it is written by urologists and people qualified with the expertise in evaluating

that quality, the quality of that evidence.

That is what happened with the WPATH Standards of Care and Endocrine Society guidelines, not the three reports to which defendants refer.

Finally, Dr. Levine also testified that clinical guidelines tend to be much more regional, much more local. If that is so, then three unpublished, non-peer-reviewed, incomplete reports from three foreign countries should have no bearing on what the clinical practice guidance and standards of care for the treatment of gender dysphoria in the United States should be.

As outlined in my opening statement, this first factor weighs heavily in favor of the provision and coverage of gender-affirming medical care and shows that this care falls squarely within Generally Accepted Professional Medical Standards.

Next, we look to the publication of reports and articles containing authoritative medical and scientific literature that relate to the health service at issue. Plaintiffs' experts, in particular Dr. Olson-Kennedy, who conducts clinical research regarding the treatment of gender dysphoria, testified to the abundance of peer-reviewed, scientific literature supporting the safety and efficacy of the medical interventions for the treatment of gender dysphoria.

When it comes to adults, as Dr. Olson-Kennedy

testified, the amount of published literature documenting this safety and efficacy is, in research language, significant and, in layperson's language, enormous.

Not one of the defendants' experts discussed this literature regarding adults, and instead, each focused on the care of minors. But when it comes to adolescents, there is more than ample scientific and medical literature documenting the safety and efficacy of puberty-delaying medications, hormone therapy, and surgery to treat gender dysphoria, particularly chest-masculinizing surgery.

Dr. Olson-Kennedy walked us through numerous cross-sectional and cohort longitudinal studies across the United States and the world documenting the safety and efficacy of gender-affirming medical care to treat gender dysphoria.

This included two of her own studies, studies that she published and have been peer reviewed that pertain to hormone therapy and chest-masculinizing surgery for older adolescents and young adults. Her testimony is corroborated and backed up by the testimony of each of plaintiffs' other medical experts, including Dr. Shumer, Dr. Janssen, and Dr. Karasic, as well as the reviews, systematic review, of literature regarding hormones conducted by Dr. Baker.

As anticipated, the defendants' experts critiqued a handful of these studies, not all of them, but a handful of these studies, because the studies have limitations.

Your Honor, every study known to science has limitations. It is impossible to design a scientific study without limitations. That is why, as plaintiffs' experts testified, we look to the body of literature as a whole. And here the body of literature goes back decades, both for adolescents and adults.

By contrast, when asked for a single study that would support the State's position that gender dysphoria could be effectively treated with gender -- with psychotherapy, the State's experts could not come up with one example, not one.

That is understandable because there is none. There is no peer-reviewed scientific literature supporting the defendants' position. The entire body of scientific and medical literature, when taken as a whole, provides strong and unrivaled evidence in support of puberty-delaying medications, hormone therapy, and surgery as treatment for gender dysphoria. This factor also weighs in favor of the plaintiffs.

Number 3, the effectiveness of the health service in improving the individual's prognosis for health outcomes. I've just discussed the overwhelming universe of medical literature that shows that this gender-affirming medical care is effective to treat gender dysphoria.

But as -- just as Dr. Janssen explained, it is a little drier, when talking about the effectiveness of gender-affirming medical care from the data perspective, when

compared to the profound positive impact we see when patients get access to this care.

The positive impact of gender-affirming medical care is corroborated not only by the clinical experience of plaintiffs' experts, but by the experiences of plaintiffs themselves and their factual witness.

Plaintiffs August Dekker and Brit Rothstein both testified as to the positive impacts of being able to access hormones and chest-masculinizing surgery and the impact that it had on their mental health, their dysphoria, and their quality of life.

And Jane Doe and Jade Ladue testified on the similar impact, positive impact, that puberty-delaying medications had on their adolescent children, Susan Doe and K.F.

August Dekker testified that his gender dysphoria felt like he had a constant void in his chest, like he had been walking around with a leaden ball in his stomach that informed everything else that he did and became unmanageable. He didn't want to sleep. He didn't want to eat. He didn't want to do anything that was even remotely human because he was, in his words, so disgusted with himself and the way that people perceived him. He was depressed and anxious as a result. Your Honor, this is on the trial transcript pages 656 through 657.

By contrast, once he was able to obtain medical

treatment for his gender dysphoria, his depression and anxiety ameliorated, and he was happier. He was more secure in himself. He was confident. He wanted to go outside and meet people. He wanted them to know who he was and wanted them to see how he presented himself because he felt proud of who he was and of himself.

Being able to obtain chest surgery meant like the world had been lifted off Mr. Dekker's shoulders. He felt like that was the way things were supposed to be all the time. It felt natural. He had confidence in his body and was not able to go -- was now able -- was now able to go swimming at the beach or even wear a white shirt to this trial. In his words, it was probably the best thing he has ever done for himself.

The plaintiffs' experiences are like that experience relayed by Kim Hutton, whose son, now 20, had been receiving gender-affirming medical care for ten years, puberty-delaying medications and hormones, as well as the experiences observed by plaintiffs' medical experts of their patients. This includes the testimony of Dr. Karasic, Dr. Shumer, Dr. Schechter, Dr. Olson-Kennedy, and Dr. Janssen.

Speaking of the effect of puberty-delaying medications, Dr. Shumer testified about how adolescents -- it's always a challenging time. But if you throw in gender dysphoria on top of that, it becomes even more challenging and difficult.

And when he sees an adolescent patient, they've

oftentimes been -- have been circling that appointment on their calendar for many, many months. Again, this illustrates that this care is provided with care and not immediately or by chance. People plan and take time to get to know each other, to get to know themselves and work with their providers to access this care.

And Dr. Shumer testified that his patients express how they've been suffering, how they're not fitting in the world because the body is changing in a way that is not consistent with who they are. And that their parents, who are there because they love and support them simply want to allow their adolescent to live the happiest, healthiest, most fulfilling life that they can live.

