No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME XI OF XXI

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

Counsel for Defendants-Appellants

INDEX TO APPENDIX

Volume	Tab	Title
1	Dkt	Docket Sheet
1	Doc.1	Complaint
1-3	Doc.11	Motion for Preliminary Injunction
3-4	Doc.49	Redacted Defendants' Response in Opposition to Motion for Preliminary Injunction
4-7	Doc 49-1	Redacted Appendix to Defendants' Response in Opposition to Motion for Preliminary Injunction
7-8	Doc.58	Reply to Defendants' Response in Opposition to Motion for Preliminary Injunction
8	Doc.60	Notice of Scrivener's Error and Filing of Supplemental Declaration to Correct Error re: Motion for Preliminary Injunction
8	Doc.64	Order Denying Preliminary Injunction
8	Doc.65	Answer to Complaint
8	Doc.108	Preliminary Injunction Motion Hearing Transcript
8	Doc.118	Order Allowing Mr. Weida's Deposition
8-9	Doc.120	Motion for Summary Judgment
9	Doc.120-27	Attachment to Motion for Summary Judgment: Dr. Edmiston Expert Report
9	Doc.120-36	Attachment to Motion for Summary Judgment: Dr. Edmiston Deposition
9	Doc.233	Amended Complaint
9-12	Doc.235	Plaintiffs' Deposition Designations
12	Doc.246	Final Order
12	Doc.247	Clerk's Judgment
12-13	Doc.248	Notice of Appeal
13-14	Doc.221	Trial Transcript, Day One
14-15	Doc.224	Trial Transcript, Day Two
15-16	Doc.225	Trial Transcript, Day Three
16-17	Doc.229	Trial Transcript, Day Four
17	Doc.232	Trial Transcript, Day Five
17-18	Doc.234	Trial Transcript, Day Six
18	Doc.241	Trial Transcript, Day Seven
18	Doc.193-1, DX1	U.S. Health and Human Services Notice and Guidance on Care

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Gary Perko
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 Appellants-Defendants

August Dekker, et al. vs. Jason Weida, et al.

February 8, 2023/Matthew Brackett

E R R A T A S H E E T

PAGE 236 LINE 11-12 CHANGE "Somewhere under 409.815, 409.905, and 409.906, F.S." Delete "409.9" to "services"

REASON Providing specific statutory citations

PAGE 237 LINE 11-15 CHANGE Delete text that begins with "the rule" to "it's". Add "and decide whether a service is experimental as to the requestor."

REASON More accurate description of Agency policy

PAGE 237 LINE 18-19 CHANGE Delete text and replace with "Yes, as to them."

REASON More accurate description of Agency policy

PAGE 237 LINE 21-25 CHANGE Delete and replace with "The requestor"

REASON More accurate description of Agency policy

PAGE 238 LINE 1-12 CHANGE Delete

REASON More accurate description of Agency policy

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Matthew Brackett — DATE 3/6/23

&

& 126:19

0

000169125 226:9
0002587 216:21
000258815 221:6
000292335 201:16
00325 125:3

1

1.05 243:5
1.050 148:23 149:3 174:3 189:13 204:19 213:8 236:1,14 238:16 239:12 242:23 243:18 246:17
1.057 239:12
1.310 260:17
10 149:16 154:21 159:4 224:25 231:4,11 240:3,7
10005 126:13
10:35 216:5,19
110 126:14
119 126:20
11:04 216:18
12 149:17
120 126:12 212:4 232:24
120.542 127:17 206:1 209:18,24 235:18
120.542. 233:2
1229 126:7
125 125:11
128 127:4 259:9
12th 126:7
13 127:11 152:14
14 127:12 162:20 163:6 227:12
15 127:13 200:4 201:24 202:11
1512 126:14
153 127:11
159g 236:1
16 127:14 199:24 213:22 213:22 214:3
163 127:12
17 127:14 213:22 214:1,3 214:8
18 127:15 221:7 221:9
19 127:16 226:18,21
19th 126:12
1:30 125:15 128:8
1st 158:2,3

2

2 125:11
20 127:17 233:3 233:4
2002 162:16
2015 208:4,5 240:4,6
2016 143:3 240:5,6 254:18
2017 139:11 151:9 230:22 232:8
2018 249:17 251:16
2019 248:25
202 127:13
2022 127:14,14 127:16 128:13 128:18 129:2 135:8 140:6 147:14,19 151:1 157:6,16 160:11 163:7 164:12,18 164:23 168:23 171:21 178:10 201:22 207:10 208:10 213:24 214:2 216:5 220:16 226:24 242:14,15,21 243:16 246:15 252:13 254:6 255:25
2023 125:14 147:13 257:6 258:14 259:16 260:3,6 261:2
2024 258:21 259:22
20th 157:24,25 158:3 227:11,16 252:13 254:6 255:25
21 127:17 248:19,21 260:3
210 137:24
215 127:14,14
21st 207:10 208:10 242:14 242:21 243:16 245:5 246:15 258:13 259:16
22 127:14,14,18 213:24 216:5 252:2,7 258:21 259:22
222 127:15
227 127:16
22nd 214:2 216:18
23 127:18 211:2 252:13,17
234 127:17
24 168:22 170:2
245,000 137:24
249 127:17
253 127:5,18,18
255 127:6
257 259:9

25th 147:13
261 125:11
26th 201:22
2727 125:17
27514 126:15
29229 258:18 259:19
2nd 166:4 168:11 169:25 184:3

3

3 254:4,6 255:24
30 212:25 260:11,17
3100 126:9
32205 126:4
32301 126:20
32308 125:17
32601 126:7
33131 126:10
34,999 138:2,3
35 138:2
35,000 136:16 136:21,25 137:23 138:23 177:22
3900 126:4
3:00 199:12
3:08 199:15
3rd 127:16 168:14 170:1 226:24 232:10

4

409 236:5,8
409.9 236:11
45 253:6
46 164:13 187:19
47 193:1
4:15 248:7
4:22 125:3
4:30 248:10
4:37 253:21

5

50 149:15,21 152:16 155:12
500 126:20
5696545 260:6
59 148:23 149:3 169:4
59g 174:3 189:13 204:19 213:8 236:14 238:16 239:12 242:23 243:5,18 246:17

6

60 216:25 217:2 217:14,16 218:7 218:17,20,23 219:23 220:7 222:3,5
600 126:9 189:14

7

7 138:4 148:23 149:3 174:3 204:19 213:8 236:1,14 238:16 239:12 242:23 243:18 246:17
70s 163:3

8

8 125:14 260:6 261:2
88 158:12
8th 128:14,25 188:8 257:6

a

a.m. 216:5,18,19
aap 162:9,10 194:7
aap's 162:11
abc 144:10
ability 132:4
able 140:15 149:20 151:25 158:14 159:14 175:11,15 178:24 179:12 179:22 182:9 185:16 192:23 192:24 229:22 230:1 232:15 246:20
above 258:10 260:7
absence 155:7
absolute 150:18 238:7
absolutely 202:3 212:13
academic 160:18
academy 190:16
accepted 204:10
access 191:21 218:11,13,19 225:10
accessible 175:10 187:23 188:4
accordance 212:23
account 132:1,2 154:23
accuracy 260:8
accurate 204:14 204:16 254:8,9
achieved 235:22 235:25
acronym 231:8
act 173:1,12,21 173:24
acting 134:21 138:10
action 259:14 259:15
active 217:11 253:1
actively 139:25

activists 161:1
activities 196:21
activity 193:24
actual 132:15 132:20 172:5 202:9 203:15
actually 132:6 133:11 137:14 139:9 144:7 149:14 153:11 153:12 163:13 167:17 179:10 180:3 182:18 192:4 205:6,8 206:18 218:3 222:25 226:10 226:14 232:6 240:18 241:4 242:24
acute 196:19
ad 192:19
adapt 140:15
add 146:12
added 145:24 146:12 155:25 216:6
adding 170:22
addition 170:10 170:13
additional 178:8 240:25 241:2 256:16 257:1
addressed 222:11
adds 216:9
adequacy 175:21
adequate 149:15 161:5 174:11 175:1 176:23 196:8 223:3 232:15
adjuvant 151:11
administers 233:18
administration 125:16 257:8
administrative 171:25 176:19 213:10,14
administrator 169:12 170:15
adolescence 228:1
adolescents 127:19 226:25 252:12
adopt 164:23 165:22 168:8,10 168:23 169:7,24 171:20
adopted 165:5 218:19 219:22 234:11 237:3
adopting 172:25 173:24
adoption 159:10 204:23 206:11 207:21 232:20
adult 186:5 247:1
adults 185:9,10 185:12,20,23
adverse 127:13 200:15 201:14 201:19 202:13 202:19 203:7,14 204:25 207:2
adversely 212:15
advocacy 160:25 179:21
advocates 161:1 179:21
affair 213:4
affect 151:13
affected 196:22 212:15
affirmatively 240:11,14
affirming 131:13 133:1 141:6,10,25 143:20 152:19 162:7 225:20 235:14
aforesaid 259:10
agencies 233:12 233:13 234:9,14
agency 125:16 130:13 134:22 140:23 141:2 143:5,6 144:18 154:1 166:13 175:18 177:5 180:17 181:4,17 181:21 185:5 186:10 192:3 205:10 212:18 212:21 219:5 228:3,18 230:15 230:22 233:18 234:20,22 235:8 239:11 242:2,3 257:7
agency's 187:3 255:15
ages 205:5
ago 135:19 191:4
agree 202:1 222:24 223:4
agreement 136:12 138:20 177:21,22,23
agreements 136:15,23 138:12
ahca 128:13 131:1 132:14,23 134:12 135:6 136:13 138:15 138:25 139:2,6 140:4 144:20 145:4,7,18 159:11 160:7 164:14 168:22

169:12 175:12 176:8,10,14,15 176:18 177:1 178:1 180:20 181:9,11,25 182:10,11,20,25 183:8 184:9 186:15 187:3 188:8 189:12,15 189:17 194:1 200:14,19,23,24 201:3,9 206:11 207:10,11,22 208:10,21 209:7 209:11,22 210:6 210:19 212:18 213:6 214:7 215:14 217:22 218:23 222:16 223:13,14 226:22 227:13 228:6,8,9,20,23 229:15 232:10 234:15 235:12 236:15 237:4,8 237:9 240:11,13 242:15 244:19 254:15
ahca's 186:18 202:15 206:11 213:13 215:13 219:20 220:11
ahead 249:12
al 125:5,8 194:22 260:5,5 261:1,1
alert 127:15 217:1 221:5,8 221:20,22,23 222:9
alicia 227:16
alignment 133:7 194:16
alliance 133:13 134:13 188:12
allocated 137:21
allow 222:1 226:6
allowed 204:17
allowing 177:6
altogether 220:20 224:18
ama 162:12,13
amending 170:22
amendment 170:19
american 162:6 190:16
amount 138:4 139:14 149:18 159:7 175:25 240:15,15
amounts 136:16 136:24 156:6
ample 213:10
analog 227:25
analyses 149:11
analysis 151:12 151:21,23
analyst 221:16 249:25
analysts 249:25
analytics 159:15
analyze 157:1
analyzed 194:12
andrew 130:13 135:24
anecdotes 132:13
angles 198:24
ann 163:15 213:23 216:3,25 221:18
announced 214:14 232:11
announcements 184:24
annually 159:11
answer 143:9 200:11 210:3
answered 200:8
antagonists 217:7 221:25
anticipate 140:8 142:3,11 143:3 174:5 179:5 182:7
anticipated 140:20 176:6 181:21
anticipating 179:11
anticipation 140:10
anybody 129:15 133:25 172:8 177:1,11,11,14 183:14 257:3
anymore 223:21 229:6 230:17
anytime 228:22 242:21 243:4
apologize 135:6
appeal 205:14 205:14 207:7 212:5,17,20,24
appeals 206:4 207:1,4
appear 181:24 181:25
appearances 126:1
appeared 258:10
appears 201:21 256:1
appellate 212:20,23 213:3 213:4
apples 150:22 150:22
application 238:15
applies 234:13
apply 218:24 233:17

approach 131:8
appropriate 129:9 155:13 256:18
approval 164:8 229:16 235:2
approved 164:9 164:14,18 217:21 234:7
april 157:24,25 158:2 227:11,16 242:14 252:13
area 172:15 225:14 229:25
areas 140:14
argument 193:10 198:9
arkansas 194:11
arlene 232:7
arrange 176:22
arrangements 178:25 179:2
arranging 174:11
article 144:8 145:24
articles 148:8 148:14 158:8,12 160:14 194:13
articulate 146:8
articulately 179:13,16
ascertain 196:16
ashley 213:25 216:5,10,17 226:23 227:4 230:6,7
aside 136:7
asked 199:17 216:1,3
asking 130:3 196:5 208:5
assessed 130:4,7 130:10
assessment 140:1,16 141:13
assist 200:19
assistance 205:4 240:24,25 242:9 242:12
assistant 169:15 215:5,16 219:10 222:22
association's 162:6
assume 256:19
assuming 231:11,12,19
asthma 151:11 250:25
atheno 250:25
attached 227:4 227:24 260:9
attacks 140:17 192:20
attend 177:11 177:14
attendance 177:2
attention 143:23 185:4 193:4,8
attorney 259:12 259:14 260:10
attorney's 202:2
attorneys 182:4 200:2 210:9
audience 175:16 179:5 187:23
auditorium 175:14
august 125:5 127:14,14 207:10 208:10 213:24 214:2 216:5,18 242:14 242:21 243:16 243:18,22,23 244:4,5,18 245:4,4,8 246:11,15 248:13 260:5 261:1
authored 136:8
authorities 169:12
authority 203:22 233:12 234:8,12 258:9
authorization 217:13 219:21 228:14
authorizations 217:20 229:6
authorize 236:15 244:19
authorized 234:9
automatically 254:10,12,14
available 152:23 153:17 162:10 175:18 178:6 236:21 238:2 260:7
avenue 126:7,9
aware 132:23 135:20 177:10 199:2,4 204:6 223:11

b

b 148:10 227:6 231:13,17
back 129:1 135:6 139:11 143:19,22,24 147:1 159:6 167:3 183:7 186:3 193:11 195:18 214:6 221:23 223:17 229:15 232:8 235:17 240:4 244:22 248:12 253:20
background 130:8

backgrounds 128:22 129:5,9
balances 233:16
bans 171:6
bar 211:10
barantorchinsky 126:19
base 200:2
based 128:22 131:7,18 132:2 132:17 133:9,19 134:1 139:7 143:25 154:16 154:16,20 157:6 157:11,14 161:15 165:2,2 185:7 186:10 191:19 220:4 231:20,20 233:9 237:11,12,25 239:1,6,18,18 239:24 242:16 246:18,18,19 247:14,19 256:3
bases 160:15,21
basic 182:22,24 182:24
basis 128:24 198:11 205:2 207:2 235:16 249:22
bates 201:15,18 202:7,8 221:6 226:16
bear 210:24
becoming 144:17
beginning 128:7 199:14 248:9
behalf 144:18 163:15
behavior 240:23 240:25
behavioral 170:16 196:15
believe 172:6,6 213:24 230:19 244:2
beneficiaries 205:1 220:12 240:1
benefit 200:15 201:15,19 202:14,19 203:7 203:15,25 204:5 204:13,15,25 207:2
benefits 127:13 203:23 245:16
best 134:7 142:23 174:18
bias 195:1
big 187:6 198:6
bigger 153:15 162:19
billing 224:7
bit 128:12 135:5 136:18 146:8 166:24 174:9 179:22 209:20 228:8 252:1
blocked 210:17
blockers 171:7 217:7 221:25 243:7,21,25 246:23
bone 251:11
bostock 195:9
bottom 212:14 217:3
bound 178:5
box 164:9 203:22 204:11
boxes 204:13
brackett 125:12 127:3 128:3 254:3 260:6 261:2,23
brand 170:11
break 128:11 199:9,17,18,19 199:21 246:6 248:4
breaking 195:5
brickell 126:9
brief 189:21 199:13 248:8 254:2 255:24
brignardello 133:10 194:24
brings 143:19 143:22
brit 246:17
broad 196:4
brock 174:7 176:21 177:5 183:12
brought 152:7 194:7
budget 137:21 138:1 148:25 151:3,7,12,15 151:25 240:21 240:21 241:11
bullets 170:22
burden 237:18 237:20
bureau 159:17 166:17 167:12 167:21 169:9,13 172:2 219:14

c

california 155:23
call 156:19 234:13
called 128:4 251:11
calling 182:17
calls 136:2 178:17
canadian 184:15
cap 138:1 177:22
capacity 134:21 136:10 143:7 175:17 176:24

187:7
capitation 246:12
capped 137:25
caps 177:25
captured 194:23
cards 197:9
care 125:16 127:13,15 131:13 133:1 141:6,10,18,25 150:9 152:19 154:9 157:7,11 157:12 159:15 161:17 162:4,7 189:4 191:21 200:6,7,21,24 201:19 202:22 205:8,10 207:2 213:7,12 217:10 217:16,17 218:2 218:4,5,9,12,17 218:19,24 219:23 220:8 221:8 222:4 225:18,20,22 235:14 244:6 245:15,23 257:8
careful 189:23
case 125:3 138:10 160:19 160:20 180:24 187:22 191:15 199:25 213:4 214:21 234:3 240:3 244:23
cases 194:1,18 195:7,10
catch 216:23
catchy 187:12
categorical 157:3 159:11 165:3,6,10,15 165:21,24 169:24 172:25 173:25 191:19 192:5 200:16 204:23 206:12 207:22 209:8,12 218:18 219:22 225:19 226:2 232:12 235:14 237:2 238:1,3 241:5 242:17
categorically 171:15 241:14
category 186:6
catherine 126:14
cause 195:18,18 197:22 220:22
cc'ing 213:23
ccm 227:5 230:24 231:8,24
certain 149:18 237:4
certainly 181:22
certificate 258:1 259:1
certify 258:9 259:5,11
cetera 132:3 137:14
chain 227:10 228:13 231:20
challenge 179:12 227:2 245:13 247:5,8
challenging 242:16
change 166:19 174:15 214:22 245:24 261:4,7 261:10,13,16
changes 145:22 147:6 167:1,4,4 167:15,24 169:20 189:13 213:13 214:13 217:12 256:1,4 260:8
changing 213:11
chapel 126:15
chapter 188:17 212:4 232:24 236:5
charge 171:22
check 201:16 203:5 233:16
checked 164:9 194:6,13 203:23 203:25 204:9,11 204:12,13 244:9
checking 187:13
chelsea 126:6
chelsea's 211:3
chen 129:19 130:20 158:5 189:19,24 193:14
chief 169:13 174:7,7,7 181:4
child 186:10
children 127:11 127:19 185:9,10 187:5 188:21 226:25 252:12
chloe 189:6
choose 164:23
chose 131:14
chriss 126:5 210:15 211:11 211:14
christian 133:22 134:8 188:9
chronic 196:19
circling 135:6
circuit 225:4
circumstance 156:9
circumstances 143:23 234:24 236:14 238:18 238:20
cite 194:20
cited 147:15,15 147:19 148:12 148:17 158:9,11