And that one of the greatest things of Dr. Shumer's job is that he gets to see these patients back in follow up and see them doing so well that he gets Christmas cards five years later from patients of the college, having that healthy, happy, productive life that they didn't think was possible when they first came. All of that, Dr. Shumer testified, was a result of gender-affirming care.

By contrast, the State could only produce, primarily, experts who have never treated or studied gender dysphoria. They couldn't really speak to its effectiveness because they didn't know how. The one expert they produced who had some experience treating gender dysphoria, Dr. Levine, provided

additional support for gender-affirming medical interventions for both adults and adolescents. To be sure, he recommends a more careful assessment of the patient, but so does the standards of care, which recommends the bio-psychosocial careful assessment of adolescent patients.

Finally, the State could not produce any evidence that gender-affirming medical care was harmful and could not produce any evidence beyond their say-so that treatment for psychotherapy alone is sufficient or effective. Gender-affirming medical care is efficacious to treat gender dysphoria. Mountains of literature document as much, the clinical experience of plaintiffs' experts shows as much, and the testimony of plaintiffs illustrates as much. This factor goes to the plaintiffs.

Next up are Factors 4 and 5, utilization trends and coverage polices by other credible insurance payor sources.

Dr. Kellan Baker testified about how, over the years, we have seen an increase in the utilization of gender-affirming medical care. He testified that this increase is attributable to both greater of an ability of coverage and the fact that the consensus about this care has led providers who are providing this care to be explicit in their coding without fear of triggering an exclusion.

That also relates to Factor 6. Dr. Baker testified that the trend among all types of payors in the United States,

all types, is to cover gender-affirming medical care as necessary. This includes private insurance in the marketplaces, employer-provided insurance, Medicare on a case-by-case basis, and state Medicaid programs.

For example, he testified that a --

THE COURT: Surely the trend among Medicaid payors is the other direction?

MR. GONZALEZ-PAGAN: Well, Your Honor, he testified --

THE COURT: And that's whether that's a political movement or what.

Yeah, he said that. Look, I read the papers, and I don't pay attention to what the newspapers say when I'm evaluating my cases. Sometimes I skip over stories on purpose. But just -- I have looked at what's going on in other states. I mean, you know, I read the decisions, but I also see the statutes and so forth that are being passed. And just in the last month, there have been two or three states that have taken action.

Surely you don't assert that the trend is all your way?

MR. GONZALEZ-PAGAN: Your Honor, if one were to take a step back from this one last year alone, the answer is, yes, it is.

THE COURT: All right.

MR. GONZALEZ-PAGAN: Because some of those were states

that already had exclusions, like Texas, for example. And the reality is that even today, as we stand here today, of the 56 U.S. jurisdictions, 46 or 47 do not have any exclusions whatsoever. A few of them in the last year have adopted them, but it is still less than 10. And at the same time, 27 U.S. jurisdictions have adopted policies requiring affirmative coverage of gender-affirming medical care.

THE COURT: I get it. And I asked partly -- you've probably heard me say something like this before. You know, sometimes it's not nearly so important what the particular subject that's being addressed by an expert is or what the facts are. Sometimes it just tells you something about the expert and the expert's credibility, and it was part of the reason I asked the questions I did at the end of Dr. Scott. When you get experts that just won't recognize plain facts, it tells you something. When you get somebody that says the trend is all one way, it's just not.

MR. GONZALEZ-PAGAN: Understood, Your Honor.

I don't believe that was Dr. Baker's testimony. Dr. Baker was taking a holistic, universal view and testified as to the -- not just Medicaid, but Medicare insurance payors, the fact that, in the marketplaces, over 90 precent of private insurance being sold has actually no exclusions whatsoever. And that, in Florida, of the six insurance companies that operate and provide insurance, only one had a limited, vague exclusion,

the rest had none, and some of them had affirmative coverage.

We all, I think, understand that Dr. Baker would acknowledge that there are policies being passed right now in certain states because of political reasons. But I think if one were to take a step back, one would see that over the decades that this care has existed, the trend has always been for more coverage. And, yes, now we face these questions of whether that should be reversed, but that is different than what the trend was at the time that this exclusion was excluded and the overall graph that we would look at right now.

THE COURT: Yeah, I get it. And if one lived in Europe, one would say that the trend was on the defense side -- on the plaintiffs' side, and now it's turned around a little bit. And in the United States, the trend was certainly on your side, and now it's turned around a little bit. I don't know --

MR. GONZALEZ-PAGAN: Only one of six factors, Your Honor, to look at.

THE COURT: I get it.

And I'll say this to both of you: It's almost -- sometimes it's almost like you think that you should only say the things that support your side, and you ought to ignore everything else. That's fine. You can do it that way, but I have to deal with everything.

So it would really help me -- on both sides, it would help me if the experts actually looked at what was going on

instead of just cherry-picking what helped their side, and the same thing for the lawyers.

Look, it's not all one way. There are facts that support one side and facts that support the other side. Just come to grips with them. Don't pretend like I'm not going to find them out. I'm going to do my best to find them out. And if you just pretend like it doesn't exist, you kind of forfeit your chance to be heard on the question.

So on this, for example, I get it. The argument is, oh, yes, the trend is against us. Recently, it's political. It might very well be that it's political. But if you just don't acknowledge the trend, you don't even get a chance to say it's political. And I would have figured that out by myself, but some things I wouldn't figure out by myself.

So, frankly, all through this, if you'll address the real issues on both sides, it will help me.

MR. GONZALEZ-PAGAN: Understood, Your Honor. Absolutely.

And my next point was the following: Florida's exclusion, just like the recently adopted exclusions in other states like Texas, they represent extreme outliers within the realm of the 56 U.S. jurisdictions. Sure, some of them have gone more extreme now than before, because Dr. Baker testified that the few places that had exclusions, they were all different, if you will, that there were exclusions that were

total, categorical, like that has been adopted in Florida, whereas other places that adopted exclusions were limited to only certain treatments, say, for example, surgery, and some of which have age exclusions, specifically.

But, overall, if one were to take a look at the whole map and take a step back, the numbers have always been in support of a trend in this care. And, of course, we are now faced with the situation that we now live in politically where certainly some states have sought to restrict this care in multiple ways: Passage of gender-affirming care which is under litigation in several states as well as Medicaid exclusions in some states. Most of those states already have them. They were part of that ten or so jurisdictions, but they were states that have now made it even more difficult, not dissimilar from the actions in Florida here from passing the AHCA rule -- adopting the AHCA rule and then enacting Senate Bill 254 at the same time.

In sum, while this factor is somewhat mixed, one would argue that, overall, particularly utilization trends and the fact, if one were to look at private insurance policies and private creditors, none of which were discussed or acknowledging the GAPMS report, those factor -- these factors actually weigh in favor of the plaintiffs.

And then the last is the recommendations or assessments of clinical or technical experts on the subject or

field. This implies that these experts have experience. Most of the experts provided by the State had no experience in this care. And, indeed, the process leading to the GAPMS report was a sham process where only opponents of this care were selected to provide input.

Here plaintiffs presented the Court with the testimony of five providers of various disciplines who treat gender dysphoria. Each of them has treated hundreds of transgender patients of varying ages for gender dysphoria. Collectively, they have treated thousands of transgender people with gender dysphoria throughout the country from California to Illinois, from Michigan to New York.

And they, Dr. Shumer and Dr. Karasic, reviewed the medical records of the plaintiffs and testified that they have a diagnoses of gender dysphoria and that their care was consistent with the standard of care. Each of these experts are recognized as leaders in their field of gender-affirming care. They are experienced. They are published. They are peer reviewed. And they provided extensive testimony about the efficacy of gender-affirming medical care from a research perspective and a clinical experience perspective.

Their testimony was further supported by the testimony of a bioethicist, a public health researcher, and a neuroscientist, those being Dr. Antommaria, Dr. Baker, and Dr. Edmiston, all of whom have studied and rated about this

care.

I believe one can break the State's experts into buckets, if you will. They are the experts that had no experience providing this care, have not published, and had what can charitably be called or referred to as extreme biases against transgender people.

They also had other witnesses like Dr. Kaliebe who had some experience, but it was very limited experience and was not published in the area. Dr. Kaliebe's testimony said he's provided treatment to four people in the form of psychotherapy.

THE COURT: Yeah, I said that when I was asking questions. It may have been 4 he didn't treat out of his 12.

MR. GONZALEZ-PAGAN: Four that he had a prolonged relationship of treatment, and 16 overall that he has diagnosed with gender dysphoria.

THE COURT: I just didn't want you repeating back my number because I thought I might have had it wrong. But, anyway, it wasn't a big number. It was part of his 12.

MR. GONZALEZ-PAGAN: Yes, correct, Your Honor.

THE COURT: Maybe it was four adolescents. I can look back at the transcript, but it was a small number.

MR. GONZALEZ-PAGAN: And he could not provide any testimony in support of his position that psychotherapy alone -- any evidence, pardon me -- that psychotherapy alone is sufficient or effective in treating gender dysphoria.

This leaves us with Dr. Steven Levine, whose testimony, in large part, not in all parts, supports the plaintiffs. To be sure, Dr. Steven Levine advocates a more cautious and prolonged approach to assessment of gender dysphoria for adolescent patients, in particular. But he does not dispute that there are positive effects of gender-affirming medical care and the effect that it has had on even the patients that he has seen. And he believes that the decisions regarding this care should be left to patients, their families, and their doctors -- we agree -- not the government. And he has provided letters to support adolescent and adult patients obtaining gender-affirming medical care.

To be sure, Dr. Steven Levine is a critic of the standards of care as they stand now and would actually argue for a more cautious and, if one will, prolonged therapy approach before accessing medical care.

But at the end of the day, that goes to the tailoring question, not whether a categorical rule that prohibits all coverage of this treatment should exist. And Dr. Steven Levine is one of many people who have experience in this care, and we have provided a significant number of others who testify in support of the current standard of care in Clinical Practice Guideline approach.

THE COURT: Dr. Levine is probably correct that politics have affected the organizational endorsements of this

care; isn't that right?

MR. GONZALEZ-PAGAN: Your Honor, I would disagree with that. I just want to distinguish between politics -- about gender-affirming care in the political sense and what is occurring with governments versus, like, internal debates on politics about what the care should look like.

Plaintiffs' experts testified that -- those that were involved in the development of Standards of Care 8 testify that there are varying degrees of views. One would argue that Dr. Steven Levine is on the more conservative side of how the care should be provided, and certainly some organizations have rejected that.

But at the end of the day, that is part of the debate in science, and one could say that Dr. Steven Levine does engage in that debate. He has published literature in this area.

THE COURT: Lots of people engage in it. But I guess -- let me give you a chance to address this, and it goes to both sides.

I mean, on the defense side they can say that Mr. Brackett didn't know what result he was supposed to reach. Okay. His boss knew.

On your side you can say, Look, the folks that have participated in developing these guidelines, the folks at the American Pediatric Society who endorsed these guidelines, weren't affected by the higher political, moral, religious

disagreement about transgender individuals. Dr. Levine said he hadn't seen this level of political disagreement affect any other medical assessments, standards-of-care discussions. Frankly, to me that rings true.

Are you going to tell me, no, that's not it, that nobody in the American Pediatric Society would be worried about speaking up for fear of being labeled a bigot?

MR. GONZALEZ-PAGAN: No, I cannot categorically say no, Your Honor, of course not.

What I will say is this, though: This is a reason why a ruling is necessary to get the government away from banning this care, and let the debate happen among the medical providers and scientists.