194:2,10,20
citing 194:13
citizens 134:13 188:12
civil 260:17,17
claim 159:16 206:11
claims 141:14 143:25 188:3 225:1
clarified 161:16
clarify 161:14 216:6 218:4 245:14
clarity 216:11
clayton 195:9
clear 130:17 162:1 222:18 254:7 257:1
cleared 210:20
clearer 159:19
clearing 225:2
clerk 212:18 234:20,22 235:8 242:2 255:3,6,7
clients 242:20
clinic 190:19
clinical 132:2 137:17,19 139:7 160:25 161:11 228:15 229:6
close 177:24
cnn 144:9
coalition 133:23 134:8 188:10
coca 163:1
code 159:21,24 160:2,3,4 224:13,19 227:6 231:9,10,11,25 232:3,9
coders 224:6,23 224:23 225:3
codes 159:22 224:25,25 230:21 231:4,5 231:7,11 232:2 232:5 246:6
codified 240:22 241:5
coding 224:22
cody 174:8 183:11
cola 163:1
cole 171:23 174:6 176:19 189:6,18,24 193:14
collaborative 215:22
collect 152:8
collecting 205:16,23
colorful 193:7
column 163:8 164:8
comb 193:25
combination 160:25 189:18 246:13
come 138:24 141:2 155:8 162:8 165:14,18 166:6,7,8,10,21 167:1,7 177:24 181:2 195:25 196:6 222:22 224:6 225:11 234:18 238:9,11 251:22 256:15
comes 149:17 150:17 151:20 155:19 185:12 186:3,5 196:13 202:23 218:12 223:17,19 235:7 255:2
comfortable 211:17
coming 187:2 195:6 224:12
commenced 125:15
comment 180:14 190:8,16 190:20,20,23 191:2,7,14 193:1 195:20,20 197:8
comments 179:13,16,23 180:1,17 189:12 190:9,11,14,24 191:3,5 192:15 192:17 193:3,5 193:13 194:2 195:6,8,10,12 197:20 256:3
commercials 163:2
commission 258:21 259:22
committed 250:11
common 162:25
communicate 158:18 176:8,10 188:9 220:17,23 226:1
communicating 160:10
communication 136:4
communicatio... 176:22 181:4 232:19
community 161:1 170:15
comparability 173:1,21,23
compared 175:18
compensated 177:16
competition 150:13
competitive 136:22
complaint 206:14,17

complaints 206:16
complete 146:18
completed 138:8 165:12 260:11
completely 170:15
completing 197:10
complexities 242:10
compliance 206:3
complicated 132:9
components 184:4
composing 146:10,10
concern 143:14
concerned 140:17 175:21
concluded 185:7 257:18
concludes 199:11 248:6 257:5
conclusion 165:15,18 168:23 185:21 195:24 197:23
conclusions 133:9 142:1 154:23 171:21 184:10
condition 196:19 224:3 246:3
conditions 196:17 246:5
conducted 212:23
confer 223:7,7 253:13
confidential 202:2
confirm 208:24 209:3
confirmation 210:3
conflict 198:4
conflicting 223:23
confusion 216:9
connected 259:14
consent 256:15
consider 131:16 135:7 141:18 149:2 150:1,24
consideration 132:22 143:17 173:24 174:24 179:24 185:14 190:12,22 191:20 192:3 233:19
considerations 185:18 186:4
considered 135:14 142:9 147:19 260:12
considering 148:22
consist 249:13
consistent 144:17 202:17 202:18 234:11
consists 236:6
consultancy 161:20
consultant 131:21 136:13 136:14 137:11 137:25 138:5,7 139:3,19 144:21
consultants 129:25 131:2,10 132:15,24 133:12 134:10 135:7 137:2 138:9,14,15,16 138:24 139:6 140:21 142:24 145:5,7,17 146:15 147:1 158:18 160:10 160:22 162:5 164:14 178:2,14 179:9 180:1,20 180:24 182:21 183:1
consulted 147:19,22
consults 235:9
contact 153:21 156:15,25
contacted 135:12,17 136:9
contacting 135:22,23 136:1
contain 209:23
contained 181:12 241:9
contains 164:13 232:16
content 145:10 145:24 170:10 172:17 190:8 191:12 214:20
context 142:18 228:12,13 230:2
continue 217:17 218:19 224:11 226:2
continued 218:7
continuity 217:16 218:2,4 218:5,9,12,17 218:24 219:23 220:7 222:3
contract 129:3 204:7 218:3
contracted 137:11,18 180:21,24
contracting 137:3

contracts 202:22
contradict 187:17 195:14
contradiction 133:4,6,7
contradictory 165:18 198:7
contribute 132:5
control 176:20 196:8 197:16
controversial 142:10 174:14
conversation 135:1,4 172:24 173:12,15 199:24
conversations 134:3,5 135:13 135:18 136:3 162:8 173:16,19 173:20 199:19 199:22
conviction 176:5
copied 211:3
copies 178:5,7 240:9 260:10
copy 145:8 184:2 210:4,6 212:18 233:1
copying 216:17
corporate 257:7
correct 130:22 130:25 131:12 143:2 145:25 146:18 147:16 147:17 150:24 150:25 151:9 154:15 164:11 164:20 167:22 168:9,11,12,14 169:1 171:4,9 171:10 173:9 178:11,13 185:24 186:1 188:24 189:3 201:17 202:7,16 203:16,20 206:9 215:13,15,20 217:19 218:15 218:16,25 219:13 220:13 237:5,7 238:24 239:9,13,14 240:8 241:14,15 247:7,22 251:23 252:6 255:4 256:2 259:9
corrected 147:3
correspond 184:18
correspondence 135:20
corresponding 160:2 232:4
cost 151:12 152:4 159:7
costs 186:20
council 133:17
counsel 126:6 129:13 135:2,24 166:9,12 181:24 181:25 182:5,8 182:11 202:1 241:21,23 253:22 255:13 256:12 259:12 259:14
counsel's 169:18 172:14 176:16 182:14 182:16 234:18 255:14
county 258:6 259:2
couple 130:15 178:16,16
course 129:12 131:4 134:22 135:13 136:14 136:23 139:10 139:12 141:10 142:8,8,19,21 144:8 153:18 154:10 163:16 163:16 165:10 166:11 169:14 169:17 170:17 171:4,5 175:2,2 176:18 178:23 179:18 182:3 184:25 185:2,2 187:9 191:4 193:19,24 194:23 195:10 196:7,21 197:10 198:3,20 202:10 206:17 215:23 218:21 219:9 220:1 223:23 224:2,5,5,6,24 224:24 233:11 233:13 234:7,13 234:23,25 235:9 236:22 240:21 240:23
court 125:1,19 147:13 195:7 212:6,20 257:10 257:13 259:4
courts 213:3
cover 150:11,12 151:8,13 152:20 154:14 155:3,24 156:12 173:8 204:17,22 220:21 222:16 222:17 223:14 237:6 242:22 243:5,10,13,17 243:21 244:3,20 245:8,23 246:16 246:22 247:4,7
coverage 127:11 137:13 143:1,14 144:12,14,15 149:17 150:1,5

150:21,21 151:20,22 152:9 153:6,9,11 155:13 156:6,20 159:8,12 160:4 160:8 167:4,20 170:11,16,20 171:7,15,25 173:13,18 175:25 185:15 185:16 186:5 190:25 191:8,17 203:19 205:1 213:13 217:12 217:17 218:7 220:1 226:2 228:24 229:8 236:15 238:16 239:9,16 244:17 245:3,20 247:20
covered 149:22 152:3 155:15 160:15,21 171:2 203:22,25 204:5 204:12,15 218:14 220:25 236:11 241:1 243:7 245:25 246:1
covering 151:16 151:19 217:23 237:9 245:15 248:14
covers 149:3 240:11,14
covid 247:25
cpt 159:22 160:2,4 224:25
craft 168:2
create 185:2,3 187:12
created 219:6 249:16 254:17 254:18
creating 222:9
credentials 130:4,8,11
cretella 134:17
criteria 131:9 150:20 154:5 208:1,1 227:5,9 227:24 235:12
critical 194:25
cross 161:24 171:7 186:7 191:24 208:11 243:10
crowd 174:5 176:20 179:11
cumulative 146:14
cumulatively 134:23
curiosity 148:3 148:5
curious 148:14
current 143:7 217:13 219:21 250:5 254:13
currently 204:17,20 205:12 244:7 247:21 249:2
curve 140:15
customer 231:1
cut 201:21 202:8 222:18
cv 125:3
cypionate 203:19

d

d 128:1
daily 196:22
dalton 163:15 167:19 213:23 216:3 223:4,6
dana 125:18 258:20 259:4,21
data 152:9 159:15,17 243:9 243:12,15
date 125:14 146:20,22 160:5 160:6 163:8,25 164:1,4,7,7 166:3 201:21 217:15 226:23 243:2,6 248:24 254:6,7,9,9,10 254:11,13 256:1 256:2,5 260:9 261:23
date's 163:19,22 164:5
dated 201:21 213:24 214:2 227:16 252:12 255:25 259:16
dates 163:12
day 157:18 164:15 168:25 178:4 216:25 217:2,16 218:17 218:23 219:23 220:7 222:3,5 224:4 227:17 258:14 259:16
days 139:14 164:19 183:22 212:25 217:15 218:7,20 260:11
deal 150:10 154:7,11 225:12
dealing 210:18
debate 155:11
debriere 126:3 127:4,6 128:10 130:5 133:5 148:19,21 152:24 156:14 162:14,18 163:4 199:10,16 202:3 202:6,12,25 203:3,9 206:24 206:25 210:13 210:16,23 211:6 211:13,18,25 212:13 213:5 214:5 216:16

221:4,13 226:14 226:20 233:6 248:3,11,23 252:9,19,25 253:5,8,13,16 253:22 255:23 256:11,19,23 257:4,12,17
december 251:16
decide 168:23 190:5 214:19 215:6
decided 129:24 142:24 165:1,23 208:1 215:9 219:6,8
decides 169:20
deciding 130:11 133:11 171:1
decision 129:2,6 130:15,18,19,21 130:24 131:1 142:4 156:8 165:8,9,9,22 166:3,5,14,21 168:5,10 169:6 169:24 171:20 207:11,15,22 208:11,21 209:1 214:25 215:12 219:13 220:21 222:21,24 223:4 228:24 239:21
decisions 166:13
declaration 147:12
declare 238:3 238:22 261:19
dede 129:21 130:23 149:19 152:10,25 158:5 163:14 172:13 213:23 215:21 215:24,24 216:3 216:17,18 221:18
dedicated 184:17 187:12
deemed 141:17 193:3,4 214:23 222:14 241:6
deems 192:6
deep 174:16 176:4
def 216:21 221:6 226:9
defend 182:11
defendant 126:17 201:16
defendants 125:9
defending 133:13
defense 126:11 254:1
defer 141:8 142:1 154:17,19 183:4,5 210:9
deferring 168:17,20
define 196:2
defined 137:8
definitely 151:22 206:2 221:14 226:3
definition 196:4 197:22 202:16
degree 140:12
dekker 125:5 243:18,22,23 244:4,5 245:4,9 248:13 260:5 261:1
dekker's 244:18 246:11
delay 228:1,6
delegate 163:14
deliberated 219:6
delivered 195:16
delivering 223:18
demonstrate 187:18 236:2
demonstrates 234:2 235:20
denial 201:11 203:8,21 206:8 208:2 209:2 227:7 239:7 242:16 245:21
denials 200:20
denied 205:1 238:25 239:3,9 245:20
deny 185:16 207:12,15,16,23 208:11 237:12 238:6
denying 185:15 203:18 207:2
department 134:15,16,22,23 140:25 144:25 175:13 176:10 181:4 184:25 187:5 227:11,17 252:11
depends 166:18 166:18,19 170:12,19 191:14
depo 253:9
deposing 260:10
deposition 125:12 232:14 252:4 257:7,18
depth 193:4,23 236:20
deputy 163:17 167:6 169:16,17 215:5,16 219:10 222:22
derive 143:8
describe 230:2

described
202:10 206:1
209:17 212:4
220:8
description
127:10 219:16
descriptions
229:3
designated
259:7
desk 163:20
164:1
despite 153:11
details 134:4
135:21
determination
142:12 143:6,15
151:21,22 155:4
191:10 194:5
201:15,19
202:14 203:8,15
204:25 207:2
228:7,21 229:15
234:15,21 235:6
235:13
determination's
235:1
determinations
137:13 200:15
202:19 228:9,9
229:6 247:24
determine
131:10 141:19
152:4 195:2
210:7 247:4
determined
144:1 164:25
235:15 241:16
determining
129:8 150:5
155:17 172:22
235:4
develop 137:11
183:16 184:9,12
184:13 200:14
200:14 201:9,9
developed
183:21,22 184:6
184:7,21 235:12
developing
140:6 181:6
200:19
development
135:7 137:22
168:13
diagnoses
171:11,12 224:5
225:13
diagnosis
159:21 171:13
171:16 192:10
196:19 220:20
224:13,14,17,19
228:5,20 231:7
246:6
diagnostic
160:3
difference 164:3
164:6 196:11
differences
234:6
different 141:6
141:17,25
143:21 153:16
165:14 167:2
186:6,14 192:10
196:5 198:24
205:9 209:4
212:7 213:4
214:21 220:19
220:19,20
224:12,17,17
225:4 238:14
differently
150:7 193:20,21
difficult 231:21
direct 180:13
214:23 222:20
242:8
directed 183:16
227:20 230:21
directions 167:2
247:3
directives
167:23
directly 138:24
198:4 201:3
255:9
disagreed
165:13,17
disappointed
143:17
disclaimer
162:3
discontinuation
217:6 221:24
225:7
discontinue
139:16 191:23
192:5
discontinued
139:10
discretion
185:15 225:15
246:7
discriminatory
227:8
discuss 145:24
194:21 232:22
242:15
discussed
172:20 178:20
251:1 254:19
discussing
236:22
discussion
158:23 172:16
172:18 253:19
discussions
172:11 193:13
193:15,16
dismiss 195:20
disseminate
141:3
dissertation
160:19
district 125:1,1
199:4 212:20,20

districts 199:3
divide 155:2,10
doctor 192:6
doctors 145:20 178:25
document 127:18 147:8 158:10 163:19 185:1 211:2,2 221:4 226:23 227:25 228:3,17 252:2,14 254:13 254:15 256:4 261:19
documentation 168:20
documents 141:1 142:8 168:19 184:24 187:18
doe 247:18
doh 252:15
doing 154:11 198:23 214:11 229:18 247:24
dollars 150:23 246:10,14
donovan 145:16
donovan's 145:15
dosages 224:8
doses 192:7
downtown 175:3,4
dr 128:12,12,20 128:21 133:10 134:17 135:2,11 136:7,7 145:14 145:15,16,20,23 177:15,16,16,18 177:18 178:23 180:5,6,7 183:4 183:5 194:23
draft 144:21 145:19 146:3,4 146:5,7,21,22 157:16,21 158:15 183:24 183:25,25 184:1 214:16,19 215:25 218:21 219:1,2,5 257:14
drafted 172:5,6 215:19 221:12 221:17 222:4
drafting 145:5 147:24 160:10 249:14
drafts 145:20 216:24
drastic 145:22
draw 185:4
drawing 143:24
drew 142:1
drive 125:17 249:7,23
drug 159:24 160:4 173:13,18 184:15,17 186:20,25 187:11 228:5 232:2,3,4,5
drugs 216:6 217:14,18,23 218:8 220:21,24 228:15
due 228:3,18 238:4
duly 128:4 258:11
dunn 126:6 211:21 226:12
duration 240:16
dvp 164:21
dysphoria 127:18 131:3,6 131:22 132:7,16 132:21 142:13 142:14 154:15 155:6 157:2 159:7,8,12 160:9 171:9,13 185:22 188:3 191:1,9,18 192:9 200:17 201:12 204:18 204:24 205:19 206:13 207:13 207:24 208:12 208:17,23 209:9 209:13 216:7 217:8,14,19 218:8 220:19 222:1 223:20 224:9,15 226:25 227:24 228:1,23 237:3 238:18 239:3,17 242:18 242:23 243:11 243:14,22 244:4 244:18 245:4,9 247:16 248:15 252:12

e

e 126:14 128:1 260:17,17 261:3 261:3,3
earlier 135:5 155:14 199:18 232:18 251:1
early 139:14 146:23
easier 175:4
easy 175:6 203:4
edit 145:7
editing 145:8
edits 145:9,11 145:12,17 146:2 147:1,9 184:2 256:3
education 126:11
effect 219:25 243:3
effective 243:6
efficacy 141:15

efficient 153:12
effort 174:6 183:11 215:22
eight 135:19 157:7 253:3
either 135:15 162:1 165:13 167:24 179:20 183:4 195:12 196:8 205:23 225:2,25 230:25 251:18
eligible 244:7,10 244:15 247:21 248:1
eliminate 171:1 171:15
elliot 232:7
else's 133:25
email 127:14 136:4 186:24 210:25 215:10 227:10,15 228:12 230:2 231:20 232:16 260:10
emailed 260:11
emails 127:16 189:20 211:19 213:22 216:14 226:15,22 229:23
embarked 186:10
employed 138:21 139:19
employee 210:19 259:12 259:13
employees 250:15
encounters 247:13
encouraged 177:8
encouraging 177:11
ended 136:6
endocrine 161:8 161:10,13,19,21 161:21,25 190:18
engage 130:11 131:11 132:12 142:24 179:25
engaged 132:15 132:24 134:12 139:18 140:21 141:4
engagement 179:22
enrolled 244:11
enrollees 205:8 217:11 218:11
enrollment 244:14,15
ensure 217:6 221:24 225:9
ensures 218:18
ensuring 235:17
enter 136:23 138:19 163:12 254:12
entire 158:20 170:2 214:16
entities 144:21 181:7
entitled 212:16 219:22,24 220:12 239:8
entrance 177:4
epsdt 173:3,6,8 185:13,18 186:3
eq 137:15 201:2
equally 204:9
equals 227:6
ernie 188:23
errata 260:9,9 260:11
errors 146:1
especially 141:14 186:6,7
esq 126:3,5,6,8 126:11,14,18,19 260:1
establish 237:16
established 161:11 234:16
establishing 129:4
estimate 159:2
estrogen 223:25 225:17
et 125:5,8 132:2 137:13 194:22 260:5,5 261:1,1
ethical 189:4
evaluate 148:24 151:2,15 197:1 198:20 237:14
evaluated 151:6 185:19 194:24
evaluating 132:4 141:23 237:22
evaluations 194:15
event 174:19,20
everybody 186:14 188:4
everything's 153:14
evidence 128:23 131:7,19,24 132:2,19 133:9 133:19 134:1 139:7,12 141:12 141:16 144:1 155:5,5 156:11 161:16 162:2,10 165:2 185:7 187:16 197:13 197:17,18 198:7 198:8,10,13 238:5 251:4
exact 230:2 244:21

exactly 183:19 250:9
examination 127:4,5,6 128:9 253:24 255:22
examined 128:6
example 138:13
examples 186:18 195:13 196:9 197:12 251:13
exceed 136:16 136:21,25
exception 229:8 233:15
exchanges 215:10
exclude 154:18 154:21 156:16 156:17
excluded 149:3 152:2 218:14 241:14
excluding 148:24 151:2
exclusion 157:3 159:11 165:3,6 165:10,15,21,24 169:25 172:25 173:25 179:12 191:19 192:6 200:16 204:24 206:12 207:3,22 209:8,12,14 213:7 216:12 218:18 219:22 225:19 226:2 227:2 232:12,19 235:14 237:2 238:1,3 241:6 242:17 245:13 247:6,8
exclusions 199:2,5
exhausting 177:25
exhibit 127:11 127:12,13,14,14 127:15,16,17,17 127:18,18 152:13,14 162:15,20 163:6 201:24 202:8,11 211:18 213:22 213:22,22 214:1 214:3,7 221:7,9 226:18 233:2,4 248:19,21 252:2 252:7,13,17 254:4,6 255:24
exhibits 127:8 248:18
exigent 251:11
exist 203:3
existing 128:23 131:5,19,24 217:20,24
expect 175:23 175:24
expedited 251:18
expenses 177:19
expensive 139:15
experience 130:9 132:15,21 170:14 180:23 223:24
experienced 131:20,22
experimental 140:1 141:20 148:23 149:23 150:6 154:24,25 155:17 165:1 173:8 185:8,22 186:8 198:10,11 204:10 237:5,6 237:10,17 238:4 238:23 239:12 241:7,17 247:5
expert 165:17 194:14
expertise 137:17 137:19 140:5,12 140:22
experts 129:12 130:16 132:4 136:24 137:16 138:10 140:11 141:5 142:13 146:9,9 165:13 177:15 179:7 236:22
expires 258:21 259:22
explain 195:21 228:7
explained 161:3
explanation 142:23 161:6
explanatory 214:22 215:8
expletive 193:18
explicitly 154:14,21 156:16,16
explore 186:16
external 144:21
extrapolation 231:22
eyes 202:2

f

f 231:18
f64 231:12
facilitate 177:1 220:24
facilities 175:12
fact 141:1 153:11 187:13 227:15 229:7
factor 131:14,22 131:23 155:16 156:8 194:4
factored 191:9
factors 132:3 174:24
facts 261:19

fail 260:13
fair 144:20 207:4 208:3,13 208:18,21 209:7 209:11,22 228:18 239:8,15 239:22
fairly 191:6 251:19
fairness 235:5
faith 188:16
familiar 132:7 148:11 154:11 200:12,13 221:11 224:22 231:3,4,6,8 232:24 233:7,8 240:17
familiarity 154:7
families 187:6
family 128:21 128:21 133:22 134:8 188:9
far 142:21,24 144:14,16 146:2 155:1,24 169:23 173:17 176:2 184:1,3 186:13 193:15 199:24 205:15 207:4 209:1 214:14 218:9,10 229:2 229:4 243:12 249:1 250:14
farrell 174:8 183:11
fast 170:13 192:21
faster 170:23
favor 214:20
fear 228:3
february 125:14 257:6 258:14 259:16 260:3,6 261:2
federal 173:1,12 173:17,21,23 199:3 246:10,14 260:12,17
fee 156:1 159:16 212:19 228:15
feedback 145:21 145:21 179:19 190:14,18
feel 174:13 211:6 221:6 225:14
feelings 174:16
felt 161:5,12 174:18 223:8
female 231:15 231:18
field 140:12
figure 186:17 224:23 229:13 256:9
file 230:25 240:1
filed 147:12 212:24
filing 212:17,19
fill 175:11
final 146:5 183:24,25,25 184:1 190:6 209:16,21,23,25 210:5,6 211:23 212:15 228:7,21 235:2 239:21
finalized 172:17 251:2
financially 259:15
find 149:18 150:15,19 151:24 153:3 186:21 229:21 230:10,18 247:19 256:8
finding 162:25 197:1,19
findings 153:18 154:16,17,19,21 157:6 187:17 239:19,25
fine 193:25 216:24
fingers 211:11
finished 145:19 253:23
finishing 184:2
first 146:3,4,7 146:20,22 150:20 157:20 157:22 158:2 163:13 171:19 184:11 215:19 226:23 228:19 236:3 255:10
fiscal 151:21,23 151:23
fiscally 156:3
five 158:19,20 158:25 164:13 170:16 188:5 193:2 199:9 248:4,10 251:22 253:3,4
fl 260:10
flexibility 241:3
floor 126:12
florida 125:1,17 125:20 126:3,4 126:7,10,20 127:15,17 134:12,15,16 149:7 150:8 155:22 156:1,2 157:1 160:7 171:2 173:7 187:6 188:12,16 188:25 200:6 206:1 209:18,24 212:23 213:6,9 217:23 221:5,8 226:6 227:17 236:5,6 237:5 242:21 243:4,17

243:21 244:3,7 244:20 245:8 246:16,22 247:22 248:13 252:11 258:5 259:2 260:12,17
fmmis 231:2
focus 155:4
focused 155:4
focuses 236:24
folder 249:7,8
folks 136:6 148:20
follow 132:13 137:5,6 206:24 232:17
following 150:16 187:15 187:16 227:11
follows 128:6 196:10
foods 251:7
forbes 226:22 230:14,15
foregoing 259:5 259:8 261:19
foremost 150:20
foreseeably 195:17
forgetting 213:16
form 127:12,16 130:2 133:2 155:18 162:16 163:7 216:13 221:8
formally 219:4
format 178:22
formulating 150:2 255:15
formulation 162:22
fort 206:18
forth 179:2 191:13 213:8 225:5 236:23
forward 210:25
found 184:10 199:3 237:4,9 239:11 240:3,12
foundation 133:15 198:6
four 158:19,20 164:17 199:14 248:7
franklin 126:14
free 186:16 211:6
freedom 133:13
frequently 142:7 148:13 194:10 214:18 251:20
friend 254:19
frustrating 169:22
full 138:5,7 196:16 247:11 251:18
fully 228:11
fun 188:1
fund 126:12
funded 150:9,10
funding 222:2
further 127:6 216:25 255:21 255:22 259:11
furtherance 208:16,22

g

g 148:23 149:3 169:4
gainesville 126:7
gainwell 231:1
galvin 189:8
gapms 127:17 128:13,18,20 129:2 131:25 132:17 135:8 137:10,11,22 138:14,16 139:8 140:6,7 141:8,9 141:19,23 142:2 142:14 143:4,12 143:15,20 145:18 147:14 147:20,22 149:5 149:10,14,16 151:2,6,9 152:2 153:18,25 156:25 157:6,9 157:16 160:11 162:16 163:7,13 164:8,12,18,23 165:3,12 168:23 170:3 171:5,14 171:18,21 173:5 176:1 178:10,10 184:10,21 185:21 187:19 188:6 194:14,21 195:14 197:2,23 198:5,6 220:16 227:13,21 248:19,25 249:2 249:4,7,9,14,16 249:24,25,25 250:6,7,13 251:18,19 254:17,18 255:25
gary 126:19 260:1
gather 179:18 182:8 256:16,25
gathers 255:7
gender 127:18 131:3,6,13,22 132:7,16,21 133:1,19 134:1 141:6,10,25 142:13,14 143:20 152:19 154:15 155:6 157:2 159:7,8 159:12 160:8 162:7 171:8,13 185:22 188:3

190:19,25 191:8
191:18 192:8
200:17 201:12
204:18,24
205:19 206:12
207:13,24
208:12,17,23
209:8,13 216:7
217:8,14,18
218:8 220:18
222:1 223:20
224:9,14 225:20
226:24 227:6,24
228:1,23 229:9
230:20 231:5,9
231:10,11,25
232:9 235:14
237:3 238:18
239:3,16 242:17
242:23 243:11
243:14,22 244:4
244:18 245:3,9
247:16 248:14
252:12
general 129:13
134:20 135:2,24
140:13 166:9,11
169:18 172:14
176:16 209:16
234:18 239:1
255:13,14
generally
149:11 154:3
157:10 160:13
163:10 166:16
167:3 180:22,22
180:24 205:18
205:20,24
230:24 249:25
gerring 171:24
174:6 176:19
189:19,25
getting 191:15
214:6
gg970595
258:21 259:22
gift 197:9
gigantic 153:10
gist 188:6
give 156:23
182:20 192:11
197:9 230:1
given 135:3
147:9 160:9
167:23 183:18
191:20 205:5
206:16 215:8
223:1,3 225:12
239:11 242:10
gives 154:7
glaring 160:17
gnrh 227:25
247:15
go 169:4,8
186:13 193:15
195:18 211:12
220:15 221:20
221:22 229:3,23
237:14 239:24
243:19,19
244:22 248:1
249:12 253:16
goes 143:24
144:14 155:1
169:11,13,15
199:25 205:15
211:15 234:7
235:8,11 249:1
255:3,10,13
going 131:18,25
141:8 142:1
143:16 144:12
147:1 151:8,13
151:13,20,25
156:10 163:25
165:7,11 168:20
169:4 170:17
175:12 178:23
179:11,19 183:7
185:20 187:3,9
187:20 189:20
191:18 192:6
193:8,22,23
195:14 199:8
201:18,20 205:5
207:4 209:2
210:25 211:18
218:11,13
223:14 225:15
232:11,14 233:1
240:4 256:13,22
257:10
gonzalez 126:11
good 162:24
175:14 211:16
250:1,7,17,18
gotten 133:20
236:18 250:24
251:2,8
govern 136:20
government
175:9
governor 234:8
governor's
134:18 144:23
176:8 177:10
gperko 260:1
grammar 145:9
grant 234:10
235:13 237:1,8
241:3
granted 233:12
234:1 235:19
238:19 240:19
grantham
172:12,14
176:16
granting 233:21
235:23,25
granular 172:22
173:11
graphic 186:11
graphics 185:3
187:4,10
great 150:10
154:7,11
greater 240:15
240:15
green 230:16

grievances 206:10
grossman 128:20 135:11 136:8 145:20 177:15 178:23 180:7
grossman's 128:12
ground 162:25
grounds 236:25
group 160:25 193:24
groups 179:21 196:8
growth 251:11
guardian 144:11
guess 146:13 186:10 195:16 204:8 234:3
guidance 140:25 142:22 142:25 143:25 173:6 192:11 227:18 252:10 252:15
guide 139:12 235:12
guideline 173:6
guidelines 132:2 139:8 161:12,13 161:14,16,18,22 227:12
guides 153:6
guys 202:25 257:15,15

h

h 261:3
half 154:13 187:25 199:9 253:4
hand 233:1 258:13
handbook 226:10
handful 243:8
handing 163:5
handle 228:14
handled 166:16 176:19 193:20 193:21 200:21
hands 163:2
happen 167:9 167:11
happened 167:12
happens 167:10 214:18
hard 243:2 247:10
hardship 234:16
hazy 245:2
head 134:22 172:2
headache 169:22
headquarters 212:21
health 125:16 126:3 127:13,15 127:18 134:15 134:16,22,23 137:15 141:1 144:25 150:9 170:16 176:10 184:25 187:13 196:15,17,18,25 201:2,19 202:20 219:4 221:1,5,8 223:3 227:17 252:2,11 257:8
health's 227:12
healthcare 221:20
hearing 128:14 128:17,25 148:20 174:2,4 175:9 176:7,13 177:2,8,11,14 177:17 178:2,3 178:4,12,15,15 179:17,18 180:13 181:13 181:18,25 182:11,15,19,21 183:3 188:8 207:4 208:3,13 208:18,21 209:22 228:4,18 239:8,15,22
hearings 175:19 180:16,25 209:7 209:11
heavily 155:16
help 145:25 176:20,20 177:1 200:14 201:9 216:6 220:24 223:15
helped 176:22
helpful 208:6
helping 176:24 182:18
helps 211:20
heritage 133:15
hey 187:23
hhs 140:25 141:14 142:8,22 142:25 143:25 184:23 187:17 188:3
hi 227:4
high 142:9 187:9 197:13 198:13
higher 158:2
highly 168:19 236:19
hill 126:15
histories 196:7 196:20,25 197:3 197:4 243:20 246:19
history 196:14 196:14,16

hit 164:1
hits 163:19
hold 175:19,20 195:5 197:18 205:13 237:23
holding 163:2 250:12
holtzman 126:19
holtzmanvoge... 260:1
hominem 192:19
honest 144:2
honor 217:12
honoring 217:24
hope 187:6
hormone 171:8 208:11 217:7,7 221:25 228:2 229:9 243:10 244:3
hormones 161:24,25 186:8 191:24 220:15 221:25 223:16 224:9 244:17 245:3
hot 142:22 144:3
hour 158:23 172:19 178:19 187:24 199:8 253:6
hourly 136:15 138:17
hours 158:25 159:4 168:22 170:2 253:3
house 225:2 229:5
housed 167:21
hub 206:15,18
huge 153:12
huh 127:23 142:16 143:2 149:25 158:7 164:20 190:1 200:10 217:9
human 127:18 187:13 252:3
humana 244:6 244:11,23 245:20 248:13
hurled 192:19
hurry 192:25
hybrid 161:2
hypothetical 239:1
hypothetically 132:11 226:5

i

icd 224:25 231:4 231:11
idea 183:17 232:9 250:1
ideal 175:17
identification 152:15 162:21 201:25 214:4 221:10 226:19 233:5 247:12 248:22 252:8,18
identified 160:24,24 197:4
identify 128:13 161:23
identities 186:17
idiosyncrasies 153:8
idiosyncratic 202:20
illness 196:19
immediate 157:8,13
immediately 220:3
impacts 196:17
implement 168:2 213:7 220:7 225:19
implementation 195:3 199:7 200:5 216:12
implemented 227:6 245:14
important 132:14 215:25 218:1 220:17,22 222:7
importation 184:15
impressions 227:12
inability 191:21
include 177:21 205:25 206:6 207:7 208:13 216:25 222:4,6 222:7 255:18
included 210:5 217:1 249:21,23
includes 145:13 145:14 188:23 189:2 227:7 247:18
including 188:14,19
inclusive 196:9
incorporate 190:6 200:16
incorporated 222:3
independent 149:20
independently 221:2
index 127:1,8
individual 223:21 225:3 236:25 240:14 246:19
individualized 235:16 236:19 236:23,24 237:13,22 238:7 254:24

individually 237:15
individuals 129:1,11 131:17 132:13,19 136:8 180:9 191:23 218:19 223:15 225:9 234:23 235:10
inevitably 143:15
information 146:17 149:15 152:7 153:4 159:14,19 161:4 182:8 188:2 195:23 205:16 206:14,19 208:7 208:8,14 209:5 210:5,21 223:24 229:21 230:1 232:16 242:2 247:12,14 255:7 256:8,17 257:1
informational 155:1
informations 205:23
informative 149:23
initial 157:16,21 164:10
initials 201:22
initiated 143:13 167:15 227:13
initiating 168:5
input 133:12 172:8,10 174:9 181:6 190:6 234:25
instance 125:13 152:1 170:14 184:15,22 218:6
instances 137:13
instituted 212:17
institution 171:18
instruction 182:25 232:7,8
instructions 182:21,24
insufficient 144:1
insulting 193:17
insults 192:19
insurance 149:2 149:22 150:1,4 150:7
insured 239:3
insurers 149:6 150:9
intact 146:3
integrity 140:18
intellectual 148:2,4
intended 185:17
inter 200:8,9,13
interested 149:5 149:6 195:11 259:15
internal 145:3 227:5,8,24,25 242:3
interpret 228:21
interpretation 231:23
invest 193:12
investigate 131:2
investigation 235:9
investigational 140:2 165:1 185:8 186:9 198:11 238:4,23 241:7 247:5
invited 182:12
involve 213:3 229:2
involved 129:8 129:17,19,21 130:14,18,19,20 130:23 136:1 146:6 174:18 201:3 213:25 219:12 224:8
involvement 128:12
ipads 211:16
iphones 211:16
irrelevant 133:8
ish 146:24
isolated 187:3
issue 142:9 209:9,12 236:3
issued 168:14 208:2 209:21 239:21
issues 255:16 256:14
it'd 220:20 237:21 239:6

j

jack 148:8 194:19
jacksonville 126:4
january 147:13
jason 125:8 213:23 215:11 260:5 261:1
jazil 126:18 127:5 130:2 133:2 152:12 155:18 162:17 162:25 199:8 202:1,4 203:2,5 206:23 210:11 212:11 216:13 248:5 253:7,9 253:25 254:1 255:21 256:12 256:21,24
jessica 226:22 230:14,15

job 219:16 229:3
join 161:2
joint 174:6
josefiak 126:19
josephina 129:14,23 135:25 166:9
juarez 174:7 176:21 183:12
judicial 211:24 212:14,16
july 128:14,25 188:8
jumped 151:11
june 127:16 128:18 129:2 135:8 140:6 147:14,19 151:1 157:16 158:2,3 160:11 162:16 163:7 164:12,18 166:4 168:11,14 169:25 170:1 178:10 226:24 232:10 237:2
justice 126:3

k

katy 126:3
keeping 213:12
kelly 230:12,13
kf 247:9,10,21
kids 181:1,1 183:8,8,13,13 185:11,11,23,25 186:6,12,12,16
kind 134:3 138:20 142:10 151:11 153:12 161:2 176:23 178:20 182:20 186:10 187:21 191:13 192:4,20 204:3 225:12 229:4 232:3 233:16 241:13 250:11
kinds 154:5 160:11 172:20 238:9
king 227:16
knew 169:3 176:3 179:19
know 137:13,23 149:9 158:1 159:10 175:8 178:22 181:15 181:16 182:5,22 182:23 183:19 187:1 191:15 198:9,15 202:25 203:3 211:9 216:8 218:1 223:13,19,20,21 224:3,10,19 229:19,20 241:2 241:19,22 242:4 244:21 245:17 256:6,22
knowledge 128:23 130:9 131:24 229:12 234:23
knowledgeable 131:5 235:10

l

labeled 248:18
lacked 197:2
ladapo 134:20 135:2
laden 193:18
lambda 126:11
language 172:5 172:7 173:11 174:3 200:14,20 200:23 201:5,9 215:23 217:1,2 219:3 221:24 222:5,11,19 233:24 239:6
lappert's 145:13 145:14
large 125:20 142:20 175:23 175:24 176:6
largely 146:3 179:11
larger 174:5
latitude 150:11 185:16
law 212:19
layman's 187:22
leadership 167:24 219:9 250:2
leaning 138:3
learned 167:19
learning 140:15
leave 225:15
leaving 221:1
left 198:14 230:7
legal 126:6,11 198:21 234:5 255:16 260:16
legalities 242:11
legality 198:19 198:22
legislative 167:24
legislature 234:7
length 194:21 244:21
lengthier 170:18
lengthy 169:8 170:8,20,24 190:16,17 196:7 196:10,12
lens 198:25
leon 258:6 259:2
leslie 227:23
letter 227:7
level 199:4 207:5 208:13,18 208:22 212:6,6

228:13
liberally 155:24
liberty 133:17
life 132:20
light 228:13
likely 153:8 179:19
likewise 169:14 185:1
limit 240:23
limitations 254:2
line 161:23 170:22 261:4,7 261:10,13,16
lines 147:7 189:21
lining 226:13
list 127:11 164:15,17 196:9 210:7 214:6 249:19,21,21,23 250:20
listed 144:9 148:23 204:18 206:7 221:16 236:15 241:25 242:1,22 243:5 243:17 246:16 250:4,21
listen 144:2,6
lists 221:23
literature 131:5 131:24 132:1,8 139:23 141:13 188:1 195:13
litigation 140:8 140:17,21 142:3 142:11 143:3,12 143:18 182:7,12
little 128:11 136:18 146:8 166:24 174:9 179:22 202:20 205:3 209:20 214:15 228:8 231:21
live 253:1
living 196:22
llp 126:9
locally 206:19
locate 246:20 247:12
location 125:16 174:23,25 175:2 175:4,6
logo 184:19
long 144:12 157:15 164:13 172:18 178:18 190:20 196:13 200:3 203:8 205:8,10 210:17 244:18,19,19
longer 143:6 220:21,25 222:16,17 225:10 247:7
longitudinal 196:7,12,13,14 196:15,25 197:3
look 133:8 143:11 150:4,14 153:3,23 156:24 156:24 187:5 188:5 190:7,21 191:12 194:6 216:4 233:24 244:22 249:8 250:3 254:3 255:11
looked 130:8 153:6,15 190:7 191:11 194:8,12 194:22 246:20 247:19
looking 131:4 131:15,17 141:10 150:20 152:18 154:1,10 195:11,15,15,22 197:17,21,25 198:1,2,2,3,7,16 198:22,22,24,25 205:3 206:3 227:15 236:8,9 236:10,20,21 241:2
looks 203:18 215:18 227:10 248:24 256:4
lose 191:19
lost 191:17 230:3 231:24
lot 134:4 141:14 144:6 148:13 155:8 169:23 176:4 185:15 187:7,7 190:8 190:10 192:18 192:19,21 231:21 247:3 249:13
low 141:12,16 162:1,2 194:25 198:10 238:5 251:7
lower 186:20
lowest 149:10
lunch 200:1
lupron 228:4,19 228:23

m

m 231:18
mac 211:13
mac's 211:16
made 129:2,6 141:14 142:12 145:22 146:2 147:10,10 165:8 165:9,11,22,25 166:3,4,5 167:6 168:11,25 169:25 170:1,7 171:20 184:23 188:3 194:9 207:11 214:25 215:12 222:21 228:7,21 229:8

234:21 235:1 241:20 251:15 256:2,4
maf 125:3
magellan 201:7 201:8 226:16 227:4 228:14,22 229:15 232:9
mahan 125:17
mail 205:8,10
mainstream 132:25 142:7
maintain 218:2
maintains 212:21
maintenance 231:1
major 144:10
make 131:18 145:9 146:13 151:20 159:19 160:16,19,20 165:2,10,10,15 165:24 166:12 166:14 187:22 188:4 191:23 194:16 195:18 198:13 207:20 222:10 230:24 257:1
makes 162:22 234:15 235:6
making 131:1 133:9 139:25 143:25 146:7 155:3 160:14 172:16 174:10 176:22 193:10
male 231:14,18
manage 213:13 221:2
managed 154:9 159:15 200:6,7 200:21,24 202:22 205:4 213:7,12 217:10 217:17 225:18 225:22 244:6 245:15,23
managing 223:12
mandated 245:19
manufacturers 250:25
map 154:16,17 154:19,21
march 258:21 259:22
mark 152:12 162:17 233:2 252:1
marked 127:10 152:14 162:20 163:5 201:24 213:21 214:3 221:9 226:8,9 226:18,21 233:4 248:18,21 252:7 252:17
marker 208:6
market 150:13
marking 221:7
marstiller 166:7 227:20
massive 197:8
mastectomy 238:17
match 246:10
matching 246:14
material 145:4
materials 153:7 178:1,6,8,9
matt 213:25
matter 210:18 231:17
matthew 125:12 127:3 128:3 260:6 261:2,23
mb 164:21
mcgriff 227:3
mckee 126:14
mean 130:7,7,13 132:11,11 137:8 137:9 141:17 142:5,18 144:5 144:5 146:3 147:4,5 150:8 150:17 151:19 153:8 156:21,22 156:22 157:9,11 157:11,12 161:11 163:8 166:12,14 167:7 167:11,14 172:10 174:16 174:17 175:8,8 179:3 180:15,18 182:3 185:6 186:5,12,14,22 186:24 187:1,3 187:5 192:16 193:7 195:9,11 196:4,14 197:5 197:12 198:2,3 198:15,18,18,19 198:23,23 199:23 202:22 206:2,2 210:4 210:20 212:3 213:9 215:5,21 216:23,24 218:3 218:5,9 219:14 220:4 222:18,18 228:8,11,12,14 228:21,22 229:3 229:13,14,24,25 230:2,22,24 231:10,10,19,20 231:21 232:21 233:14 234:5,6 234:9,12 236:4 236:9,10 237:11 237:12,25 238:5 238:8,22 239:23 243:12 251:17 251:19 252:23 256:19

means 147:18 164:8 217:16 219:15 220:6 231:11,12 235:22,22 242:4
meant 185:4 217:22 233:23
measure 163:25
media 142:7 143:24 144:3,4 144:12,14,15 148:18
medicaid 127:11,12,15 141:7,20,23 149:7,8,13 150:8,13,17,19 150:23 152:9 153:5,7,7,16,21 154:1,3,4,9,13 155:6,15,20,21 155:22 156:1,2 156:3,5 157:1 160:7 162:15 163:6 166:17,22 167:13,14,21 169:10,14,18 171:3,7 172:1,3 173:1,7,12,21 173:23 185:13 190:25 191:8,17 192:12 200:7 201:10,20 203:15 205:1 209:22 213:7 217:23 220:12 221:5,8 222:2 226:6 236:5,6 237:5 238:16 239:9 240:1 241:19 242:7,22 243:4,17,21 244:3,8,9,20 245:8,22 246:10 246:16,22 247:22 248:1,13
medical 132:25 137:16 147:4 179:20 187:25 202:15 204:10 205:4 207:25 224:2,6,24 225:13 237:23 238:10
medically 218:10 239:13
medicare 149:7 150:8,16,23
medication 192:2 225:7
medications 196:20
medicine 133:19 134:1
meds 227:6
meet 204:10 208:1
meeting 172:11
meetings 178:14 178:21
member 226:10 246:13
memo 143:4 171:5 255:25
memories 250:15
memory 250:11 250:14
memos 143:11
mental 196:17 196:18,25
mention 197:13 212:9
mentioned 204:7 232:18
message 185:5
met 145:21 233:21
metaphors 193:7
meter 177:16,18 179:1 180:5 183:4
miami 126:10
michelle 134:17
mid 146:23
mind 202:4
mine 146:10
miniscule 147:6
minnich 126:23
minor 216:22 216:22
minors 247:11
minute 193:2 199:9 248:4
minutes 188:5 200:4 253:3,4,6
misdiagnosis 238:11
mission 187:1
misunderstood 207:18
mma 205:3,6,6 205:11 227:23
mo 202:25 252:21 257:13
model 141:11 161:23
modern 198:12
modified 251:7
mohammad 126:18
mohammed 254:1
mol 128:12,21 135:11 136:7 145:23 177:16 177:18 179:1 180:6 183:5
molina 127:13 201:18 202:14
money 152:5
monroe 126:20
month 246:13
months 135:19 191:4 240:20 244:24,25
mortal 195:16 195:25 197:22

mortally 195:24
move 170:6,13 170:23 193:16 193:18 226:15
msnbc 144:10
multiple 252:3
muster 159:17
myers 206:18
myriad 197:12