I will say this: I believe, and I believe the testimony shows and the evidence provided shows, that Dr. Steven Levine disagrees with some of the plaintiffs' experts, certainly. And that is part of the debate that can happen and should happen. But he doesn't represent a majority view within the medical provider community, and there's no evidence that he does.

I don't disagree that there is significant debate around this, but part of that has to do with the fact that this care is being banned by states like Florida or being prohibited from being covered by states like Florida and injected politics into what would otherwise be routine medical care.

This may be outside -- completely outside the scope of what my closing is, Your Honor, but arduous debate in science is actually the norm. Some of my co-counsel and I were talking about this recently, because we spotted a pileated woodpecker, and I can note for the Court that there is vigorous debate as to whether the ivory-billed woodpecker is currently extinct or not, and scientists go at each other's throats at that fact.

But it's not a political issue that should be handled by the government. And the scientists put forth research, put forth papers about that, and they then, as a community, debate what makes sense.

Here -- here the standards of care were not just drafted in a vacuum. It involved 119 individuals all debating internally about what they should look like, having divergent views. The standards of care were actually published for public comment and then finalized. And in doing so, for the finalization, they were subjected to the peer-review process. That is how science should work.

So I do agree there are some folks that disagree with this care; they do. That is fact. But the fact that that is a reality doesn't mean that plaintiffs and transgender Medicaid beneficiaries should not have access to the care that their doctors believe is appropriate that they need and believe is appropriate and that we have shown has been documented to be effective, efficacious, and safe for their gender dysphoria.

I don't disagree with Your Honor that there is debate about this care in multiple spheres, but the overwhelming view of experts in this field is that this care is appropriate. And even the State's expert, that would be in the more conservative end of people who have some experience with this care, would agree that it is appropriate in some circumstances.

This rule prohibits coverage of that care in all circumstances. It just doesn't meet the moment and endangers the safety and lives and health and well-being of transgender people in Florida who are low income or are disabled and, therefore, rely on Medicaid for access to care.

Your Honor, I would argue that this discussion of the six factors illustrates that even under AHCA's own regulations, gender-affirming medical care conforms with Generally Accepted Professional Medical Standards and is not experimental.

Given this, AHCA's rule and Section 3 of Senate Bill 254 discriminate on the basis of transgender status and sex. They, therefore, violate Section 1557 of the Affordable Care Act and are subject to having -- under the Fourteenth Amendment.

Further, because these treatments are not experimental and they ameliorate gender dysphoria, Florida must cover these services where they're medically necessary for beneficiaries under the age of 18 -- of 21 under the Medicaid Act. Beneficiaries under the age of 21 are entitled under the EPSDT requirements of the Medicaid Act to have access to any care that

will ameliorate a condition.

Finally, because these services are covered for the treatment of other conditions for adults, Florida must cover the services as treatment for gender dysphoria under the Medicaid Acts comparability requirement, which prohibits discrimination among individuals with the same medical needs stemming from different medical diagnoses -- medical conditions. I can point the Court to *Davis v. Shah,* 821 F.3d 231, a decision by the Second Circuit in 2016.

Turning back to the equal protection argument, the State has intimated, but not shown, that care is being provided without caution. To be clear, the State has provided no evidence that this is the case in the state of Florida. But plaintiffs are not here to argue that every medical or healthcare professional out there is perfect or that they do things all the time by the book. That is neither their burden nor what is required of them under the Constitution and these laws.

Rather, plaintiffs have shown that when care is provided consistent with Clinical Practice Guidelines, it is safe and effective to treat gender dysphoria. That has been their experience, and that has been the experience of plaintiffs' experts.

It is the State's burden to show that their actions are substantially related to an important governmental interest

and that they had an exceedingly persuasive justification for doing so. The defendants cannot. Defendants point to the experience of the transition and have provided one out-of-state witness who testified to her own experience with the transition, Ms. Hawues (phonetic).

But the transition does not necessarily mean regret, although I believe in Ms. Hawues's case she testified that it does, and everyone acknowledges that the transition or regret may happen. It is a fact that no one denies. However, the uncontroverted evidence is that the transition and regret are extremely rare. We are talking 1 percent each. And this is for a population that is already so extremely small. This is born by the fact that defendants cannot find a detransitioner from Florida, notwithstanding that it is the third largest state in the country.

Defendants have repeatedly referenced the experience of one of the clinicians who offered a letter in support of Mr. Dekker to obtain chest-masculinizing surgery, that of Ms. Rolf. They ignore -- and that is -- the letter from Ms. Rolf is Exhibit 237A admitted into the record.

They ignore that a student clinician at the time, Ms. Rolf, was operating under the supervision of not one, but two licensed and well-practiced clinical mental health professionals, and they also fail to mention or ignore that it was an unnecessary letter. It was a second letter on top of the

first letter that Mr. Dekker obtained from his own psychiatrist with whom he had a long-standing relationship with. Mr. Dekker did that as a belt-and-suspenders approach to avoid being denied coverage.

I don't think the State would be arguing that medical residents cannot practice medicine if under the supervision of another doctor. Otherwise, how would they get experience? It is true as well with mental health counselors.

In sum, these two arguments or examples are wholly insufficient to support the State's actions, let alone to meet their burden under intermediate scrutiny to show as exceedingly persuasive justification, and one that is substantially related to the actions that they have taken.

Finally, Your Honor, it is worth noting the intentional nature of the State's actions. Not only was the AHCA rule a predetermined outcome of a fixed process, but the rule in SB254 is part of a constellation of actions by Florida officials seeking to erase transgender people from Florida. In signing Senate Bill 254 -- if I may, Your Honor -- the Governor signed other measures targeting LGBTQ people and transgender people in particular, and he also stated he -- and he also used the same slogan as AHCA did in adopting the rule: "Let kids be kids."