n

n 128:1 148:10
nabd 203:1
nabd's 202:21 202:23 205:7,11
nai 129:19 130:20 158:5 189:19,24
name 133:20,25 134:17,24 135:3 144:6 148:9 155:23 201:20 211:1
name's 210:17
named 258:10
names 232:5
nation 149:14
national 159:24 232:2,5
nature 136:17 140:2,8 141:15 166:19 170:12 170:19 174:14 182:3 186:9 192:17
navigate 154:8 154:12 223:13
nbc 144:10
nc 126:15
ndc 159:21,23 160:4 232:4
ndc's 231:25 232:1
necessarily 132:10,20 135:14,14 151:5 164:1 192:8 196:18 198:20 246:3
necessary 165:4 170:25 176:25 179:8 192:14,16 196:16 214:24 215:9 218:10 225:14,17 239:13 250:4
necessity 202:15 207:25
need 141:2 142:13 149:12 151:24 156:24 159:21,21,22 160:1,2,3 162:18 165:2 166:2 174:13 175:6 192:1,4,7 220:23 232:14 242:8
needed 140:11 140:23,24 141:3 176:25 183:5,6 223:15
needs 132:18 151:23,23
negative 127:23
network 188:25
neutral 148:25 151:3,16,17
neutrality 151:7
never 203:2 207:15,18 208:2 211:16 218:21 239:13
new 126:13 144:10 155:23 157:12,14 162:22 165:10 168:2,4 170:11 170:16 184:14 187:2,4 251:15 251:17,21
news 144:3 148:17 176:2
nitrous 151:10
non 193:5 203:22 204:5 222:2 227:8
normal 174:5 181:17 184:9,20 187:14
normally 175:19
northern 125:1
nos 214:3
notary 125:19 258:20 259:21
note 148:19 214:1 260:9
noted 220:14 227:23
notes 259:7
notice 127:13 168:13 169:25 191:3 201:14,19 202:13 203:7,14 205:14,21,22 207:1,7,8 211:24 212:14 212:17,24 213:11,11 220:1 220:9 222:15 223:3 241:24
notices 200:15 201:1,4,10 202:18 204:25 205:24 206:8
noticing 223:2
notified 223:14
notify 201:10 217:10 225:8
notion 156:11
npr 144:2,6,7
number 170:9 196:1,23 202:9 208:20 221:7
numbered 259:9
numbers 209:15 226:12

numerous 180:16
nw 126:7
ny 126:13

o

o 126:18 128:1,1
oath 256:13,21 258:1
object 130:2 133:2 155:18 216:13
observation 144:19
observe 182:9
obtain 159:14 206:21 208:8,15 208:19 209:15
obtained 196:23
obtaining 206:20
obviously 165:13 187:2 192:25 193:2,8 210:4 256:14,22
occurred 209:11
october 201:22
odd 251:21
offer 179:4
offering 136:7
offhand 191:4 208:7
office 134:18 144:23 169:18 172:15 176:8,16 177:10 180:18 180:19 181:5 234:19 255:10 255:14
offices 225:4
official 219:3 258:13
officially 219:2
oh 144:5 157:17 158:19 164:21 167:18 189:15 211:8,13 215:11 226:12 232:25
okay 129:15,23 130:17 131:20 132:23 133:22 136:2 137:1 138:5,9,13,19 138:19,23 144:20 146:6,15 146:20,20,24 147:12 148:6 151:1 153:3 154:20 157:15 157:22,25 158:5 158:14 159:3,6 159:25 160:3,6 160:9 162:9,12 162:14 163:5,19 163:22,25 164:5 164:12 165:5 166:2,5 167:18 167:25 168:13 168:22 170:7 171:6,6,14 172:20,24,24 173:20 182:20 183:7 188:25 190:2 192:14 193:16 194:4,17 195:2,2,4 200:1 200:3,5,12,23 201:7 203:14,21 204:3,8,14 205:13,18,24 206:7,10 207:6 207:10,20 208:25 209:4,6 210:2 211:5,6,6 211:15 212:9 213:6,21,21 216:4,14,20,22 217:5,22 218:17 219:19 220:6,11 220:14 221:20 226:17 228:17 232:6,13,17 233:1 236:13 238:13 240:6,9 241:8,12,16,19 242:14 243:7 244:11 246:15 246:22 247:16 247:18 248:3,6 248:17 250:12 251:24 253:5,11 253:14,17 254:5 255:14 256:11 257:5
olsen 189:2
omar 126:11
once 135:1 140:9,9 146:10 171:20 180:6,6 189:20 206:21 219:25 222:15 223:19 255:2
onces 190:21
one's 193:17,17 193:17
ones 142:15,17 168:1,3 182:22 189:23 193:6,9 193:19 250:22 251:13
online 153:19 153:20 156:22 178:6
open 231:22 253:9 254:14
operations 245:24
opinions 165:17 174:15 223:7
opportunity 230:10,18
oppose 132:25
opposed 150:13 179:12 180:4
opposition 131:13,17 133:4 180:10 223:9
optional 236:12
options 225:9 231:17

order 200:15 210:5,6 212:16 212:25
ordering 257:10 260:11
orders 183:18 209:16,21,23,25
organization 133:21 161:2,11
organizations 132:25
original 212:17 251:5
originally 254:18
originating 166:20
outcome 201:1 201:4 207:8
outcomes 205:21,22
outlets 144:10
outpatient 217:13,18 218:8
outside 138:14 139:6,18 141:4 181:7,24,25 182:8,11,14,16 245:15
outstanding 250:1,16 251:12
outweigh 131:23
overhauled 170:15
overriding 173:6
oversee 229:25
oversees 171:24 219:14 231:2
overturning 209:1
overwhelming 156:6
own 181:3 186:16
oxide 151:10

p

p 128:1
p.m. 125:15 128:8 199:12,15 248:7,10 253:18 253:21 257:9,19
pa's 217:25
pagan 126:11
page 127:3 184:16 186:11 187:12 193:1 202:15 211:23 215:11,18 261:4 261:7,10,13,16
pages 153:6 154:12 164:13 187:20 259:9
paid 136:24 137:18 138:5,7 138:23,24 159:16 160:8
pam 189:2
panel 128:24 175:16 176:18
paper 178:7
paragraph 211:23 217:3
part 187:1 220:16
partial 203:12
partially 185:18 185:18
participants 176:15 196:7,10 197:2,5,9
participate 128:14 139:25
participated 176:13 180:12 180:16
particular 140:22 141:15 154:25 171:16 177:7,12 185:5 194:17 202:13 203:14
particularly 191:24
parties 259:12 259:13 260:11
partners 189:4
party 143:17 212:15,22 233:17
passed 134:16 163:23 181:13 181:18
passing 181:22
past 143:11 144:17 237:24
pastor 188:14 188:23
patients 223:18 225:16
pay 138:15 149:11 150:16 177:14 193:8 246:11,12
payers 149:8,9 149:11 150:16 150:21
paying 150:19
payment 222:2
payments 139:3
pays 139:10
peace 163:2
pediatrics 185:17 190:16
peer 132:1,7
penalties 261:19
pending 249:2 250:1,7,19,20 250:23 251:6,12 251:14
people 129:24 130:10 132:6 136:9 164:17 166:10 170:9 175:10 176:4 177:6,7 187:20 189:24 190:24 191:17 197:10

220:14 229:25
period 158:17 158:21 159:1 160:9 196:10 197:8 218:24 219:23 220:7 222:4 244:14,16
periodically 144:7 158:23
periods 158:22
perjury 261:19
perko 126:19 260:1
person 137:19 146:6 164:9,15 215:19 234:1 235:20,22 237:16 238:15 256:6
personal 144:19 148:4 198:25
personalities 199:24
personality 199:23
personally 134:25 157:15 258:10
pertinent 234:23 235:10
petersen 133:10
petersen's 194:24
peterson 188:19 214:1 216:5 226:23 230:6,7
petitioner 234:16
pgs 125:11
pharmacist 229:3
pharmacy 229:2 229:2
phi 210:21
phone 136:2
phrase 203:8
physician 137:15 138:14
physicians 190:19 225:4,12
pick 164:2 174:22
picked 174:22
pickle 129:21 130:23 149:19 152:10,25 158:6 172:13 213:23
piece 160:17 194:24
piecemeal 142:19
pillsbury 126:9
piloting 168:4
pittman 126:9
place 143:18 152:23 225:1 231:24 232:13 259:6
placing 237:18
plaintiff 126:2 248:12
plaintiff's 163:6 253:22
plaintiffs 125:6 125:13 182:6 247:1 248:2
plan 202:20 204:17,20,22 205:14,14 207:7 207:11,25 213:15,17 214:7 214:16 217:10 219:4 223:12 224:10 225:18 226:1,4 244:6 244:12 245:15 245:16,18,23,24 245:25 246:1,4 246:7,8,9
plan's 246:7
planned 174:2
planning 176:7
plans 157:5,13 159:15 200:6,7 200:21,24 202:22 204:2,4 205:3,6,16 206:5 213:7,12 216:11 217:17 218:1 220:1,6 220:17,23 221:1 223:3 225:8,22 232:19,21,22 244:15 245:23 246:12
play 134:9
please 162:18 216:8 231:24 257:17 260:9
plus 155:12 161:1 253:3
point 182:10 212:3 214:15 218:23 222:19
points 193:10
policies 149:13 149:17 153:10 153:17 155:7 167:5 168:2,3,4 170:16,17 171:25 213:13 213:14
policy 127:12,14 152:21,22,23 153:11,23,24 156:23 162:15 163:6 166:17 167:13,14,20,21 169:10,14,16 170:11,20 172:3 211:19,20 213:18,20 214:2 214:7,13,14 215:1,9,17,19 215:25 217:4,15 219:14,15,17,19 222:10 248:14
policy's 156:22

portion 257:6
position 161:9 161:10 162:6 219:20 220:11 250:13 255:15
positions 160:22 160:23 162:11
positive 127:23
possible 130:14 132:10,11 140:24 141:4 175:10 212:11 225:11 229:24
posted 227:5
potential 142:11 142:22 182:12
potentially 155:11
practice 128:22 132:8 139:8
practices 140:13
practitioner 128:22 225:15
practitioners 140:13 223:17 224:2,21
prayer 188:25
preceding 183:23
precisely 168:7
prepare 129:3 178:15 182:21 231:24
prescribe 224:11
prescribed 212:19 217:13 217:18 218:7
prescription 173:13,18 184:15,17 186:20,25 187:11
present 126:23 143:5,22 240:6
presented 141:22
press 184:18
pretty 149:18 151:10 157:17 161:3 162:24 171:17 196:4 203:4 214:11,22 214:23 222:19 222:19 238:12 241:10 250:1
prevail 239:15
previous 176:2 202:7
previously 128:4 137:18 139:6,9 152:3 171:2 218:14 220:14
pricing 184:17
prides 156:2
primarily 149:4 149:6,8 155:3 161:25 183:15 195:11
primary 132:3,3 132:18,22 198:9 198:16
principal 130:15
principle 235:5
principles 235:5
print 148:14 254:10
printed 193:24 256:1
printing 181:11
prior 128:11 137:10 142:14 142:15,17 157:3 159:10 176:3 178:2,12,15 184:5 188:8 207:10,21 208:10 217:13 217:20 219:21 227:1 228:14 229:5 232:19,22 242:21 243:4,6 243:16 245:12 245:13 246:15 247:5
priority 149:10
private 149:2,6 149:11,22 150:1 150:4,7,9,15
privately 150:10
privy 169:19
pro 242:4
probably 144:17 159:17 166:4,6 167:17 184:4 186:9 208:24 209:2 236:10,11 255:12 256:10
problem 169:21 210:22
procedure 137:2,4,7,9 232:3 260:17,17
procedures 176:19 182:9,19 206:6,7
proceed 165:21
proceedings 212:22 259:5,10
process 131:25 141:8,19 146:4 157:10 163:9 166:24 167:20 168:19,21 169:8 169:9 170:2,6,8 170:18,24 171:18,22,23,24 182:19 190:5 191:20 197:2 205:9,25 206:4 206:20 209:17 209:24 212:2,7 212:8,10 225:1 227:14,21 229:24 232:24

233:13 235:8 236:20 237:22 237:24 238:2,8 239:21,24 242:16 254:20 254:24 255:19 256:20
processes 212:4 213:2 229:2 242:3
procurement 136:17,22 137:1
produced 148:15 203:1
professional 139:23 148:5 259:4
professionals 161:1 179:20 192:12 224:3
profile 142:9 187:9
program 139:12 152:9 154:9 155:6 156:3,5 160:8 170:14
programmed 231:7
programming 230:21 231:3,4
programs 149:7 149:13 150:14 150:19 153:7,16 153:21 154:8,13 155:16,21,21,22 184:14 186:19 187:2,4,8
project 126:3 128:20 188:21 189:10 236:25
projects 154:5,9
promoting 187:6
prompt 180:13 182:23 183:2
promptly 179:13,15
promulgate 166:15
promulgating 165:4
promulgation 171:23,24 227:2
proposed 170:1 174:3 189:13
proposes 167:1
prospectus 137:17
protect 188:21
protein 251:7
provide 129:5 132:6 136:14 140:16 145:4,17 149:10 163:11 175:15 178:1,9 179:22 188:2 202:9,23 204:4 206:21 208:22 213:10 220:9 250:20
provided 133:12 145:21 147:2 179:14,16 191:15 195:23 197:4 209:7 216:7,11 228:3 228:18 232:7 239:2 246:5 248:20 251:3
provider 221:22 221:23 222:9 223:13 224:10 225:24
providers 206:15 217:11 220:23 221:2,21 223:3 224:21 225:8,23
providing 195:12,13 244:6
provision 236:7
prudent 225:7
psychiatric 162:6
psychiatrist 128:21
pubertal 154:14 154:22 207:12
puberty 143:4 161:24 171:7 185:20 186:7 207:23 217:6 221:25 223:16 228:1,6 229:10 243:7,21,25 246:22
public 125:19 149:5,8,9 174:2 174:4 176:7,13 179:17,18 180:14 181:24 182:10 188:8 195:24 213:11 233:14 258:20 259:21
publication 184:24
publication's 213:9
publicly 227:5
published 141:1 156:23 158:1
publishing 185:1
pull 210:4,13 249:3,9 250:3
pulled 146:16 194:11 243:9 246:19 247:3
pulling 250:14
purchase 136:15
purpose 179:17 200:8 233:10,11 233:20 234:2 235:18,21,24 236:2
purposes 148:5
purview 215:6

put 152:25 153:18 159:20 162:3 187:21,22 206:24 223:1 224:25,25 251:25 252:20
putting 193:9

q

qual 200:8,9,13
qualified 129:25
quality 141:12 141:16 162:2 169:16 194:25 196:1,1,2,3,6 197:13 198:10 198:13 215:17 238:5
question 132:9 141:22 143:9,19 150:3 159:19 173:10 192:22 201:1 204:1,8 207:19 208:16 209:19 235:4 247:9
questioning 197:18 232:17 252:25 253:6,23
questions 160:11,13,14 179:4 191:22,25 206:16 214:6 221:15 225:18 225:21,25 229:4 238:9 252:20 253:10 255:21
queue 127:17 248:19,25 249:4 249:24 250:10 250:21
queues 249:9
quick 170:18 183:8 188:1 200:2
quickly 140:15 159:6 170:6 191:6 192:15,23 248:12 253:14
quite 144:9 192:22 252:1
quoted 148:13 148:16

r

r 148:10 261:3,3
rainbow 189:10
randomized 197:16
ranges 160:5,6
rate 136:15 246:13
rates 138:17 246:12
rather 170:18
rct's 197:13
reach 156:21 206:17 234:22
reached 142:4 154:23 228:24
read 129:25 158:8,10,14 187:21 189:15 190:4 191:6 193:5 201:17 212:11 260:8 261:19
reading 188:1 257:19
real 132:20 162:23
realized 192:4,8
really 131:25 132:18 133:8,8 135:20 149:5,9 150:18 155:4 159:6 170:19 180:5 183:7 187:17,18 190:11 192:25 196:16 210:17 249:24
reason 198:7 203:21 260:9 261:6,9,12,15 261:18
reasonable 260:12
recall 135:3 139:18 254:20 254:24
receipt 260:12
receive 189:12 190:14,24 191:16 238:16
received 163:25 164:4 176:1 191:7 193:6 225:21,24 227:1 228:4,19,22 244:22
receiving 146:19 191:8,13 191:24 217:11 247:15
recent 199:21 230:8 248:24 249:4,9,10,15
recently 230:7
recess 199:13 248:8
recipient 201:11 201:20,22 203:16 210:21 228:4,19 236:21 237:19 240:20 241:19 242:7
recipient's 243:20 246:19
recipients 192:12 197:5 205:5 206:15 241:24 242:1 243:9 244:14
recognize 232:4 232:5
recognizing 254:2
recommend 134:9
recommendati... 134:10 140:1

recommendati... 131:18 161:15 162:7
record 128:8 134:5 168:17 199:15 248:10 251:25 252:21 253:2,15,16,17 253:19,20 254:7 256:13 257:2 259:10
recorded 257:6
records 224:24 236:21 237:23 238:10 244:22 246:18 247:13
red 147:7
redemption 189:10
redirect 255:24
reduction 203:10,11,12
reevaluate 157:5 251:9
reeves 125:18 258:20 259:4,21
refer 218:4
reference 178:7 195:6 205:25 209:17,23 211:8 222:3 231:14 240:10
referenced 139:13 195:8,10 252:3 260:7
referencing 234:4
referred 242:2
referring 213:18 217:5 227:9 252:1,4 252:14
regard 260:13
regarding 130:13 145:25 174:2 188:3 205:7 206:11 252:11
register 213:10
regular 249:22
regulations 136:20
reimburse 177:20
reimbursed 138:10 139:2
relate 212:1
related 128:15 128:18 131:3 143:11 205:18 206:11 211:19
relates 132:8
relation 128:20
relative 259:11 259:13
release 157:7,12 157:14 176:3 183:23 184:5,8 227:11
released 161:12 168:25 227:17
releases 142:25 184:14,19
releasing 161:14
relied 147:14 201:1
rely 130:15 140:5 149:25 156:10
remain 253:15
remember 135:16 147:5 172:11 189:19 194:17 249:14
reminder 230:20
remove 231:25 232:8
removed 230:21
rendition 212:25
reopen 157:9 251:9
reopened 250:24 251:5
repeat 140:19 149:24 209:10
rephrase 192:24
report 132:5,18 135:15 140:9,18 140:23,24 141:9 142:2 145:13,14 145:15,18 146:13,16 147:2 147:15,20,24 148:12 153:18 157:6,16 158:15 160:11 164:12 164:18,23 165:12,20,25 168:24,25 171:21 173:5 176:1 178:5 183:23,24 184:4 184:10 185:6,21 187:19,24 188:7 194:14 195:14 198:5,6 205:10 251:5 254:17
reported 125:18
reporter 125:19 153:24 257:10 257:13 259:1,5
reporters 153:23
reports 129:2,3 129:6,10,25 131:7,18 135:10 136:7,8 142:20 144:21 145:5,7 146:10,11,12,16 146:19 149:16 154:5 164:13 194:15 197:11 205:7 249:14,16 250:9,16,24
represent 219:4

representative 257:7
represented 241:21,22
representing 126:2,17 182:6
reproducing 214:12
request 159:21 203:19,24 220:16 228:18 228:22 231:1 234:19,24 236:1 236:18,23,24 239:4,23 240:11 240:18 241:20 242:8,10 251:2 255:2
requested 204:12 236:13 257:14
requesting 237:17 240:24 241:5,13
requests 228:4,5 228:20 237:13 240:2,4,7,19 242:6 249:3 250:24 251:8,15 251:18,19,21
require 170:17 204:3 205:6,9 206:4,5
required 228:20 233:15,17 242:13
requirement 150:18 205:12
requirements 173:6,17 202:23 234:10
requires 173:13
research 143:8 154:4 232:15 240:3
reserve 232:14 253:8,10
resides 212:22
resolutions 205:14 207:7
resource 188:2
respond 179:6 179:13,15 180:1 180:7,17 182:24 183:1
responded 180:6,6
responding 167:23 182:23
response 127:23 127:23 141:3,9 180:9,13 183:5 189:12 194:9,10 204:4 212:7
responses 156:23 180:8 194:8
responsibilities 219:17
responsible 156:3 181:9,11 181:15,22 213:12 255:15
result 169:22
resulted 145:22
resulting 142:11
retained 139:6 182:11
retract 195:19
returned 260:11
reuben 230:12
reuben's 230:13
revealed 243:15
revenue 246:14
reverse 207:11 207:22 208:11 208:12
reversed 207:15 208:2,21
review 137:15 139:7,12,22 141:13 145:5 163:12 169:15 170:18,24,24 178:2,12 187:16 191:2 192:14,23 193:23 194:1,21 195:6 197:20 200:23,24 201:4 208:3 210:21 211:24 212:14 212:16,22 224:24 238:10 240:13 251:3 260:7
reviewed 132:1 132:7 148:7 158:2 163:23 164:14,17 189:17 207:25 213:1
reviewing 164:2 164:6 193:25 235:25
reviews 189:23 228:15 238:6
revise 172:8
revisions 195:18
rh 125:3
richmond 126:4
rick 188:14
rides 235:1
right 132:22 141:20,24 147:10 148:22 185:9 199:7 200:5 201:14,17 202:13 204:20 212:14 215:10 215:16 220:9 227:18 230:20 232:23 241:18 242:20 248:12 251:24 257:13
rights 219:17
risk 194:25
rivaux 126:8
rivera 188:23

rl 126:23
robust 140:23 140:24 141:3
role 134:9 163:17 166:14 182:14,16 250:8
romina's 133:20
rotate 225:3
rothstein 246:17,23,24,25
rough 257:14
route 255:12
routed 163:13 170:1 255:8,9
routes 255:6
routing 127:12 162:15 163:7,9 169:8
rule 128:14,16 132:17 164:24 165:4,5,23 166:15,19 167:1 167:1,4 168:8 168:11,13,24 169:7,25 170:1 170:3,4,10,19 170:20 171:6,21 171:23,24 172:5 175:19 180:2,4 180:10,12,16 181:18 182:12 190:6 195:19 200:6 209:13 214:12,13,13,21 214:22 215:8 217:16 219:25 222:15,16,18 223:1,1 224:14 233:17,18,20 234:1,3,6 235:20 236:16 237:11,12,25 239:6,18,25 240:22 245:6 260:17,17
rule's 198:5 213:11
rulemaking 166:23 167:20 168:19,21 233:12,13
rules 169:10,11 170:12 171:25 172:2,15 212:24 214:13 220:4 234:8,11,11,13 260:12
ruling 243:3
run 132:13 252:23
runs 202:15

s

s 126:20 128:1 260:13 261:3
safe 217:6 221:24 225:6 242:11
safely 225:11
sake 217:24
salaried 138:17
save 152:4
saw 153:17,17
saying 152:20 152:21 188:6 190:9
says 212:13 216:5 227:4,23 228:17 236:19
schedules 156:1
scope 136:12
scroll 211:7,9
se 242:4
seal 258:13
search 153:19 153:20
seated 174:16 176:4
seating 175:1,17 175:22 176:23
seats 175:11
second 146:24 157:19 195:5 198:8 202:14 210:24 215:11 226:9 253:11 254:14
secretary 129:7 129:13,23 163:16,17 166:7 166:8,12,22 167:6,7 169:16 169:17,19,20 172:13 174:8 176:17 183:3 215:3,4,5,13,13 215:14,16 219:11 222:23 227:20 235:1,2 235:11 255:8,9 255:13
section 146:18 147:15 158:9,11 169:3,12 212:4 233:2 234:11,12
security 174:11 174:13,21
see 144:5,8 146:23 148:3,14 152:1,1,18,19 154:6,10 156:4 156:6,6 162:25 164:21 182:7 194:6,12,14,15 195:8 198:3 210:5 211:7,7 223:23 249:8 256:23,23
seeing 176:2
seems 155:7
seen 142:7 181:18,20
selecting 128:24 174:10
self 197:11 214:22 215:8
semantics 131:16 186:13
send 137:14 145:19 185:5

210:24 213:20 214:7,9,17,25 215:7,7 219:7 222:21 223:5 251:3
sending 202:24 205:11 219:17 223:9 229:15
senior 167:24
sensationalist 190:10 192:18
sense 250:17,18
sensitive 176:4 182:3 187:24
sensitivities 174:17
sent 204:25 215:14 218:22 219:2,3,20 222:13 232:8
separate 138:12 142:20 164:13 177:22,23
september 157:6
series 127:16 226:21
serve 176:23
serves 227:25
service 139:17 140:2 141:7,20 141:23 143:16 149:23 150:6 151:7 152:3 154:25 155:15 155:17 159:16 173:8 203:24 204:12 223:15 225:1 228:15 231:1 237:17 238:22 240:11 240:14,23 241:1 241:4,6 245:19 245:21,25 246:1 251:9,19
services 127:18 148:23,24 149:3 151:3 154:24 155:25 156:12 171:2 185:17,19 187:13 191:13 204:18 205:2 208:22 218:10 218:13 220:2 221:3 222:17,17 225:13 236:11 236:12,15 237:4 237:6,9 238:3 239:11,16 240:24,25 241:2 241:8,12 242:22 243:5,17 245:24 246:5,16 247:4 252:3
session 253:11
set 157:12 213:8 254:12
sets 254:10,11
seven 137:23
several 216:14 240:19
sex 161:24 171:7 186:7 191:24 208:11 243:10 245:24
sg 256:7,7
shani 126:8
shantice 230:16
share 144:20 249:23
shared 249:7
shaw 126:9
sheena 172:12 172:14 176:16
sheeran 130:14 135:24
sheet 177:4 260:9,10
shorthand 259:7
show 179:23 187:23 210:12 247:14
showed 243:12
showing 226:8
shows 235:23
side 154:8
sign 127:16 163:15 165:20 169:6,13,15,17 169:18,19 177:3 177:6 221:8 260:9
signature 186:23 258:18 259:19
signed 163:16 163:17 165:12 166:1 169:11 260:13
significance 231:16
signing 257:20
similar 155:21 156:4 199:2
simone 126:5 148:19
simple 150:3
simplistic 187:22
single 158:10 190:8
sit 179:2 189:19
situation 218:25 225:13 237:8 239:2
situations 240:13
six 191:4 240:20 244:24,25
size 174:23,25
skim 193:2
skip 226:11
slogan 181:1,9 181:12,23 183:7 183:9,13,16,20 183:21 184:6,7 184:9,12,16,20

185:4 186:21
slogan's 185:25
slogans 181:17 184:13 186:18 186:25 187:4,10
slow 209:19
small 170:10 192:7 224:16 243:8
smaller 224:8
smatterings 144:15
smc 229:7
smmc 127:14 214:2
snapshot 197:11
snippets 146:12
society 133:19 134:1 161:8,10 161:13,19,21,22 162:1 190:18
solutions 137:15 260:16
somebody 234:19 256:4
somebody's 196:17
sophia 189:8
sorry 131:21 133:11 135:25 137:3 166:2 195:3 207:18 211:8,14 226:11 226:11,12 229:9 231:24 246:25
247:3 249:12
sort 141:17
sought 238:15 239:16 256:17
sound 170:7
sounds 192:22 229:1
sources 144:6,9 147:14,18,22 222:2
southern 126:6
span 164:18
speak 128:5 136:18 143:7 167:10 223:6 228:2 236:17 238:7 256:7
speaker 177:3
speakers 182:17
speaking 132:12 133:10 144:18 144:19 171:6 180:9
special 229:8
specialized 140:14
specially 251:7
specific 166:2 183:20 202:23 233:24 234:13 236:7,7,25 242:20
specifically 131:15 235:18 238:17
specifics 147:5
specify 245:19 246:4
spell 148:9
spends 157:2
spent 157:2 159:8,9,11 177:17
spirit 233:21,23
spite 226:2
split 156:9 190:2
spoke 198:19
spreadsheet 152:10 153:1
staff 143:5 174:7,8,11 176:21 177:5 180:18,19
staff's 181:5
stamp 201:18 201:21 202:7,8 221:7 226:16
stamped 201:15
stance 131:2 132:24,25
stances 152:18
stand 197:15 203:5
standard 161:17 162:4
standards 157:7 157:11,12 204:10
start 133:11 163:8,9,19 164:2,5,5,7 169:9 213:25 227:21
started 146:19 157:19,22 189:20 193:25 227:10
starters 186:4
starts 169:9,10 217:5
state 125:20 127:11 149:6 150:23 152:5,8 153:4,5,7,16,16 155:15 234:14 245:15,18,23,24 245:25 246:1,4 246:14 258:5 259:2
state's 154:1 187:1
stated 147:12 154:19 214:12 223:9 261:19
statement 147:16 156:20
statements 152:20
states 125:1 149:15 152:16 154:6,8,11,12 154:13,21 155:2 155:3,8,8,9,12

156:4,7,7,11,15 156:19,21,25 185:13,14 235:19
statewide 154:9
status 250:10
statute 127:17 206:1 209:18,24 233:2,7 234:2,3 234:6,17 235:18 235:21,24,25 236:3,4,6 260:12
statutes 234:6,9
stay 151:25
stayed 145:3
steeped 132:19
stephanie 227:3
stevens 188:14
stickers 181:12 181:23
stimulator 251:11
stones 198:14
stood 191:19 250:10
stop 220:2
stories 148:17 176:2
straight 138:2 222:19 239:2
straightforward 223:2
strategy 214:21
street 126:4,12 126:14,20
strike 159:9
studies 160:14 194:2,7,15,18 196:1 197:1,6 251:4
study 196:1,2,3 196:6,12
stuff 137:14
style 145:8
subcontractors 138:18,22 139:5 139:20 140:4,5 140:12 217:11
subject 140:8 142:6 150:12 176:4 209:12 226:24 234:1 235:11,20
subject's 143:23
subjective 197:11
submit 205:7 206:15
submitted 190:23 200:24 206:10
subpart 233:25
subscribed 139:13
subscription 139:15,17
subsequent 227:7
substance 190:13
substantial 234:16
substantiate 171:5 173:5
substantive 145:11,12 146:3 184:3 189:22,22 190:21 193:3,5 193:9,19 194:2
subtract 138:3
sudden 198:12
suffer 223:22,22
sufficient 156:23 158:4 162:11 175:13 204:9 210:7,10 210:11 222:15 222:25
sufficiently 202:10
suggested 145:23 260:11
suitability 129:5
suite 126:9,14 126:20
sunshine 175:9
superfluous 214:15
supervision 259:8
supervisor 163:14 250:3
supplement 149:12
supplemental 131:7
support 160:20 162:11
supporter 180:2
supporting 141:12
supports 162:2
supposedly 187:13
suppressant 229:10
suppression 143:4 154:14,22 161:24 185:20 186:7 207:12,23 223:16
sure 160:15,16 160:20 168:18 172:16 174:10 176:22 191:23 194:16 198:14 199:10 207:20 209:21,21 222:10 226:16 230:23,23 248:5 249:20,22 250:4 253:7
surgeon 134:20
surgeries 161:25
surgery 159:25 171:8 208:16

243:13 245:8 246:1,2,11 248:14
surprised 167:18
survey 149:20 197:8
surveyed 149:15 152:16
susan 226:15,22 227:4 230:4 247:18
sustain 198:12
swear 168:16
switch 244:12 244:15
sworn 128:5 258:11
symptoms 192:9 223:22,25 224:1
sync 165:16 222:9,9
system 150:9 163:13 224:22 228:16 231:7 232:4 247:13
systems 230:25

t

t 128:1 148:10 261:3,3
take 131:7 142:18 154:22 170:21 172:18 174:24 179:23 187:20 190:11 190:21,22 192:3 193:11,22 194:6 244:22 248:3 250:3 255:11
taken 173:24 259:6
takes 132:1,1 169:23
talk 162:13 166:23 167:4 200:3 248:17 256:14
talked 158:25 199:23
talking 128:11 128:16 131:16 133:3 147:11 152:2 167:3 170:3 173:10 178:22,24 179:1 208:4 211:22 218:6 225:6 232:10 240:20 242:25 243:2 252:14
tallahassee 125:17 126:20
tamayo 129:14 129:24 135:2,25 135:25 166:9
targeted 185:25
taste 162:23
taxpayer 150:9 150:23
team 183:11 253:13
technical 146:2 216:23
technological 178:25
technologies 231:2
tell 157:22 160:7 208:20 209:4 211:1 241:10 250:9
template 203:1 226:10 254:12 254:15,16
ten 154:18
term 157:8 205:8,10
terminated 245:4,7
termination 201:11 203:10 203:11
terminations 200:20
terminology 146:1 147:2,5 187:25 234:5
terms 173:13 187:22 238:7
terribly 190:20
territories 152:17,17 155:12
test 151:11
testified 128:6 254:23 255:3
testimony 254:21,25 256:25 260:8,12
testosterone 192:5 203:19 223:23 224:16 225:16
tests 250:25
texas 153:10,10 153:14,15 194:11
text 161:22
thank 212:9 213:6 226:17 252:10 254:19
that'd 137:23 210:11 218:16
theirs 130:16 184:25
theme 144:17
therapy 143:4 154:22 171:8 207:12,23 208:11 223:16 228:2 229:9 243:10 244:3
thesis 160:18
thing 162:23 187:15 197:21 198:5,16 216:6 225:8 252:20

things 144:9 148:6 155:24 160:15 165:16 178:20 186:24 192:20 197:24 198:15,18 222:12 230:3 236:22
think 129:6,11 129:12,13 131:15 134:3 135:5,23,23,24 135:25 142:5,17 142:23 144:16 145:22,23 146:22 151:10 152:7,17 158:19 159:2,3 160:23 162:18 163:3 166:4 171:17,18 172:12,13,13,14 172:15 173:14 173:18 174:5,6 174:8,8,19 176:19,20,21 177:3,4,4,23 178:25 179:24 180:3,5,6 181:3 182:16,16,17,22 183:10,10,10,11 183:12,12,22 184:7 186:13,13 186:25 189:18 190:15,18 192:24 193:11 194:19,20 195:9 197:6 198:24 201:16,17 202:9 204:7 205:15,16 205:22 207:5 208:9 209:25 210:1 212:5,6 215:2,10,24,25 216:3,8,22 222:7 225:21,24 232:13 236:18 242:11 244:5,5 244:25 246:25 247:13,23,23 249:18 250:22 250:22,23,24 251:5,10,11,13 252:19 255:12
thought 216:10 218:23 222:25 223:1
three 128:8 171:1 176:17 177:24 189:24 199:11
time 125:15 128:8 129:13 135:2 139:14,18 142:17,18,21,23 142:25 149:19 157:13 158:17 158:20,22 159:1 160:5,9 165:23 169:3 170:21 171:14 177:5,17 177:17,19 187:20 193:12 197:11 199:12 199:15 215:12 215:13 219:21 222:8,23 224:9 227:13 228:6 232:14 240:20 240:24 243:16 244:9 246:15 247:10 248:7,10 248:16 250:6 252:21,23,25 253:1,21 254:2 257:8 259:6
time's 170:24
times 137:10,23 144:10 158:19 158:20 208:20 233:14 252:3
titled 221:4
titrate 223:15
today 152:8
together 152:25 190:4 193:10
told 183:19 257:14
tom 227:20
tomorrow 257:15
ton 153:9
took 132:24 168:22 243:3
tooth 193:25
top 202:4
topic 142:22 144:4
topics 172:20
tordoff 194:22
tossed 199:5
total 137:21 158:25
totally 186:5
touch 200:2
touched 135:5
touches 184:2
touchscreen 211:8
touchy 142:6
tough 228:11
towards 138:3
tracking 127:12 162:16 163:7
traditional 141:18
transcript 260:7 260:13
transcripts 260:10
transition 220:24 222:1 224:8
translated 259:8
translation 230:3
transmittal 127:15 211:19 211:20 213:15

213:17,18,20 214:2,7,16 215:1,9,19,25 217:4,15 219:3 219:15,18,19 220:8 222:10
transmittal's 214:15
transparency 184:17 186:25 187:11
transparent 161:13 233:14
transportation 175:13
travel 177:19 178:24 179:1
traveling 177:18,19
treat 171:8,11 171:12 223:20 224:9 228:23 229:9 238:17 243:22 245:3
treating 131:21 131:22 132:16 132:21 192:11 224:1,3
treatment 127:18 131:3 132:6,12 141:11 154:14 157:2 159:7 160:8 161:23 171:16 185:22 188:4
190:25 191:8,18 196:20 200:16 201:11 204:18 204:24 205:19 206:12 207:12 207:23 208:12 208:17,22,23 209:8,13 217:8 217:12,14,18 218:8 222:1 223:18 225:10 226:24 229:10 237:3 242:17,23 243:11,13 244:4 244:17,19,20 245:9 247:16 248:14 252:11
treatments 155:5 185:8 227:14
trials 197:16
trouble 148:20 150:2
troy 188:19
true 205:13 241:8 250:12 259:9 261:20
trust 224:2
truth 128:5,5,6
try 148:3 150:15 156:4 163:10 254:2 256:22,25
trying 164:2 185:5 197:9 229:13,23
233:24 247:12
tuning 216:24
turban 148:8 194:19
turn 198:21
turned 151:22 250:2,19
turning 129:1 159:6 195:3 199:7 200:5 232:23 235:17 242:20 248:12
turnout 175:23 175:24 176:6
two 129:24 130:4,10 131:9 155:23 164:18 189:21 194:8 211:11 215:22 233:25
type 179:20
types 171:1 195:23 199:23 201:10 240:12
typical 166:14

u

u 148:10
uf's 190:19
uh 127:23,23,23 142:16 143:2 149:25 158:7 164:20 190:1 200:10 217:9
ultimate 191:10 194:5
unable 149:12
unanimous 156:13
unconstitutional 199:3
under 138:12 141:23 149:22 155:15 172:2 173:1,8,21,23 177:5 185:17 186:23 217:16 221:5 232:24 233:25 234:8,12 234:16 236:11 236:11,14 237:1 238:18,20 240:21 256:13 256:21 259:8 260:12 261:19
underlying 194:1,18 233:20 234:2 235:18,21 235:24
undersigned 258:9
understand 158:15 164:3 187:19,25 188:6 228:12
understanding 207:21 233:9 250:7 255:4
undertake 139:7,22 143:8

undertaking 197:20
undertook 151:1
unfamiliar 136:19
uniform 204:4
union 156:7
unique 151:5 180:23
unit 169:11 172:2
united 125:1
units 167:20
university 190:17 193:1 194:7,9,10
unnecessary 216:8
unruly 174:20
unturned 198:14
unusual 137:16 170:5
update 157:14 168:2 248:25 250:5
updated 227:7 249:10,21
updates 230:25 254:14
ups 158:2
upset 174:20
use 133:12 136:6,9 140:4 153:24 185:20 190:5 211:11 214:20 224:20 228:2,5 237:24 239:20 242:16
used 131:10 141:19 171:15 186:19 201:10 222:11 227:25 246:10 260:13
using 135:7 138:14 186:22 186:23 193:6
usual 137:2,6,8
usually 138:17 149:10,16 155:16 163:10 163:10 175:20 196:22 225:1,2
utilize 214:20

v

v 126:19 195:9 260:1
valid 159:2
valuable 140:16
van 128:12,21 135:11 136:7 145:20,23 177:16,16,18,18 178:25 179:1 180:5,6 183:4,5
variance 205:25 209:17,24 212:1 212:3,7,10 233:16,19,22,25 234:19,25 235:3 235:13,19,23 236:1,10,14 237:1,9,12,13 238:2,6,6,8 239:4,20,23 240:2,18 241:13 241:20 242:8,15 254:20,23 255:2 255:18
variances 206:6 232:23 234:10 235:7,15 236:18 240:9,12 241:9 242:6 255:11
various 153:16 213:2 236:22 240:19
vendor 131:20 137:1 138:20,24
venue 174:10,22 175:14,17
verbal 134:2,4 135:13,18 136:3
verbally 147:9 183:18
verbiage 227:8
verified 244:13
verify 202:21 256:10 260:8
veritext 260:10 260:16
veritext.com 260:10
version 157:7
versus 159:9
vet 228:9,23
veto 219:17
vetted 228:6
vetting 228:10 228:20 229:4,14
video 128:7 199:11,14 248:6 248:9 257:6
videographer 126:23 128:7 162:24 199:11 199:14 248:6,9 252:22,23 253:3 253:15,17,20 257:3,5
videotaped 125:12
viewed 142:21
viewing 254:13
views 219:5
violate 173:1 248:13
violated 235:5
visibility 175:16
vogel 126:19
volume 125:11 191:5
vouch 250:15
vs 125:7 260:5 261:1

w

w 125:18 258:20 259:4,21
wait 165:19 169:20,20 198:8
waive 257:19
waiver 205:25 209:17,24 212:2 212:10 233:22 233:25 235:13 235:23 236:1,13 237:8 238:15,19 238:24,25 239:20 240:21 240:22 242:16 254:20,23 255:2 255:18
waivers 232:23 234:10 235:7,19
wall 126:12
wallace 163:18 227:20
want 146:23 148:3 149:9 150:19 152:12 154:6 159:20 160:20 179:21 187:8,8 188:4 190:21 192:24 198:13 207:20 209:3 210:23 212:5 214:1 238:7 248:17 251:25 253:5 254:7 256:10
wanted 129:4 160:16 172:17 175:9,11 179:12 179:15 183:1 187:18,21,21 188:2 190:7 191:22,25 222:10 252:20
wants 216:25 234:19 240:15
warranted 193:3
warriors 188:16
watch 144:3
way 136:19 156:20 159:18 176:5,24 210:2 213:8 251:24
ways 196:5
we've 149:19 173:4 186:22 199:8 200:7 203:2 222:14 241:6 248:18 251:2,25 252:3 252:14 253:1
weak 141:11 161:15,15
wean 192:7
weaned 192:2
web 153:5 154:12 184:16 186:11 187:12
website 185:2,3
websites 154:2
week 146:24 157:19 184:3,8 230:9
weeks 184:5
weida 125:8 129:7,13,23 163:16 166:8 172:13 174:9 176:17 183:4 213:23 215:3,4 215:4,4,5,11,14 219:11 222:23 260:5 261:1
weigh 155:16
went 146:9 152:11 153:5,15 163:15,17 192:20 218:9 219:25 229:7 249:6
whatsoever 189:22
whoever's 250:6
wholly 181:9
williams 226:15 226:22 230:4
wilson 227:16
window 163:11 163:11
winthrop 126:9
withdraw 223:12 225:16
withdrawal 192:1,9 220:15 220:18,22 223:22 224:1,1 224:16
witness 127:1 128:4 130:3 133:3 152:16 155:19 162:22 163:1 203:7 210:20 211:5,9 211:15,22 213:2 216:14 221:11 257:19 258:10 258:13 260:8,8 260:9,13
wol 145:20
wondering 191:12
word 147:7
words 195:14 196:21 229:14 245:20
work 138:6,8 157:15 158:9 160:18 169:23 213:6 216:3 230:4,6 256:16 256:24,24
worked 154:4 158:5 183:12 216:23
working 128:19 129:11 140:10 149:20 157:17 157:23 184:8 215:23 250:6

works 147:15 150:7 158:10
world 163:3
wound 195:16 195:25 197:22
wounded 195:24
wpath 160:22 161:6
wps 157:7
write 129:9 135:15 168:2 202:4
writing 147:21
written 132:17 134:5 135:19 209:23 231:14 251:8
wrong 228:25
wrote 129:1 135:10 136:15 146:15 190:19 190:20

y

yale 190:17 193:1 194:7,8 194:10
yeah 130:7 137:4 146:25 147:21 152:11 153:20 158:4,22 162:22 164:7,22 166:25 168:1,15 168:17 169:21 170:21 180:15 180:15 186:22 186:24 187:23 187:24 193:6 194:3 197:17 204:16 207:6,9 207:17 210:16 210:16,16,20 211:15 215:21 217:24 220:5 221:19 222:6,6 226:14 227:15 229:11,17 230:11 237:25 238:5,21 239:5 239:6 240:17 241:10 242:1 243:12,20 247:17 249:5,18 250:10 251:17 251:23 253:1 254:16 256:3
year 144:17 245:1
years 196:24 251:22
yep 211:21
york 126:13 144:10 155:23

z

zero 207:5 208:24 209:2
zoom 178:16 257:3

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.