The implication, Your Honor is that a trans kid is not a normal kid. I believe that is wrong. Indeed, the Governor's

own words demonstrate as much. In signing Senate Bill 254, he stated: *As the world goes mad, Florida represents a refuge of sanity and a citadel of normalcy.* This thinking permeated an influence, the numerous deviations of process at AHCA, as they pursued the rule. These deviations were confirmed by the testimony of Jeffrey English as well as the State's own witnesses, Ann Dalton and Matthew Brackett.

Jeffrey English would have been the person who ordinarily would have handled the GAPMS report at that point in time. He was excluded. Never had AHCA hired consultants in the process of promulgating a GAPMS report. For the first time they did so here, and they chose only individuals with opposing views to gender-affirming care. In fact, they chose five to include attachments and two additional ones to serve as advisers.

At the end of the day, Your Honor, transgender Floridians are just a part of the fabric of this race date as any other person. Their medical needs are as important as those of any other person. They're as important as to those -- of any other person in Medicaid. This Court has now heard from them and from those who love them and those who care for them. August Dekker, Bri Roth, Susan Doe, and K.F. can see a future for themselves because they had access to gender-affirming medical care that they needed. It is our responsibility to ensure and protect that future for them.

For this trial, we have demonstrated that medical

treatment for gender dysphoria, which AHCA previously covered, is not only safe and nonexperimental, it is effective and necessary. Lives are at stake.

Your Honor, we thank the Court for allowing us to present this case and for hearing our arguments. We also thank all of the court staff for their care and attention throughout these past two weeks.

We ask that the Court declare AHCA's rule and Section 3 of SB254 unlawful and that it permanently enjoin defendants from enforcing them.

Thank you, Your Honor.

THE COURT: All right. Thank you.

Mr. Jazil.

MR. JAZIL: Thank you, Your Honor. May it please the Court, Mohammad Jazil for the defense.

Your Honor framed the issues in this case around the *Rush versus Parham* test, whether, based on current medical opinion, Florida's determination that certain treatments for gender dysphoria are experimental is reasonable.

The State's contention is that its conclusion was reasonable, and, Your Honor, I'd like to start with Dr. Levine's testimony. On page 982 of the record, there was a back and forth with the Court in follow-up to some questions from direct, and the testimony from Dr. Levine on page 98 [sic] essentially lays out the framework that -- the frameworks that can be used

to treat gender dysphoria.

I like to think of it as a continuum, because that's how the testimony comes across to me. On one end of the continuum, you've got the reversion model. This is pejoratively referred to as conversion therapy, where you're telling folks that they ought to revert back to their natal gender.

On the other end of the model is -- other end of the continuum is the affirmative model, where you're telling folks, Look, we are going to recognize the gender you've selected. We're going to acknowledge that this is your new gender, and we're going to work with you along that way.

And then there's the middle ground, the psychotherapy model, which I'll refer to as the ambivalence model because you're not trying to revert someone back to their natal sex and you're not trying to affirm someone into their new recognized sex. So that ambivalence model, the psychotherapy model, is what Dr. Levine was advocating for, in essence, in his testimony. And Dr. Levine talked --

THE COURT: He did say rather clearly that some people need medical treatment, puberty blockers, cross-sex hormones; true?

MR. JAZIL: Yes, he did, Your Honor. And he said that -- as his testimony was developed, he said that, Okay. They do. If I use a psychotherapy model, I see them for years. After I do my careful evaluation, I may write a letter

recommending that if they want to chose surgeries or medical treatments, et cetera, they should go forward and get those. What he did refute, though, was that -- look, this isn't something that you can just pick up on, even if you have a multidisciplinary team, in a matter of minutes. It takes years.

THE COURT: Absolutely, absolutely. You have to do it right.

And if the Florida Legislature adopted a statute consistent with Dr. Levine's testimony, we wouldn't be here, or if we were, the plaintiffs would be in a much weaker position. But that's not what the legislature did.

And I guess the question you need to answer -- and this is a constitutional question, not just a *Rush versus Parham* question. When I said what I did there, I was dealing with a preliminary injunction, and the statute hadn't been adopted. So the constitutional issue is now here, dead center of the case. What you need to deal with is: Why is it that the State of Florida -- that the Legislature and the Governor get to decide the medical care that an individual gets when even your own expert says this kind of care is sometimes needed?

MR. JAZIL: Understood, Your Honor, and I'd like to approach that two ways.

One, Dr. Levine talked about the three models, and he talked about what people believe they know, not what they actually know, and he was advocating for one of those three

models. He said also that the affirmation model has gotten a lot of credence and has become sort of a model du jour.

And Dr. Levine then talked about some of the concerns that are associated with that model, because the Court asked the question and said that I should be prepared to address this at closing; that, look, at the end of the day, if the affirmative model is supported by low-quality evidence or very low-quality evidence but we're giving certain treatments -- puberty blockers, surgeries, et cetera -- why -- what then -- what kind of evidence supports the model that we' advocating for, which is the no puberty blockers, no surgeries, other model?

And so this question was also -- a variation of it, as I recall, was framed for Dr. Levine, too, and Dr. Levine, in advocating for his caution model -- and this appears in the next page, 983 of the transcript, said that, Look, if we're talking about the affirmation model and we're quick to start with the puberty blockers, the surgeries, et cetera, we're talking about possible long-term negative impact on fertility, sexual dysfunction, et cetera. So that was his discussion.

It was like, okay, if we're doing the affirmation model and we begin with supposition that we should prescribe puberty blockers, cross-sex hormones, et cetera, we are then entering into an area where there's a greater chance of these other issues happening. That's where Zoey Hawues and Yacov Sheinfeld's testimony comes in.

So if we take that, Your Honor -- that testimony at a 10,000-foot level, what Dr. Levine is saying is caution is the watchword. Caution is the watchword. Then, in Dr. Levine's perspective, that caution should come without blanket prohibitions, but should come with exceptions for those instances where these treatments are and aren't required.