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

AUGUST DEKKER, et al.
Plaintiffs,
vs. NO. 4:22-CV-00325-RH-MAF
JASON WEIDA, et al.,
Defendants.

VIDEOCONFERENCE DEPOSITION OF
G. KEVIN DONOVAN, M.D., M.A.
LOCATED IN SAND SPRINGS, OKLAHOMA
TAKEN ON BEHALF OF THE PLAINTIFFS
ON MARCH 22, 2023

REPORTED BY: JANA C. HAZELBAKER, CSR

A P P E A R A N C E S

(All parties are appearing via videoconference.)

For the Plaintiffs:

Chelsea Dunn
Simone Chriss
Southern Legal Counsel, Inc.
1229 N.W. 125th Avenue
Gainesville, FL 32601
(362)271-8890
chelsea.dunn@southernlegal.org
simone.chriss@southernlegal.org

and

Carl S. Charles
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square
Suite 105
Decatur, GA 30030
(404)897-1880
ccharles@lambdalegal.org

For the Defendants:

Michael Beato
Holtzman Vogel Barantorchinsky & Josefiak PLLC
119 S. Monroe Street
Suite 500
Tallahassee, FL 32301
(850)270-5938
mbeato@holtzmanvogel.com

C O N T E N T S

	Page
Index of Exhibits	4-5
Stipulations	6
Direct Examination by Ms. Dunn	7
Cross-examination by Mr. Beato	281
Jurat Page	284
Reporter's Certificate	286

* * * * * *

PLAINTIFFS' INDEX OF EXHIBITS

	Page
Exhibit 1 (Expert Declaration)	12
Exhibit 2 (Bibliography)	13
Exhibit 3 (Curriculum Vitae)	27
Exhibit 4 (Ethical and Religious Directives)	34
Exhibit 5 (Why Religious Health Care Restrictions Often Take Patients by Surprise)	38
Exhibit 6 (Press release issued by the Catholic Medical Association)	56
Exhibit 7 (Professionalism in Pediatrics 2007)	76
Exhibit 8 (The Disabled and Their Lives of Purpose)	76
Exhibit 9 (Ebola, Epidemics, and Ethics)	88
Exhibit 10 (Beneficence in Utero) ...	89
Exhibit 11 (Bioethics website)	89
Exhibit 12 (How We Should Conceive of Creation)	93
Exhibit 13 (Laidlaw, Cretella, and Donovan article)	100
Exhibit 14 (Homosexual Parenting: A Scientific Analysis)	114
Exhibit 15 (Psychotherapy for Unwanted Homosexual Attraction Among Youth)	115
Exhibit 16 (CMA Resolutions)	117

* * * * * *

PLAINTIFFS' INDEX OF EXHIBITS

	Page
Exhibit 17 (Williams Institute report)	149
Exhibit 18 (Littman Correction)	157
Exhibit 19 (Neurobiology of Gender Identity and Sexual Orientation)	160
Exhibit 20 (Abbruzzese Article)	171
Exhibit 21 (PDF of Texas Planned Parenthood website)	181
Exhibit 22 (Clayton Article)	183
Exhibit 23 (Robbins Article)	186
Exhibit 24 (Levine Article)	188
Exhibit 25 (App G to GAPMS 236-244)..	210
Exhibit 26 (Medicaid Coverage for Gender-Affirming Care)	213
Exhibit 27 (Swedish Guidelines)	245
Exhibit 28 (Washington Examiner article)	257
Exhibit 29 (CNN article)	260
Exhibit 30 (Email dated May 12, 2022)	276
Exhibit 31 (Draft Report)	277

* * * * * *

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that the videoconference deposition of G. KEVIN DONOVAN, M.D., M.A., may be taken on behalf of the Plaintiffs, on MARCH 22, 2023, located in SAND SPRINGS, Oklahoma, by Jana C. Hazelbaker, Certified Shorthand Reporter within and for the State of Oklahoma, pursuant to Notice.

IT IS FURTHER STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that all objections, except as to the form of the question, are reserved until the time of trial, at which time they may be made with the same force and effect as if made at the time of the taking of this deposition.

* * * * * *

G. KEVIN DONOVAN, M.D., M.A.,
having been first duly sworn at 9:03 a.m. CST,
deposes and says in reply to the questions propounded
as follows, to wit:

DIRECT EXAMINATION

BY MS. DUNN:

Q So, good morning, Dr. Donovan. As I mentioned before, my name is Chelsea Dunn. I'm an attorney for the plaintiffs in the lawsuit Dekker, et al. versus Weida. I will be deposing you today. I work for an organization by the name of Southern Legal Counsel.

If you don't mind just introducing yourself and stating and spelling your name for the record, I would appreciate it.

A Yes. My full name is Gerard Kevin Donovan. G-e-r-a-r-d, K-e-v-i-n, D-o-n-o-v-a-n.

Q Thank you, Dr. Donovan. Just as an initial question, have you ever been deposed before?

A Yes.

Q Okay. I'm going to go over a couple ground rules, just so that we're on the same page for expectations today and that there's no confusion.

The court reporter here is writing down everything you say, so if you can respond to my

questions using verbal answers, for example, yes or no instead of shaking your head or nodding, that would be a lot -- it's a lot easier for her to transcribe our conversation today.

We also -- I think in natural conversation people have a tendency to start answering a question sometimes before it's done, so if you can be careful not to speak over me or to begin answering my question until I finish it, I will try to do the same and not talk over you as well. Is that fair?

A Yes, ma'am.

Q You're welcome, as we mentioned before, to take a break at any time. Please just answer -- if you'll finish answering the question that's on the table before you request a break, that -- you know, that -- we would ask that you finish answering the question before we take a break.

You can also speak to your attorney at any time, but, again, please finish answering my question unless there is an issue of privilege.

You can also -- if you, later in the deposition, realize that you gave an answer earlier that wasn't full and complete, you're welcome to supplement your testimony. Or if you realize that you were mistaken, you can also correct your

testimony, please just let us know.

You can also ask for documents to refresh your memory as to something. So if there's something that would help your memory, please let us know what that is.

Have you taken any medications today that would affect your ability to answer my questions truthfully and fully?

A No.

Q Are you ill or is there anything else going on that would affect your testimony today?

A No.

Q The oath you've taken that the court reporter provided is the same oath that you would take in a court of law. So do you understand that you are testifying today under penalty of perjury?

A Yes.

Q And your oath is to answer, not just truthfully, but also the whole truth. So do you understand that you're expected to give full and complete answers today?

A Yes.

Q Thank you.

Before we begin, I just want to talk a little bit about the topic of our deposition today.

So this case is about healthcare that is commonly used to treat individuals -- I'm sorry, to treat gender dysphoria for transgender people. We refer to that sometimes as "gender-affirming care." Are you comfortable with my use of that term?

A You can use any terminology that you want.

Q And if I refer to gender-affirming care, do you understand that that means, for example, medical treatment such as the administration of cross-sex hormones, gender-confirming surgeries, or puberty-blocking medications?

A I do.

Q Have you been retained as an expert witness by the defense in this case?

A Yes.

Q And you understand that you -- your report was submitted to the Court by the defendants as expert testimony in order to advance their case against the plaintiffs?

A Yes.

Q And what expert testimony were you specifically asked to provide in this case?

A I was asked to testify as a medical ethicist.

Q And what opinions were you asked to

provide?

A Opinions about the propriety of the gender-affirming care.

Q And what are your opinions as to the propriety of gender-affirming care?

A I think it's problematic.

Q And when you say "problematic," what do you mean?

A I mean I think that there are some problems regarding the approach, the diagnosis and treatment approach.

Q Can you explain what problems you believe there are with the diagnosis and treatment approach for gender-affirming care?

A Well, geez, that's a lot, but then we have hours, don't we?

I think that the -- that there are problems in the concept.

I think there are problems in the application of that concept to a diagnosis for individuals.

And I am aware of problems that have been identified by many others, in terms of the treatments themself and the justification for them.

Q When you say problems identified by

"others," who are those others?

A Oh, they're in the literature.

Q Your opinions are fully set forth in your expert declaration that was signed on February 15th, 2023; is that correct?

A I believe so.

Q So I will pull up that document so that we can both confirm.

(Document is displayed).

Can you see the document labeled "Expert Declaration of Kevin Donovan, M.D., M.A."?

A Yes, I can.

Q Is this your expert report?

A Looks like it.

Q Do you need to review it to be sure?

A No, no. Let's just go ahead.

Q Okay. I'll just quickly scroll down to where your signature is.

Can you confirm that you signed this document?

A It looks like it. Thank you.

(Whereupon, Exhibit Number 1 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So I would like to ask that

this be marked as Plaintiffs' Exhibit 1.

Did anyone besides you contribute to writing this report?

A No.

Q Did anyone besides you edit this report?

A I don't recall. I know I submitted it to the defense attorneys and I don't think that they -- they may have edited something on it for clarity. I'm not sure.

Q And when you say you "submitted it to defense attorneys," who did you submit it to?

A Well, I sent it in to -- to Gary Perko or Michael Beato or somebody in that group.

(Whereupon, Exhibit Number 2 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to stop sharing this document and I'm going to show you a document that was provided to us as your bibliography for your report.

(Document is displayed).

Dr. Donovan, do you recognize this document?

A It looks -- I think so, yeah.

Q And is this a document that you prepared?

A Yes.
Q And what -- what is it?
A I'm sorry?
Q What --
A It's a bibliography.
Q And it's a bibliography for -- for what?
A In reference to my previous paper.
Q And so this is a bibliography of the sources you considered and relied upon in the expert declaration that we marked as Plaintiffs' Exhibit 1?
A Yes.
Q And this is -- I'll -- this exhibit will be marked as Plaintiffs' Exhibit 2.

This document was not originally sent along with your report; is that right?
A Correct.
Q So this was provided upon request by plaintiffs' counsel?
A Yes.
Q Are these all of the sources you relied upon in preparing the report and expert declaration that was marked as Plaintiffs' Exhibit 1?
A That would be difficult to say because so many things I rely on are also part of my own expertise. But in terms of articles, I think that's

a reasonable summation.

Q Are there any other sources you can identify that you relied upon for your expert declaration that is not listed in this bibliography?

A No, not at present.

Q When did you first become aware of this case, Dr. Donovan?

A Some months ago.

Q Can you give us an estimate of perhaps the time of year?

A I'm trying to think when I first was contacted. It was -- it was probably -- I'd have to go back and look. It was probably in the fall or something. Or, no, it was probably the end of summer.

Q End of summer.

And do you recall who contacted you?

A I believe I got an email from Gary Perko asking if I would be willing to help them with the case.

Q When were you formally engaged as an expert witness in this matter?

A If I can -- I think I've got this handy.

MR. BEATO: Dr. Donovan, just from your memory.

THE WITNESS: Oh. Sometime in the fall.

Q (By Ms. Dunn) Have you been contacted by Holtzman Vogel previously to be an expert witness in any other matter?

A No.

Q You also prepared a report to support the Florida Medicaid rule prohibiting coverage for gender-affirming medical treatments; is that right?

A Yes.

Q That report was an attachment to a, quote, "generally accepted professional medical standards" report prepared by the agency for healthcare administration?

A I believe so.

Q All right. So a couple of those terms that I just used are terms where we frequently use abbreviations.

So when I refer to GAPMS, G-A-P-M-S, I'm referring to Generally Accepted Professional Medical Standards, which is a -- it's a standard employed by the Agency for Healthcare Administration of Florida.

When I refer to AHCA, that's A-H-C-A, and that stands for Agency for Healthcare Administration, and that is the Florida Medicaid agency who is the defendant -- one of the defendants in this case.

Do you understand that?

A Thank you. Yes.

Q And if you -- if you later in the deposition can't recall what those acronyms mean, please feel free to ask for clarification.

A It's almost certainly going to be needed.

Q Okay. Who contacted you to provide your report in support of the AHCA GAPMS memo?

A Someone from -- I believe it was the health department in Florida.

Q Do you remember the name of that individual?

A No, I'm sorry, I don't.

Q I apologize. I have a sinus infection, so I might cough occasionally.

Do you recall any -- the names of any other individuals at AHCA that you worked with in providing and submitting the report for the GAPMS memo?

A I think there was only, like, one or two names. And, no, I'm sorry, I don't -- I don't have those in my head.

Q You don't recall them. Okay.

Do you know how the agency got your name in order to contact you about that report?

A It must have been suggested to them by

someone else, but I'm not sure.

Q What did you do to prepare for today's deposition?

A I re-read some of the things that I had submitted, as well as some other articles on the topic.

Q And when you say you "re-read things you had submitted," which things that you submitted did you re-read?

A The two that you've just mentioned. Perhaps I should be -- re-familiarize myself with what I said.

Q And so that would include the expert declaration that we marked as Plaintiffs' Exhibit 1?

A Yes, ma'am.

Q And that also includes the report you submitted to the Agency for Healthcare Administration in support of its GAPMS process?

A Yes.

Q You said you reviewed some other articles in preparation for today. Which articles were those?

A Oh, about perhaps a dozen different articles, including the one I just saw in the British Medical Journal yesterday.

Q Can you please clarify what article that

was?

A Well, fortunately, that one I can tell you because it's still sitting here.

It was entitled "BMJ Investigation: Gender Dysphoria in Young People is Rising and so is Professional Disagreement," by Jennifer Block.

Q All right. What other articles have you reviewed?

A Well, certainly articles that I'd already used to -- to compose my various expert witness and expert opinion papers.

Q That --

A And other things -- and, quite frankly, other things I just kind of peruse randomly, so I didn't really make notes of which they were. I probably have -- some of them were online and some of them I actually have as printouts from an old file. And I -- I couldn't tell you specifically.

I also was sent the -- some of the forms or reports from the attorney's office, and of course I reviewed those as well. But some of those --

Q What --

A -- were some of the things we've just been talking about.

Well, the -- the expert witness

declarations from the people on the plaintiffs' side.

Q Which expert declarations from the plaintiffs' side did you read?

A Karasic and Antonnaria.

Q Were there other expert declarations in this case that you reviewed, including any of the defendants' expert declarations?

A I'm sorry, there was a third one from the plaintiffs' side, but it seemed to have so little to do with what I had been talking about. I'd have to go back and see who that was by.

And I actually didn't have a -- an opportunity, because I got them so late, to look at all the defendants' declarations.

Q Did you look at any of the defendants' declarations?

A Not in depth, no.

Q Did you review even briefly any of the defendants' declarations?

A Probably. Probably.

Q Do you recall --

A But because they were -- yeah, not -- I cannot specifically recall because they just were parallel to what I was focusing on and didn't overlap that much.

Q Did you have any meetings with anyone in order to prepare for today's deposition?
A We had about a 10- or 15-minute meeting with the defense attorneys.
Q Which defense attorney?
A I think it was Gary Perko and one other in the room.
Q Did you talk or speak with anyone else about your deposition in preparation?
A My wife.
Q I'm sorry, I was getting some background noise on my laptop I wanted to get rid of.
So you earlier mentioned that you had some things right beside you that you had used to prepare for today. What are those things?
A Oh, the -- I'm trying to make sure I have the right -- my expert report.
The -- the "Ethicist's View of Transgender Treatment for Children" that I had sent in.
And, actually, I was just looking at that BMJ article because it had just come out.
Q Are those the only three things that you have?
A Oh, I mean, no. Look at my study. I've got a lot of things in my files, but not things that

I've been looking at this morning.

Q So when you say you have things right beside you, it's merely your expert report, your report that you submitted during the GAPMS process, and the article from the British Medical Journal that you referenced?

A That's -- yeah, that's a pretty fair summary.

Q Is that --

A I mean, there are other things I could find, but that's it.

Q But when you're -- I'm sorry. I'm speaking about the things that you're referencing that are right beside you that you said you could refer to.

Is there anything other than those three documents that I just listed?

A Not currently, no, but I -- like I said, if you need me to, I can find things. They're all close by.

Q Well, so -- so I think what we're experiencing right now is one of the limitations of a virtual deposition, which it's obviously much more convenient because we're all able to be in our own respective locations.

But, generally, if someone were to come to

a deposition with paperwork, we would be entitled to see what that paperwork is.

And so what I'm trying to understand is what paperwork have you compiled in order to use in this deposition? What is sitting beside you that you intended to reference or that you brought with you or -- or put together for the purposes of this deposition?

A Okay. No, I think you've got it then. That was it.

Q Okay. Thank you.

Have you been deposed -- I'm sorry, you told me you've been deposed before, Dr. Donovan. Can you explain to me the circumstances in which you've been deposed before?

A Well, I've been an expert witness for both sides in malpractice trials.

Q How many times have you been deposed before?

A Maybe as many as half a dozen.

Q Is medical malpractice the only subject on which you've been deposed in the past?

A There was one trial in which we were discharging a faculty member with cause and so I testified in that as well. "We" being the

university.

Q But that would be an employment dispute?

A Yes, I guess so.

Q And which university was that that you were working for?

A That was the University of Oklahoma.

Q The malpractice cases that you were deposed in, what types of care were at issue in those approximately six cases?

A I'm not sure what you mean by "what types of care." Medical care.

Q What type of medical treatment was at issue?

A Oh, my background is in pediatric gastroenterology, so those were all associated with that type of care.

Q Okay. So they were all cases related to pediatric gastroenterology treatments?

A Correct.

Q And have you testified at trial in any matter?

A At one of those, yes.

Q Which --

A One of those malpractice cases.

Q So one of the medical malpractices?

A One of the medical malpractice cases went to trial.
Q Were there any other cases that you have testified at trial?
A Not that I recall.
Q Okay. Have you submitted written expert reports in other cases?
A I actually don't recall doing that.
Q Have you -- is it fair to say that you have never provided an expert report previously about the treatment of gender dysphoria?
A Yes, that's fair.
Q Is it also fair to say that you've never testified previously about the treatment of gender dysphoria?
A That's correct.
Q Did you know any of the defendants' other experts prior to this case?
A Personally, no.
Q Had you ever met any of the defendants' other experts prior to this case?
A No.
Q Did you know any of the plaintiffs' experts prior to this case?
A Not personally. I mean --

Q How did you -- did you know them in some other capacity?
A I have seen people at meetings.
Q Has a court ever disqualified you as an expert witness, to your knowledge?
A No.
Q Has a court ever limited the scope of your testimony, to your knowledge?
A No.
Q Have you ever provided testimony in support of the claims of a transgender person?
A No.
Q All right. I'm going to pull up another document, if it will cooperate.
MR. BEATO: Take your time.
(Document is displayed).
Q (By Ms. Dunn) Do you recognize this document, Dr. Donovan?
A Can I see this? Is that the question?
Q Do you recognize the document?
A Oh, yes.
Q And what is this document?
A This is my curriculum vitae that was prepared for Georgetown University School of Medicine.

Q And this is the curriculum vitae that was provided to us, along with your expert report. Do you recall providing it for that purpose?

A Yes.

Q Is this document a complete and accurate depiction of your professional experiences, your curriculum vitae?

A I believe so.

(Whereupon, Exhibit Number 3 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I would like to mark this as Plaintiffs' Exhibit 3.

So I'm going to begin by asking you some questions about your education. So you received your medical education at the University of Oklahoma in the years of 1970 to 1974?

A Correct.

Q And then you received your -- I'm sorry, you completed a pediatrics residency at the Baylor College of Medicine --

A Yes.

Q -- in -- 1974 through 1977?

A Correct.

Q Your fellowship was in pediatric

gastroenterology at the University of Oklahoma from 1977 to 1979; is that right?

A Yes.

Q And then you did an additional fellowship at the National Institutes of Health in the neonatal and pediatric medicine branch?

A Yes.

Q And that was in 1979 through 1980?

A Yes.

Q And then you additionally got your masters in bioethics at the University of Oklahoma in 1994?

A Correct.

Q Why did you return to graduate school in order to get your degree in bioethics?

A I had been asked to be the chair of the ethics committee at our teaching hospital and I thought that I should develop more expertise. And I had a great interest in the topic.

Q And when you say "at the university" or "medical school," are you speaking of the University of Oklahoma?

A Well, I was at the University of Oklahoma, but I took a sabbatical and went to study at Georgetown with Edmund Pellegrino at that time. That's when I began the masters and then completed it

at the University of Oklahoma.

Q But you said you had been asked to chair the ethics committee at -- at where? At which institution?

A At one of our teaching hospitals, Saint Francis Hospital.

Q Okay. I see a hospital. Okay.

Have you received any other medical education besides what we just discussed?

A Well, all physicians receive continuing medical education, so quite a bit of that, but I haven't acquired any other degrees.

Q All right. And you mentioned the Pellegrino Center for Clinical Bioethics. I'm going to scroll down to your reference to your position there.

What is the Pellegrino Center for Clinical Bioethics?

A It is probably best characterized as a think tank in bioethics. It provides education, provides for both students and trainees in medicine, as well as for faculty. It provides ethics consultation in the hospital and pursues scholarly activities, including writing papers.

Q You were the director of that center from

2012 to 2020?

A Yes.

Q And what is that? What did being director of that center entail for you specifically?

A Well, I basically helped with the -- the planning and the activities of the center, as well as the education -- educational activities and the consultation activities in the hospital.

Q In this role, did you routinely work in a hospital where you would evaluate patients for medical conditions and refer and prescribe them for treatment?

A That isn't a part of bioethics.

At the time I was still seeing patients in my medical specialty and so I did consultations there as well. But bioethicists do not directly treat patients. They do respond to consultations from treating physicians, nurses and families to help them sort through ethical issues.

Q And as the director of the Pellegrino Center, were you actively consulting on those types of cases?

A Yes.

Q Did you engage in your clinical practice in pediatric gastroenterology the entire eight years

that you were the director of the Pellegrino Center?

A No. I stopped around 2018. They were short-handed when I arrived, but they acquired more faculty, and I was fairly busy with my primary job.

Q Can you quantify how frequently you would provide ethical consultations as the director of the Pellegrino Center?

A We did it in rotation. We had a team that did it. And I think we were getting maybe 150 or more consults annually.

Q So the center would receive 150 consults total annually?

A Uh-huh. Yes.

Q And how many -- it was on a rotation. How many different individuals from the Pellegrino Center were rotating through those consultations?

A Approximately, four.

Q So would it be fair to say that there were approximately 35 to 40 consultations for each -- each individual?

A Approximately. The problem with the math is that we had a couple of people who didn't take consults as frequently because of their other jobs and others who did it more frequently. I was in the "more frequently" category. But, overall, that's

close enough.

Q The Georgetown University -- I'm sorry, the Pellegrino Center at Georgetown University was established to "fill a unique need for bioethics that's oriented towards clinical medicine and strongly rooted in the Catholic and Jesuit tradition."

Is that a fair description of its mission or purpose?

A Yes.

Q Can you explain what it means to have a program of bioethics that is strongly rooted in the Catholic and Jesuit tradition?

A Well, Jesuits have a somewhat unique approach to education, as you're probably aware. They do like to focus on what they call "cura personalis", or care of the whole person.

The particular approach that Edmund Pellegrino used in the ethical sphere was called "virtue ethics" as opposed to, say, the more -- other approaches. Some would be casuistry, some would be ideological, and some would be -- well, he was also heavily philosophical, although he, himself, was not a philosopher. Several of our members were and had Ph.Ds in philosophy, as well as other things.

Q How does theology interact with ethical challenges that arise in the care of particular patients for ethicists at the Pellegrino Center?

A I'm sorry, could you repeat that? You kind of flaked out a little bit.

Q Yeah, of course.

What role does theology play for the consultants at the Pellegrino Center in assisting with the ethical challenges that arise in the care of patients?

A I wouldn't say that it plays a direct role because, you know, it is theological principles just like philosophical principles. And just ethical principles are always there in the background, in terms of how we assess and -- and work through various cases.

Q Is Georgetown University Medical Center a Catholic healthcare institution?

A Yes.

Q I want to share another document.

(Document is displayed).

Do you recognize this document, Dr. Donovan?

A Yes.

Q What is this document?

A These are the Ethical and Religious Directives for Catholic Healthcare Services, commonly referred to as the "ERDs."

(Whereupon, Exhibit Number 4 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) ERDs.

I'd like to mark this document as Plaintiffs' Exhibit 4.

Is Georgetown University Medical Center -- I'm sorry. Let me -- I'm going to restart that question.

Are ethical consultations and advisements at the Pellegrino Center for clinical bioethics guided by these ethical and religious directives?

A Yes, they are.

Q And are your views as an ethicist guided by this document?

A Yes.

Q Did you rely on this document during your active work as an ethical consultant at the Pellegrino Center?

A Yes.

Q I'm going to turn to Page 9 of the document and zoom in on Directive Number 5.

This directive reads: "Catholic Healthcare Services must adopt these directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the directives for administration, medical, and nursing staff, and other personnel."

Did you follow this directive during your time as the director of the Pellegrino Center?

A Yes.

Q I'm now turning to Directive Number 9 which states that, "Employees of a Catholic healthcare institution must respect and uphold the religious mission of the institution and adhere to these directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good."

As director of the Pellegrino Center and an employee of G Medical Center, are you bound to uphold the religious mission of the institution?

A Yes.

Q And as the director of the Pellegrino Center and an employee of the Georgetown University Medical Center, you had to adhere to these directives as well; is that correct?

A Yes.
Q And you have to adhere to these directives without exception; is that correct?
A I don't know what that would mean.
Q Well, so it means that a doctor at a Catholic hospital can't provide a patient with medical care that is not aligned with the mission of the institution; is that right?
A Yes, I can accept that.
Q So you can't even refer a patient for a type of care that is not aligned with these directives?
A That would depend on the circumstances of the issue at hand.
Q So I'm going to stop sharing this document and open one more.
(Document is displayed).
Do you recognize this article, Dr. Donovan? I'm happy to scroll through it if that would help.
MR. BEATO: Oh, Dr. Donovan, I believe you're muted. Happens to me all the time.
THE WITNESS: Yes, I was muted and also not recognizing it, so it's a twofer.
Q (By Ms. Dunn) This is an article that was published in 538. I'm going to scroll down to Page 6

of this article and I will show you -- here you are quoted in this article.

Is that -- is this "Dr. G. Kevin Donovan, a bioethicist at Georgetown University," is that you that this article is referencing?

A It should be, yes.

Q And so you say here that, "Catholic healthcare institutions need to be careful to ensure that they're not perceived as offering or endorsing a prohibited form of care."

Is that -- do you recall making that statement?

A I don't recall. I must have been interviewed over the phone, but I would agree with that statement.

Q And so would referring a patient for a type of care that is not aligned with a Catholic healthcare institution be consid- -- or be potentially perceived as offering or endorsing a prohibited form of care?

A It would be -- depend on why it's not aligned with the -- with the values you're talking about.

Q Well, let's give an example. Would this include a referral for contraceptives?

A For contraceptives, you really -- well, it also depends on how you're using the term "contraceptive" because, you know, birth control in general is not prohibited, but certain forms are.

Q So it would include referring a patient for a prohibited form of contraceptive?

A Yes.

Q In this article you're referred to as a "Catholic ethicist." Is that something you would label yourself as?

A I don't typically, no, although both words are correct.

(Whereupon, Exhibit Number 5 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I don't think I asked yet, but I would like to mark this exhibit as Plaintiffs' Exhibit 5.

I'm now going to return to the -- what has been marked as Plaintiffs' Exhibit 4, the Ethical and Religious -- the ERDs, as you refer to them.

And we're going to look at Directive Number 3, which is on Page -- and, I'm sorry, I'm going to share my screen in just one moment.

(Document is displayed).

We're looking at Directive Number 3 which is on Page 9.

So this lists certain people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination.

Are LGBTQ people included in this list of people whose social conditions make them particularly vulnerable to discrimination?

MR. BEATO: Object to form, but, Dr. Donovan, you can answer that question.

THE WITNESS: Well, I was -- I was reading the paragraph that she mentioned. And the -- the answer would be they're not specifically listed. They're certainly not eliminated. They would be considered people vulnerable to discrimination.

Q (By Ms. Dunn) But they're not listed here in this list of individuals that the Catholic Healthcare Institution should distinguish itself by service to an advocacy for?

A I don't see them in that particular listing, no.

Q All right. Thank you. So we will move away from this document for now.

I want to go back just briefly to a piece of paper I can't find right now. Here we go.

(Document is displayed).

Are you currently the director of the Pellegrino Center?

A No.

Q When did you leave?

A Just before -- well, during the pandemic.

Q Okay. And why did you leave?

A Well, because I had been doing it for nearly ten years and had already found someone to turn it over to.

Q And so you made the choice to leave that institution?

A Yes.

Q Do you remain on faculty at the Pellegrino Center?

A I am still working part time until the end of this semester.

Q And what does that mean, to be working part time?

A That means that I participate in educational activities and meetings by Zoom primarily, but also write papers with my colleagues and such.

Q How many hours -- are you still currently teaching classes at the Pellegrino Center?

A Not this semester.
Q How recently were you still teaching classes there?
A I had been helping out last semester.
Q And did you teach a full course on your own or would your role have been more of a guest lecturer?
A More of a guest lecturer.
Q When you were the director of the Pellegrino Center, did you teach classes?
A Oh, well, we had classes for medical students, classes for residents, and classes in our master's program, so, yes.
Q And would you be the professor of an entire course or, again, would it be more of a guest lecturer role?
A Both.
Q What classes did you primarily teach?
A For students, it was really just bioethics, medical ethics. It was an ongoing course for medical students throughout the year.
Q So it was just a general bioethics/medical ethics course?
A Yes.
Q Did you do hospital rounds as a treating

doctor at the Georgetown Medical Center?

A I did that in pediatric gastroenterology until I stopped, as I mentioned before.

Q And are you currently a clinical ethical consultant at the center?

A No.

Q When did you stop doing ethical consultations?

A When I was no longer in the vicinity.

Q So when you left in 2020, that would be when your ethical consultation --

A Yes.

Q You also have listed on your resume -- and I will quickly open it. I'm sorry, "resume." Your CV. I'm using the lawyer term.

-- that you are a -- if I can pull it up. Sorry.

(Document is displayed).

-- "senior clinical scholar at the Kennedy Institute for Ethics."

How is that different from being the director of the Pellegrino Center?

A The Kennedy Institute of Ethics is a separate think tank at the other end of the campus and they tend to focus more on philosophical issues

rather than patient care issues.

Q Were the ethics practiced at the Kennedy Institute also aligned with the Catholic and Jesuit tradition of Georgetown University?

A For some --

Q Were they --

A -- but not for all of the faculty, no.

Q Okay. Were they impacted at all by the ethical and religious directives issued by the U.S. Conference of Catholic Bishops that we referenced as Plaintiffs' Exhibit 4?

A Those only apply to hospital practice.

Q All right. And then prior to your work at Georgetown, you were the director of the Oklahoma Bioethics Center?

A Yes.

Q What did this role entail?

A It was a very similar position to the Kennedy Institute.

Q It was more philosophical rather than patient care?

A No, excuse me, I'm sorry, to the Pellegrino Center. No, it was not philosophical, it was teaching students, it was working in the hospital, it was writing papers.

Q So you provided ethical consultants (sic) related to patient care?

A Yes, but not as the director of the Bioethics Center. That was a separate issue for the various hospitals in town, each of which had their own --

Q Okay.

A -- arrangements.

Q So your role as the director of the Oklahoma Bioethics Center was mostly teaching and writing?

A Yes.

Q And any clinical ethical consultations you were doing were in your role at various hospitals?

A Correct.

Q You're also -- later in your CV -- and let's see how quickly I can get here.

(Document is displayed).

Here you list that you're part of the "Dean's conference committee on medical ethics."

What was that?

A Oh, well, the -- the Dean was having us put on little conferences for -- educational conferences on ethics.

Q Okay. So that was just in order to plan

and arrange for educational conferences on ethics issues?

A Right.

Q And you have listed your role as chairman. Were you chairman for all 25 of those years?

A Yes, I believe I was.

Q All right. I'm going to stop sharing temporarily.

So I'd like to talk a little bit about your clinical experience as a pediatric gastroenterologist. So we've -- you have said that before your bioethics appointments your practice primarily focused on pediatrics gastroenterology; is that correct?

A Correct.

Q Can you just give kind of a broad overview of what field of practice that is?

A It concerns itself with the digestive disorders in childhood.

Q Your last position in pediatric gastroenterology was when you were the chief of the division of pediatric gastroenterology at the University of Oklahoma?

A Yes.

Q And that ended in 2012?

A Yes. That's other than the work I -- I also contributed at Georgetown.

Q Okay. So you did do -- I recall now. You said that you did some pediatric gastroenterology work while you were at Georgetown until 2018; is that right?

A Yes.

Q Are you currently working as a pediatric gastroenterologist?

A No.

Q Are you currently teaching any pediatric gastroenterology courses?

A No.

Q Have you ever treated patients experiencing gender dysphoria?

A Not to my recollection.

Q In your report on Page 3 -- so we'll look back. Your report was marked as Plaintiffs' Exhibit 1. So we'll look back at that document.

(Document is displayed).

On Page 3 you say that you "have never prescribed medications nor referred for surgery any patients that consider themselves transgender."

Is that an accurate statement?

A Yes.

Q Is that professional decision guided by the ethical and religious directives of the Catholic Healthcare Services?

A No.

Q You wouldn't -- as a routine matter, you would not have been providing such treatment as a pediatric gastroenterologist; is that right?

A That's correct.

Q And as a bioethicist, you do not typically do routine evaluations of patients and refer them for treatment; is that correct?

A That's correct.

Q So in your professional capacity, referring or providing -- I'm sorry, providing gender-affirming care or referring patients for gender-affirming care would not be something you would have had routinely done, even if you hadn't chosen, personally decided not to do it; is that right?

A Correct.

Q Do you currently have an active license to practice medicine in any state?

A In Oklahoma. I've given up the Washington license.

Q So you no longer -- your license to practice medicine in Washington has expired?

A Yes.
Q And when we say "Washington," we're speaking about Washington, D.C., not the state of Washington?
A Correct.
Q Your Oklahoma medical license, what type of medical license is it?
A It's like an emeritus license. I use it for my --
Q And what is that?
A I use it in my volunteer work here. I'm not practicing as a clinician anymore.
Q And what does your volunteer work entail?
A I have worked for the Oklahoma emergency response people and for various charities around town.
Q And are you providing patient care in those capacities?
A No, not directly.
Q So under this license, can you actively practice medicine?
A No, I no longer am an active clinician.
Q Have any -- has any of your previous medical licenses been suspended for any reason?
A No.

Q Have you ever received any formal discipline by the Board of Medicine of any state or jurisdiction?

A No.

Q Have you ever been the subject of a medical malpractice lawsuit?

A Once.

Q Can you describe the circumstances of that lawsuit?

A There was a complication in a -- after a procedure, and the family filed suit and the defense prevailed.

Q Was that one of the six cases that you referenced being deposed in earlier or --

A Yes.

Q -- was that separate?

Have you ever been the defendant in a lawsuit about discrimination in your medical practice?

A No.

Q Okay. I would now like to talk a little bit about the awards and professional associations that you list in your curriculum vitae, so I'm going to share my screen again. Let me first get to the right place.

(Document is displayed).

So here we have -- let's see -- the section of your CV that lists "Honors and Awards." And I'd like to ask about the Knighthood that you have received.

You list it as "Knight Grand Cross Vatican, the Equestrian Order of the Holy" -- I'm not going to say this properly, I'm sorry -- Equestrian Order of the Holy -- what's that -- the word that starts with "S"?

A Sepulchre.

Q -- "Sepulchre of Jerusalem." What is this award -- or "Knighthood," what does that mean?

A Well, this was an organization founded by Godfrey of Bouillon during the crusades, and they now provide funds for the care and education of Palestinians in the Holy Land.

Q What is the significance of this honor to you specifically?

A It's -- yeah, I think it's a good thing to do.

Q Why did you receive the honor? What did you do to receive this honor?

A They never specifically told me.

Q Does it have any significance to your

career in medicine?

A I would assume it must. I didn't have to slay any dragons.

Q I guess I'm wondering, like, why is it important to list on your CV?

In what way is it relevant to your professional experience?

A Well, it's -- it's an honor, much like the other things that are listed.

You know, if I were British and the queen had knighted me, I would probably list that, too, and assume it had to do with something in my career.

Q So you assume that you received the Knighthood because of your professional service?

A That's a fair guess, but I've never -- never been told.

Q Okay. Are there any requirements or expectations of you as a result of receiving this Knighthood?

A Yes. We are supposed to contribute financially for the welfare of the people living in Palestine and the Holy Land.

Q And those financial contributions are the extent of the expectations?

A Yes.

Q I'm now going to scroll down to what you've listed as "Public Service." So here you list your position as the chairman of the board of directors of Birthright, Incorporated, of Tulsa.

What is this organization?

A Oh, it's an organization to lend assistance to pregnant women and their babies.

Q As chairman of the board of that organization, what do you do?

A Well, I don't anymore. This thing needs updating because I -- I stopped when we left the Tulsa area.

But, basically, the organization looks for ways to supply things like diapers and formula and medical care, or direct them towards medical care, things like that. And some educational things about parenting.

Q When did your service to this organization end?

A When I moved to Washington, D.C.

Q Okay. So that would have been in 2012?

A Correct.

Q Birthright, Incorporated, is not any sort of medical association; is that right?

A Not -- I wouldn't characterize it as

"medical," no.

Q The next line you note that you have been the medical ethics consultant to the Catholic Diocese of Tulsa.

Is that still an active service that you're providing?

A No. The problem -- and I'll explain it now -- is that Georgetown required the CV to be split, for whatever reason, rather than chronological. So those things that were being done while I was at the University of Oklahoma or in Tulsa were separated, which also means that they didn't all get updated.

Q So this would have also ended when you moved to Georgetown in 2012?

A Yes.

Q And that also goes for your role as the director of healthcare issues for the Catholic Diocese?

A Everything. Everything that was listed in Tulsa would have stopped when I was no longer in Tulsa.

Q Under what circumstances does the Catholic Diocese need advice regarding healthcare issues?

A Just from time to time for one issue or

another. I might be --

Q Can you -- oh, I'm sorry.

A -- called or -- pardon?

Q Do you recall any specific examples of why you would be called on these issues?

A Issues such as -- you know, currently there's a lot of concern about brain death, but before that, things like salpingectomies and such. Just -- no, I -- it's rather random and it didn't come up very often, in terms of the Diocese itself.

Q What about your role as a medical ethics consultant. What did that entail?

A Oh, well, you mean like for the various hospital systems?

Q No, for the Catholic Diocese of Tulsa, this position here.

A I assume that that was referring to what we've just been talking about.

Q Are these two positions separate?

A Honestly, I don't remember the study section for the community organization.

This terminology was apparently dictated by Georgetown when my secretary re-did the resume, CV, so I'm not quite sure how she abstracted that out of my previous CV, which is a lot easier to read.

Q I see. So to your recollection you served a single role with the Catholic Diocese of Tulsa and not two distinct roles?
A Yes.
Q And the Catholic Diocese of Tulsa is a religious institution?
A Yes.
Q Are you familiar with an organization by the name of the Catholic Medical Association?
A Yes.
Q Are you a member of the Catholic Medical Association?
A No.
Q Have you ever been a member of the Catholic Medical Association?
A I was going to say no, but I think they actually gave me an honorary membership, when I gave them a talk once, for a year. So possibly, yes.
Q Do you recall when that was?
A I don't know. Ten years ago.
Q Give me just one moment of patience.
MR. BEATO: No problem. Take your time. Technology is not my friend, I can say on the record, so take your time.
THE WITNESS: And doctors are noteworthy

for their patience.

MR. BEATO: Very true.

MS. DUNN: I'm looking for a document. It's not where I expected it to be, but I will be -- I will be able to find it quickly.

(Document is displayed).

Q (By Ms. Dunn) So I'm showing you a press release that was issued by a Catholic Medical Association that we obtained online.

Have you ever seen this document before?

A I -- no.

(Whereupon, Exhibit Number 6 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I've marked this exhibit as Plaintiffs' Exhibit 6, and I'm just going to zoom in briefly.

Were you ever appointed to the Human Fetal Tissue Research Advisory Board of the National Institute of Health?

A I was.

Q Do you know why the Catholic Medical Association would have issued a press release stating that one of their members, you, was appointed to this board?

A I don't know. Wishful thinking?
Q Are you familiar with the mission of the Catholic Medical Association?
A In a general way, I suppose.
Q Are you familiar with resolutions that the Catholic Medical Association has endorsed?
A I'm sorry, as I said, I'm not a member and I don't keep up with what they're doing.
Q Are you familiar with the -- and I hope I'm saying this right -- Lozier Institute?
A Yes.
Q Are you affiliated with the Lozier Institute?
A Yes. They have asked me to speak on various occasions.
Q They've listed you on your website as -- on their website as an associate scholar. Is this an accurate description of your affiliation?
A I believe so.
Q Okay. Is your affiliation with the Lozier Institute active?
A I wouldn't say so, no.
Q When would you say that it ended?
A It was never particularly active. I mean, they did list me as -- on their -- on their list of

associate scholars and I did go out and give a talk on research ethics for them in Kansas at one point, but it was never a very active relationship.

Q Did you provide them with a biography to list on their website?

A I would assume so, yeah.

Q Other than the one talk you mentioned, what other -- have you played any other roles with the Lozier Institute?

A I believe they were the ones who suggested that I be on the human fetal advisory committee.

Q And how did you get appointed to that? Was that a position that you sought?

A No.

Q So how did the Lozier Institute -- how was the Lozier Institute involved with that appointment?

A I think that they made a suggestion. I actually don't know. People approach me at times and say, "Will you serve? Would you be willing to help?" And if I'm interested, I'll say, "Yes."