From the constitutional perspective, the question then becomes -- and from the *Rush versus Parham* perspective, the question then becomes if caution is truly the watchword, who gets to draw that line, and how do we figure out where to draw that line? Now, Your Honor, I would submit --

THE COURT: Draw it anywhere other than just flat prohibiting care that's going to make lots of people much better off than they are without it. So draw a line. But that's not what the legislature did.

MR. JAZIL: Understood, Your Honor. That is not what the legislature did. And, frankly, Your Honor, I am not certain about the line that the legislature has drawn, because at the preliminary injunction hearing when we were talking about just the rule, I brought up the variance and waiver process, and the variance and waiver process would have aligned with Dr. Levine's perspective, because someone --

THE COURT: Only if it was real. But I get it. And, frankly, other than you, I haven't heard from anybody suggesting that the exception, which applies to rules in general, ever had

any chance at all to be applied here. You brought it up, and I told the other side when they started to take issue with you, Do you really want to take issue with that? Because, look, this is good for you. And here we still are, so I guess they haven't gotten an exception, even though they've presented pretty good facts.

MR. JAZIL: Your Honor, here -- one, it was a legal argument, so I think it's appropriate for me to be the one who provides the agency's perspective on it.

Two, no variances and waivers were submitted.

Three, had a variance or waiver been submitted and granted, I think it would have strengthened my case and the perspective that I've presented.

THE COURT: It would have.

In any event, the legislature put the end to that because there is no exception to the statute; right?

MR. JAZIL: Well, Your Honor, there, too, I'm a little confused, and I think it would be worth having a variance or waiver as a test case to see how this works, because the way that provision reads is that state funds cannot be expended for these treatments under Medicaid, state funds.

I went back; I checked. So the Medicaid program is intended to be a matching program. The question in my mind, from an accountant's perspective, comes down to can the funds be segregated into state funds and the federal matching funds. If

the answer is yes, the variance and waiver could theoretically apply. So, Your Honor, I'm just -- I'm being candid with the Court.

THE COURT: Whose check gets cut to the hospital when they provide care? I was going to ask one of your witnesses that, and I forgot. But -- we can go look it up, but I think the answer is it's a state check.

MR. JAZIL: And, Your Honor, I don't know, and the legislation happened and got signed in the middle of my case, so I haven't had the --

THE COURT: But the way this is set up is the State pays for it and gets reimbursement from the federal government, I think. We can look at that up.

Look, if the argument is this is really not a flat ban --

MR. JAZIL: It probably is.

THE COURT: Yeah, I think it probably is.

MR. JAZIL: Your Honor --

THE COURT: Let me ask this: Is preventing individuals from being trans, from having a gender identity different from their natal sex, is that a legitimate State interest?

MR. JAZIL: I do not think so, Your Honor. I don't think that would be a legitimate State interest.

THE COURT: So when, for example, the folks on your

side argue -- and I don't know if you've adopted this, but one of the things that keeps being said is, Oh, 90-plus percent of the people that get puberty blockers go on to get cross-sex hormones. Actually, I do think that's in your briefing.

MR. JAZIL: And, Your Honor, that didn't come from me. That was Dr. Olson-Kennedy when asked on cross-examination if you start on puberty blockers, what percent go on. 98 percent is the plaintiffs' number, not ours.

THE COURT: And that's fine. And if, in fact, this is appropriate treatment for a trans individual, the fact that they got appropriate treatment at stage A and then continued into stage B seems to me to only back up the theory that this was the appropriate treatment and we're on the right track.

98 percent, probably, of people that get the first round of chemo for cancer when they got assigned to a 3-chemo set or a 12-chemo set, if 98 percent or 99 percent go on to round two, that doesn't tell you something was wrong at stage 1. That tells you something was right at stage 1.

But when the defense comes in and argues, Oh, look, we know something's bad here because if you get puberty blockers, 98 percent go on to cross-sex hormones, it seems to me that that's bad because that's recognizing trans identity, and the State's really opposed to that.

That's what I take out of that argument. When the defense comes in and says, Oh, the sky is falling, because if

you get puberty blockers, you're also going to get cross-sex hormones, I take that as an argument that the sky is falling because these people are going to keep being trans.

Am I missing something?

MR. JAZIL: Yes, Your Honor. From my perspective, what you just highlighted starts out with the supposition that the trans identity and the gender dysphoria diagnosis are intertwined and that if you are transgender, you have gender dysphoria and, therefore, you need to go down this road. And I don't think that was the testimony.

THE COURT: No, no. I'm not the one that believes that. I understand that one can be trans and not have trans -- gender dysphoria.

MR. JAZIL: So, Your Honor, if we start by saying that one can be trans and not have gender dysphoria, and then we say, Okay, if you have gender dysphoria, you're on puberty blockers, and once you're on puberty blockers, there's a 98 percent chance you're on cross-sex hormones.

So to go back to Dr. Levine's perspective, we're not giving folks the opportunity to explore, you know, the reasons for this and that in creating the room for possible desistance, if that's going to happen naturally without, you know, reverting to the reversion model, and that was the point of the State, Your Honor.

That if -- if we're doing the puberty blockers -- if

we assume that the gender affirmation model is the one and only true model and that gender affirmation model requires that puberty blockers be prescribed, then once we prescribe the puberty blockers, we're taking away that opportunity for the person to, as Dr. Levine may say, explore what's going on, and naturally desist if given the space or naturally go onto the next step if that's what they want. That was the point, Your Honor.

THE COURT: All right. That's why I asked. I understand the argument.

MR. JAZIL: So, Your Honor -- and, again, I'd like to just circle back to the point about line-drawing. I know the Court may disagree with it, but my position is this: That if we assume that caution is appropriate, then the State gets to choose where it's drawing its line. If the State has chosen to draw its line towards a complete prohibition, that, too, can be defensible because we're dealing with a health, safety, welfare regulation. And I think it would be appropriate to defer to the State in that instance. A way to look at it is if I'm going to fix the road, at some point I have to stop the traffic and sort of reassess.

And, Your Honor, I point out --

THE COURT: Why did they shut down the research?

MR. JAZIL: Your Honor, I don't think there is testimony saying that we shut down the research.

THE COURT: Didn't you shut down the research? I mean, they were treating patients at Florida and doing research, and now they're going to have to disband the clinic because they can't treat patients at all with these drugs.

MR. JAZIL: Your Honor, I'm not sure that that is testimony that came in during the course of the trial. I know the section 3 would say that postsecondary institutions can't be reimbursed for prescribing these treatments, but I'm not entirely sure that there is testimony saying that the research is shut down.

There's testimony from one of the parents -- I think Ms. Lapado -- that she had an appointment at the St. Petersburg Johns Hopkins clinic, and those appointments didn't go forward.

THE COURT: Here's my understanding -- and I haven't gone back to recheck this. Been a lot of information coming in, so I may not have sorted it out accurately.

Here's what I thought: There was originally a proposal to allow research -- this may have been at the rulemaking process at the board of medicine. The proposal was we were going to allow research, and then that got pulled back out, and the research exception is gone. And if it's illegal for a doctor to provide this, it certainly -- there's no way for anybody to study it.

MR. JAZIL: There's no way for some -- Your Honor, you're right. If there's a prohibition on minors for the use of

these treatments, then there's no group for the research institutions to study. But, Your Honor, I point out that -- as my friend pointed out, there is a movement going around in the various United States dealing with this issue. My friend pointed to Texas and some of the other states that have perhaps aligned with Florida on the issue, but there are others, like California, who are going the other way.

And, Your Honor, I wanted to bring a California provision to the Court's attention because it does also go to the child custody issues that we discussed on Friday that deal with section 1 of the legislation that was passed.

And it's Senate Bill 107, Chapter 810. It was signed by the governor of California on September 29, 2022. And, Your Honor, section 5 of that bill is a mirror image of the Florida child custody section. In Florida the child custody section says if you're going through a divorce, you know, the courts have the ability to take temporary jurisdiction over your kid if the kid is getting or threatened with gender-affirming care.

California goes the other way and says that the courts of the state can take temporary emergency jurisdiction if the child has been unable to obtain gender-affirming health care or gender-affirming mental health care. So what you're seeing in the states is you've got a true opportunity for the laboratories of democracy, and more so just laboratories generally.

California is taking the approach, based on this statute and the others they've passed, that gender affirmation is the model we're going to use. Gender affirmation is the thing that will be done. So California can provide us a subset of studies that say, Okay, what happens when gender affirmation is what we're doing and how we're treating folks?

Florida, Your Honor, we have approved, and we are still reimbursing for, a whole list of mental health treatments, and so you can do a psychotherapy approach and see what happens, and we can use this to fill the gaps in the data.

THE COURT: And for those adolescents now whose doctors say, after a -- after a team approach that meets all the requirements, This adolescent is going to be far happier, less anxious, less depressed, have a better long-term outcome if we give this treatment -- and we have lots of clinical experience that says that will be true for many people -- at least for a period of time. There are no 50-year studies because this hadn't been going on for 50 years.

But for as long as we've had this, we've got clinical experience, widespread clinical experience, saying this works. For the adolescent in Florida who needs that care, the answer is, Let him eat cake. He's either going to move out of the state or he's going to be less happy, more anxious, more depressed. He cannot get the treatment that his doctor and the widespread clinical experience says is best. That's what the

State has said.

MR. JAZIL: Your Honor, I reframe that as the State saying, Look, when you're saying and your physicians are saying that you need these treatments in adolescence, you cannot get it. You can get it once you reach the age of majority, right, because that's --

THE COURT: Too late.

MR. JAZIL: And I guess what the State is also saying that that person who truly needs it in the adolescent stage is the exception, not the rule.

And so if we're crafting a statutory scheme, Your Honor, I would suggest that if the State is right about the rule, then the exception itself should not defeat the statutory scheme.

Your Honor, I'd also like to talk about the clinical experience. We heard from Dr. Shumer. We heard from the others who work on multidisciplinary teams. You also heard from Dr. Kaliebe. On some level Dr. Kaliebe's experience is also relevant because he's a line psychiatrist. He is dealing with these folks in -- he's dealing with patients, lots of patients in lots of different settings, and he's telling you that I just don't have the time to spend a lot of time with folks and go through the years long psychotherapy approach that Dr. Levine was advocating for.

So I think it's important to note that as well. If we

could go to some of the plaintiffs' medical records -- not on the public screen, please.

So, Your Honor, I'd like to start with K.F., and if we could scroll through.

Now, Your Honor, this is an institution that even Dr. Shumer recognized is outstanding. It's where he did his training. Here we've got the medical records for a young patient. 25 minutes were spent, and this is Plaintiffs' Exhibit 235, and the Bates number is 4243. This is the endocrinology visit. The risks were discussed.

Can we go onto the next page, please.

Now, this is another statement from the visit where the long-term side effects of the medical treatment was discussed, and there was going to be issues on future fertility, et cetera. This is the material that Dr. Shumer said he thought was somewhat conservative. He wouldn't have discussed issues this way.

So you've got -- you've got folks who are providing the gender-affirmation treatment who are discussing these issues with patients in 25-minute visits, and there isn't absolute uniformity in what it is they're telling folks.

And, Your Honor, this is -- this is something that came up as well. The patient's mother testified before the Court about a visit on August 6th. And what you can see from this document, Your Honor, is -- and this is in the record, is

that the visit was done by a telemedicine, right?

So it's a telemedicine visit, and the patient's mother testified that the patient, who was 11 at the time, was concerned about, well, is this going to hurt. 11-year-old concerned about, Is this going to hurt? But then the last sentence on the first blowup says, *He desires having kids in the future, specifically not birthing them, and does not desire ovarian preservation at this point.*

So this is an 11-year-old. We're having a discussion about future fertility, whether or not there's a desire to birth kids and whether or not ovarian preservation is necessary. And, Your Honor, again, just to pull out for a minute, this is an 11-year-old. We don't trust 11-year-olds to drive, to drink, to vote, to watch PG-13 movies, but we're talking about ovarian preservation.

THE COURT: You suppose a parent was involved in these discussions?

MR. JAZIL: For sure, Your Honor, a parent was involved in this telemedicine discussion about a --

THE COURT: Look, telemedicine -- this is August of 2020. It's -- COVID is raging, and there is no vaccine. So, yeah, people were getting medicine over the video, but, I mean, I take the point.

Look, I didn't need the expert to tell me that adolescents' brains don't work the same as adults and that

they're more likely to engage in risky behavior. It was more than 50 years ago, but I was an adolescent once, and I don't know that they've changed that much, so I get it. Adolescents, and certainly 11-year-olds, aren't in a position to make the same decisions they would be able to make later in life, but that's why we have parents involved.

I mean, what we had discussed before -- and I don't know that we're going to get much farther discussing it -- but here's the problem: A decision is going to be made, and if the child is 11, the child is 11. So the child and the parents are going to make a decision. There's going to be medical treatment -- and by that I mean puberty blockers and cross-sex hormone treatment -- or there's not.

You can't say the 11-year-old and the parents aren't able to make a good decision, and so we're going to decide for option B instead of option A. It's going to be a decision, and the same people are going to make it unless, of course, the Governor and legislature make it for them. And that's really the question in the case.

When you have someone who may need treatment, the decision whether to get treatment or not is going to be made because it has to be made at that point. So who's going to make the decision? Is it going to be the parent and child in consultation with a doctor who does this all the time and knows all about it or is the decision going to be made by the

legislature and Governor?

MR. JAZIL: I take your point, Your Honor. I'd simply add on to that that it's a little bit more complex. If we take Dr. Levine's testimony, and we assume that the gender affirmation model is the one that -- you know, is the one that's being trumpeted as the one and only model, and doctors are afraid to disagree from it because they might be labeled bigots, are the doctors giving the best possible information to the parents and the patients?

If gender affirmation -- we start out that gender affirmation is it and the Levine psychotherapy model is not it, so if that is the starting point, are we then putting the patients and the children in the best possible position to make the decision?

THE COURT: Absolutely a concern. Absolutely a concern.

And you heard I asked some questions earlier about, you know, not everybody goes to the University of Michigan or the University of Florida. And what -- am I to be concerned about somebody else, some lesser quality of care? It's -- it's absolutely a concern. And the solution to that is make sure this gets done right.

You keep saying, by the way, the gender-affirmation model as if that's the only way to do it and without psychotherapy, and that's not what the testimony is at all.

There's psychotherapy for all of these patients. That goes hand in hand with the administration of these drugs. Nobody has suggested otherwise.

And nobody has said everybody that appears and says they identify in the other gender is going to be rushed right in to these medicines. The testimony is exactly the contrary, that we're going to make the evaluation, and only some patients are going to get this.

I'll grant you -- and I asked the question to the other side -- and sometimes you have to evaluate the evidence in the record, but you have to consider some common sense along the way. And I've lived in this world. And so it -- does it concern me that maybe at the medical society people were afraid to speak up for fear of being labeled a bigot? Absolutely it does.

Do I think there are no bigots in the world involved on this issue? I don't think that either. I'm pretty sure there are some bigots. When you put on witnesses who don't believe that there is such a thing as being trans and that gender identity is really not a thing, that's not very impressive. I shouldn't label that person a bigot. Sometimes that is a sincerely held religious belief. I understand that.

I'm old enough to remember when people had sincerely held religious beliefs that Blacks and Whites shouldn't be able to go to school together or eat at the same restaurant. People

have all kinds of religious beliefs, but that's not -- upholding that religious belief is not a legitimate State interest.

MR. JAZIL: Understood, Your Honor. And I apologize for not being more precise when I was talking about psychotherapy.

What I mean to say is what I'm calling the ambivalence model where you're not using psychotherapy or any other kind of treatment to push folks one way or the other, and that's what I mean, Your Honor.

And I would like to point the Court to the Endocrine Society guidelines, which are DX24, page 15.

Can we pull up DX24, page 15, 1-5?

Can we blow up the section that says *Evidence*.

So, Your Honor, we saw this before, and this section talks about how, in prepubertal kids, the dissidence rate is 85 percent. And then it goes on to say that: *If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty. Social transition is associated with the persistence of gender dysphoria/gender incongruence as a child progresses into adolescence.*

And this is from the Endocrine Society guidelines. And, Your Honor, I think this aligns with what Dr. Levine was talking about. If we don't take the ambivalence approach, if we take the affirmation approach, we sort are of pushing kids --

THE COURT: Yeah, look, you're talking about a different stage in life and a different problem.

I don't suggest that a doctor needs to be what you call ambivalent when a child appears in early childhood. So the 7- or 8-year-old shows up at the doctor's office with parents concerned about this kind of thing, I don't suggest that there is anything wrong with a doctor being a little bit skeptical. Most people are cisgender. And most times when something has happened that may concern a parent, it's just -- it's not an indication of real transgender identity.

I get it. And so I'm not suggesting there is anything wrong with a doctor being skeptical, and that's consistent with what Dr. Levine said. I don't think he said you have to be completely ambivalent. I think he said you have to make a good, honest evaluation. It has to be a good, honest evaluation. You can't start out, as I think some of the folks on your side would, by saying, Oh, this can't be real. But you certainly don't have to jump right into it. Surely, you can be skeptical. Surely, you can do a long-term evaluation.

And if the State had standards that required that, I don't know how the plaintiffs would challenge it. But that's not what the State has done.

MR. JAZIL: Understood, Your Honor.

And, again, I'd like to get back to the point that everyone is getting these diagnoses at wonderful

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023 /s/ Mohammad O. Jazil