Q And who approached you about that appointment? Was it someone from the Lozier Institute?

A I think it was actually from HHS.

Q So I guess I'm just curious why you mention

that they were involved with that --

A Because I --

Q -- like, eventual appointment.

A I -- I believe they asked if I would be interested if I were approached.

Q Okay. And then you were later approached?

A To the best of my knowledge.

Q Are you familiar with an organization known as the American College of Pediatricians?

A Yes.

Q Are you a member of the American College of Pediatricians?

A No.

Q Have you ever been a member of the American College of Pediatricians?

A No, I don't believe so.

Q Are you at all familiar with the various position statements of the American College of Pediatricians?

A No, not really.

Q Okay. I'd like to move on to your "Research Publications and Presentations."

So, first, with regard to your clinical research, have you ever conducted primary research involving patients?

A When you say "primary research," how are you using the term?

Q I suppose I'm using it like -- so not like a literature review, but an actual research study that involves human subjects.

A Yes.

Q Can you describe what those research studies were?

A We've been involved in research studies that were multi-institutional on things -- on drugs, and we've been involved in some smaller studies, if I recall, you know, at the local level as well.

I'm struggling right now to remember what would be --

Q Well, let's start --

A All of these were within the realm of pediatric gastroenterology.

Q Okay. So, do you recall, were they during your time with the University of Oklahoma?

A Yes.

Q All of them were during your time at the University of Oklahoma?

A In terms of clinical research, yes.

Q And they were all related to -- the research studies were all related to pediatric

gastroenterology?
A Yes, I believe so.
Q Have you ever conducted any sort of research -- primary research on gender-affirming medical treatments?
A No.
Q So you've not conducted primary research on, for example, puberty blockers?
A No.
Q You haven't conducted primary research on cross-sex hormones?
A No.
Q And you haven't conducted primary research on gender-affirming surgeries?
A That's correct.
Q Have you ever been the principal investigator of a publicly-funded research grant?
A I'm sorry that I'm blocking -- I'm trying to remember if I was PI or not.
Q Well, would it --
A Yeah. But I've been involved in research grants, yes.
Q So let's say either a co-investigator or a principal investigator, have you --
A Yes.

Q -- ever been?
A Yes.
Q Do you recall what that research grant was for?
A Not at present. I'm sorry.
Q That's okay. Were you ever an investigator for a publicly-funded research grant for the study of gender-affirming medical care?
A No.
Q And would that -- the research grants that you are -- that you referenced where you may have been an investigator, was that while you were at the University of Oklahoma?
A Yes, it would have been. Well, there was -- there were a couple of small grants that we did in bioethics issues at Georgetown, but they weren't clinical investigations.
Q Have you ever been an investigator on a privately-funded research grant?
A Well, the Scholl Institute gave us some money at Georgetown for the small thing I was talking about. But, once again --
Q But it wasn't that one?
A -- it wasn't -- it wasn't a clinical thing. We were looking at the -- it's been over ten years

ago, but we were -- I could look it up.

Q You say, "we," you mean yourself and other individuals at the Pellegrino Center?

A Correct.

Q And you've never received a privately-funded research grant to study any sort of gender-affirming medical care?

A Correct.

Q And you've never received any grant that involves the treatment of gender dysphoria?

A Correct.

Q Have you ever taught a course on gender dysphoria?

A No.

Q Have you ever addressed gender dysphoria in any of the courses you have taught?

A Yes.

Q Which -- can you describe in what context?

A Well, in the courses that we've had for either medical students or -- actually, for graduate students.

Q And can you explain what -- what the curriculum was that addressed gender dysphoria?

A It would be a single class on that, not a curriculum.

Q But what was being taught? What specifically -- what was the subject that was being discussed?

A Well, we'd be talking about basically gender dysphoria and transgender individuals and gender-affirming care.

Q And what perspectives were being discussed or shared?

A Without recalling specific aspects of it, they would be very compatible with what I've already written in the reports you just referenced.

Q It would be consistent with the -- when you say "reports," we're talking about the expert report you submitted in this matter that's Plaintiffs' Exhibit Number 1?

A And the -- and the other one, which was --

Q The GAPMS memo report?

A Yes, ma'am.

Q And when were you teaching these courses?

A In the past five years.

Q While at the Pellegrino Center?

A Yes.

Q And were these for medical students or graduate students?

A To my knowledge, only for graduate

students.

Q And when you say "graduate students," that would be -- was there a particular graduate school that was receiving the course where this was discussed?

A It was at Georgetown.

Q But -- I'm sorry, like a specialty. Like a specialty of graduate school or was it a cross-discipline course?

A It would have to be a cross-discipline course from the way you describe it, yes.

Q I guess I'm just cur- -- you know, how do I -- so, for example, my husband is a professor. He teaches a type of physics. So he teaches primarily students in the department of physics. They're students of the University of Florida, but they're graduate students in the department of physics.

So my question is, was there a particular department that the students were graduate students in, or was it -- was it a course that was available to multiple disciplines?

A It -- it was a master's program at Georgetown that's all done through their graduate education office, but it would be open to a wide variety of people who are interested.

Q Okay. And how many times would you say that this topic was addressed in that course?
A In the course? Once.
Q So you only -- I'm sorry. How many courses did you teach for that? So it was one day of a course. How many times was that particular topic addressed?
A Probably once or twice.
Q Okay. And what is the name of the course?
A It was -- the problem is I'm -- I'm struggling because I didn't like the name of it, but it was assigned. But it was basically an introductory course in bioethics.
Q Okay. Is that the name that we would -- if we were to look in the graduate school catalog, is that the name it would be?
A No. I could go find it. They had an abbreviation for it, CACE, but that didn't really give me a good name for the course, either.
Q What did "CACE" stand for?
A I was afraid you were going to ask that. I actually -- I -- it was, like, Advanced Clinical Ethics or something like that. I don't recall exactly. I'm sorry.
Q That's all right. Thank you for searching

your memory.

A And finding nothing.

Q All right. So a large part of your CV includes presentations that you've given. And so in order to make this a little more manageable, I'm going to adhere to the different sections that you have in your CV, which include a division of presentations for -- you know, between those done while you were working at Oklahoma and then those done while you were at Georgetown, which begin later in your CV.

Is that a fair way to kind of -- to try to break it down?

A Sure.

Q So here we start on Page 11. And these are lectures and workshops that you've listed that are national pediatrics.

And that goes until this section -- I'm sorry. There's "National Pediatrics" and then "Regional Pediatrics." So these are all "Pediatrics: Lectures and Workshops," and it goes until Page 25 of your CV.

Were any of these presentations related to the treatment of gender dysphoria in pediatric patients?

A No.
Q And these are presentations, so it looks like they may have started in 1982 and they go until 2004.
So is it fair to say that for that whole period of time you didn't present on the topic of gender-affirming medical care?
A That's true.
Q And then the next section, which starts on Page 26, is about your bioethics presentations. And this is a similar time period, appears to be from the early 1980s until -- until maybe 2008 or 2009.
Were there any bioethics presentations about the treatment of gender dysphoria in either pediatric or adult patients?
A No.
Q All right. I'm just going to ask. So, obviously, in some cases the title of the presentation and the forum isn't totally clear to us from what's listed, so I just have a couple questions about specifically some of these presentations.
So here in 2009 you gave a presentation to the Bioethics Dean's Conference at the Schusterman Learning Center. That was called "The Faith Factor: How does religion or spirituality affect medical

care?"

What was this presentation about?

A Dr. Meixel was talking about some of his patients that -- where either religion or spirituality had made some effect in how they were approached and how we supported them.

Q How does religion affect medical care?

I guess, what is the takeaway?

A Well, it -- there was no single takeaway because, of course, different people have different approaches.

If you're a Jehovah's Witness, everybody will know, you know, that you're supposed to be avoiding blood products.

You know, if you are Muslim or if you are Jewish, not only are there dietary requirements, but if you're observant there may be some strict requirements in terms of the approach to medicine, brain death, transplantation, issues like that.

Q On a couple different pages -- so you list presentations to St. Mary's Church in Tulsa.

Was that your church?

A Yes.

Q And so in -- I guess, in what capacity were you giving presentations at your church?

A Because they asked me.
Q And were you presenting your views as a doctor or your views as a Catholic in these presentations?
A I don't know what presentations we're --
Q So here we have --
A -- talking about.
Q -- on one, "Life and Death Issues: The Catholic Perspective."
A Again, I -- actually, that was 1997. I really don't know what was discussed except I assume it had both to do with life and death.
Q There's another presentation on the topic "Catholic Morality."
Do you recall this presentation?
A No. That was 1993. Been a while.
Q You presented at Oral Roberts University in 1991. I know, obviously, it was quite some time ago, but the title of the presentation was, "Is There a Christian Medical Ethic?"
Do you recall what that presentation was?
A No, I don't.
Q All right. So I'm going to ask about just a couple more presentations and then I think we're due for a short break.

So I'm going to move to the presentations that are listed later in your CV. We -- I mean, I believe -- and you can correct me if I'm wrong -- that these would have been presentations that you would have given since you went to Georgetown. I think that's what this title indicates; is that correct?

A Yes, I believe so. Once again, I'll have to apologize. I didn't prepare this CV myself. This was done by a couple of people trying to fit the Georgetown format, but -- that's the way it looks like it's divided.

Q So -- and that's -- you know, I think we got the hang of it, but obviously if there's anything that needs clarification, please let us know.

So were any of these presentations that you gave while at Georgetown University specific to the treatment of gender dysphoria?

A Not that I recall. It really wasn't something people were requesting at that point.

Q You have never given any sort of lecture or presentation on the treatment -- medical treatment of gender dysphoria, aside from that course that we talked about where you would do one session for your students?

A I think that's correct.
Q And have you ever presented on or lectured on providing informed consent for gender-affirming care?
A Providing informed consent, quite a bit. For gender-affirming care, no.
MS. DUNN: All right. I think that's all of my questions about presentations, so I -- if we'll just -- I think we'll take maybe a five-minute break.
(Recess taken from 10:31 a.m. to 10:37 a.m.)
Q (By Ms. Dunn) We're going to return to your CV, Dr. Donovan, and I'm going to Page 60, which lists your publications. And this is described as "Original Papers in Refereed Journals."
Does the word -- does "refereed" mean the name thing as "peer-reviewed"?
A Yes.
Q Okay. I will use the term "peer-reviewed" today, but our understanding is those are interchangeable?
A Yes.
Q So you have 17 papers listed under "Bioethics" as "original papers and refereed journals."

Of these 17 papers, which were original articles that you were the primary author that underwent a peer-review process?

A These are the papers, I think, before Georgetown then. And if I'm the first author, my name will appear first.

Q So on a number of these articles your name doesn't appear at all.

A Then I'm the sole author in that case.

Q I'm sorry?

A Then I would be the sole author.

Q Well, so here I'm looking, for example, Number 3, which is from the AAP Committee on Bioethics titled "Professionalism in Pediatrics."

There are two other authors and the AAP Committee on Bioethics, but your name is not listed at all. What was your contribution to this article?

A Mary Fallat and Glover and I were all on the Committee on Bioethics. And so she was the primary author on this, but we all contributed and discussed it.

Q Contribute to the actual text of the article or just to discussions about the article?

A Both. Depends on the article, but, yes, usually both.

Q For Number 5, again we have an author DS Kiekema and the AAP Committee on Bioethics called "Responding to Parental Refusals of Immunizations of Children."

Is this also an article that you were an author on?

A Yes, these all were while I was on the Committee on Bioethics at American Academy of Pediatrics.

And Doug Diekema, in that case, was the primary author.

Q Is it common that someone who contributed to an article isn't listed as an author?

A When you look at the paper itself, they list all the members.

Q All right. Well, so let's look at one of these then.

(Document is displayed).

All right. So this is a copy of the article listed -- that we just talked about. I believe it's listed as -- one quick second.

This article is listed as Number 3 in the "Bioethics" section of "Original Papers and Refereed Journals," and this is the article called "Professionalism in Pediatrics."

And the listed authors are Mary Fallat, Jacqueline Glover, and then it says the "Committee on Bioethics."

So are you saying that because the Committee on Bioethics is listed that every member of that Committee on Bioethics is an author of this document?

A Yes, we co-author it.

Q How many members would -- are on the Committee for Bioethics -- or Committee of Bioethics?

A If you scroll down you should be able to get all their names. There are about half a dozen typically. It would sometimes vary.

Q So this is what you're referencing?

A Yeah.

Q Okay.

A That's me.

Q All right. So other than the publications that were -- that you are a co-author on because you are a member of the Committee on Bioethics, which -- let me -- I'm going to pull back up your -- oh, that's the wrong -- I'm sorry. I'm pulling your CV back up.

(Document is displayed).

Which of these articles -- and just let me

know if you need me to scroll further. So other than the publications that were -- that you are a co-author on because of your membership in the Committee on Bioethics of the American Academy of Pediatrics, which articles are peer-reviewed journal articles?

A Well, everything listed in this list should be a peer-reviewed journal article.

Q So let's start with this first article, bio -- sorry, "The Disabled and Their Lives of Purpose."

So this article, do you recognize this?

A Uh-huh. Yes.

Q And actually I'm just realizing, for the court reporter's benefit, I probably need to note that the exhibit we just looked at, which was the "Professionalism in Pediatrics" article, is going to be marked as Plaintiffs' Exhibit 7.

(Whereupon, Exhibit Number 7 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) This article -- did you write this article, Dr. Donovan?

A Yes.

(Whereupon, Exhibit Number 8 was marked for

identification purposes and made a part of the record.)

Q (By Ms. Dunn) I will mark this article as Exhibit 8.

So this article was published in 2007; is that correct?

A Yes.

Q And it is four pages long?

A Approximately.

Q Looks like maybe a little over four.

Did this article summarize any sort of original research?

A It was all original. Typically, the articles in bioethics may be empirical research or they may be learned opinion, if you will, or perspectives.

Q So how would you describe this particular article? Was it --

A More like the latter.

Q The learned opinion?

A Uh-huh.

Q Okay. And where was this article published?

A It says "The Linacre Quarterly."

Q Do you know anything about that journal?

A Yes. It's the journal published by -- I believe that's CMA.

Q So The Linacre Quarterly is the official publication of the Catholic Medical Association?

A Yes.

Q Do you know if the individuals who serve as peer-reviewers for this journal are required to be members of the Catholic Medical Association?

A You're not even supposed to know who the peer-reviewers are in a refereed journal.

Q Yeah, I understand the concept of blind review, but do individuals who have -- that's a different question.

Do peer-reviewers have to be members of the Catholic Medical Association?

A I don't know.

Q Now, do you recall what the peer-review process for that article entailed?

A I don't remember it being any different than the peer-review process for any other articles. You submit it, they send it out to their peer-reviewers. Peer-reviewers make suggestions or -- or recommend that it be published or not be published.

Q All right. So going back to your CV. So

this first article there was -- it did appear in a peer-reviewed journal and that journal was the -- is the official journal of the Catholic Medical Association.

This article -- Number 2. This article -- was this article published in a peer-reviewed journal?

A Oh, I had forgotten Mary and I did that.

Okay. I believe it was being peer-reviewed, but that publication looks like was in eMedicine and I don't know.

Q What is that publication?

A That's an online journal.

Q So we attempted to find this article using that website and could not.

So this says "From WebMD" and we're -- I'm just trying to figure out what that means. Is this a Web -- is this an article that was published on WebMD?

A Apparently, yes.

Q So -- but WebMD is not a peer-reviewed medical journal.

A It shouldn't be, no, so I don't know why that's there, but --

Q Okay. So, then, are --

A If, unless -- yeah, I don't know. I don't know.
Q So is 2 -- we can say that's not an article in a peer-reviewed medical journal?
A I would have to try and find it myself.
Q Okay.
A Once again, these things may have been jumbled a little because they were all redone upon my arrival at Georgetown.
Q Sure. Number 3, we already talked about, that is a publication that you were a co-author on as a member of the Committee of Bioethics.
A Uh-huh.
Q Number 4 is an article that was published in a state medical journal?
A Uh-huh.
Q Is that -- that was a peer-reviewed medical journal?
A I believe it was.
Q Do you know that for sure?
A I can't recall.
Q Number 5, again, it looks like this was -- oh, no, I'm sorry, this was also in a state medical journal. Do you know if this was a peer-reviewed medical journal?

A It was the same journal and I believe -- I'm not sure they're publishing that journal anymore, but I believe they were reviewing it at a peer review. I believe.

Q Do you know that for sure?

A I couldn't tell you.

Q Number 8 was another -- it's a clinical report from the American Academy of Pediatrics.

Is that -- was that something that you were a co-author on because of your position on the Committee of Bioethics or was it a different type of publication?

A Well, Mary and I were on the committee together. She's a pediatric surgeon. I don't know if that was done separately or through the committee at the time.

Q Okay. Number 8 here, we have an article titled "Ethical Issues with Genetic Testing in Pediatrics."

This was also one that you are a co-author on as a member of the AAP Committee on Bioethics?

A Yeah. It looks like all the rest on that page fit in that same category.

Q Okay. So we -- we -- so 8 through -- well, let's go down. Eight through 14, it looks like, were

all publications that you were a co-author on as a member of the Committee on Bioethics?

A Looks like it.

Q And do you know if these -- that type of publication is peer-reviewed?

A Well, it's peer-reviewed but not in the usual fashion because it goes through the internal workings of the American Academy of Pediatrics.

And I'm not sure the best way -- maybe that's why they listed these as "refereed" rather than "peer-reviewed." Although, I wouldn't have thought there was a difference. But they are reviewed and then sent back or accepted or not accepted. So to that extent there's a similar mechanism.

Q When you say "accepted" or "not accepted," do you mean --

A For publication.

Q -- accepted by the Academy of -- the American Academy of Pediatrics at large?

A Well, no. No. The academy at large doesn't peer-review. I mean, it would be -- or referee. It would be through the mechanisms of the various editorial boards and the hierarchy.

Q Okay. And these types of publications, the

clinical reports and the policy statements, are these -- do you consider these types of publications reliable?

A I'm not sure what you mean by "reliable."

Q Are they the type of materials that physicians would routinely rely on in conducting a clinical practice?

A Yes.

Q All right. The last three articles on this page are Numbered 15 through -- I'm sorry, not on this page, in this section -- are Numbered 15 through 17.

And so 15 was published in a journal by the name of Christian Bioethics and it was titled "Decisions at the End of Life: Catholic Tradition."

Was this a peer-reviewed article?

A Yes.

Q And are you familiar with the mission statement of the Christian Bioethics Journal?

A No.

Q Is it -- are you -- are you aware that that journal offers contributions and publications from Christian perspectives?

A I would have assumed that by its name, yes.

Q 16, the article "Does Shooting Abortionists

Reveal a Lack of Faith?"

This is also a publication in Linacre Quarterly; is that right?

A Yes.

Q And that Linacre Quarterly, again, is the journal -- the official journal of the Catholic Medical Association?

A I believe so, yes.

Q Do you recall if this article would be considered empirical research versus a learned opinion like the article we discussed before?

A No, that would be a learned opinion.

Q And I should have asked that for 15 as well. Would that article have been empirical research or a learned opinion?

A If I recall -- and remember, that was, you know, a long time ago, about -- over 20 years ago, but it would have combined a little bit of both because it would have required some research, but not empirical research. It wasn't -- you can do bioethics articles that actually involve live people sometimes, but this was not in that category.

Q Okay. And then 17, again, was published in that state journal we previously discussed?

A Yes.

Q All right. And then this next section of articles, these are all articles related to your practice as a pediatric gastroenterologist?

A Yes.

Q All right. I'm going to now skip down to the end of your CV where your publications from your time at Georgetown are listed.

So I am flipping to what is Page 78 on your CV. I guess there's no limitation here like in the other section that notes that these are publications in peer-reviewed or a refereed journal.

Do you know which of these articles appeared in peer-reviewed or refereed journals?

A Well, the journal articles should have been in peer-reviewed or refereed journals, but not everything there is a -- a journal article, as you can see. Some of them were chapters in books.

Q And your Number 1 is a chapter in a book; is that right?

A Correct, in the geriatrics book.

Q Okay. Number 2 and 3 are pieces in the Italian Encyclopedia of Bioethics?

A That's right.

Q All right. Number 4, is this a peer-reviewed journal article?

A Yes, it is.
Q You're sure it's a peer-reviewed journal article, not an editorial?
A On which one, Number 4?
Q Ebola, Epidemics, and --
A I think that was -- no, that was in an online journal. I think that was just an article, I believe.
Q Are you seeing this new document?
A Oh, it says "editorial." Okay. So that must have been an editorial.
Q Okay. So this article was an editorial, not a peer-reviewed research article -- or peer-reviewed article?
A Correct.
Q Okay. The next -- oh, I should go back to your -- let you see, too.
(Document is displayed).
The next article here, Number 5, also -- this is also an editorial by the name of "Doctors, Documentation, and the Professional Obligation: Has everything changed?"
A Okay.
Q That's an editorial; is that right?
A Yeah. That surprised me because they

decided to make it an editorial.

The next one was just a local publication at Georgetown, though.

Q And this is like an online student newspaper; is that right?

A Yeah.

Q This article here titled "Beneficence in Utero, a Framework for Restricted Prenatal Whole-Genome Sequencing to Respect and Enhance the Well-Being of Children," that was an article in the American Journal of Bioethics?

A Yes.

Q And this is -- was that article peer-reviewed?

A Yes.

Q Do you -- are you aware of the difference between an open peer commentary and a peer-reviewed article?

A Well, this was AJOB commentary, as I recall, but it's a peer-reviewed journal.

Q Well, it's a peer-reviewed journal but was the article itself peer-reviewed?

A I don't know how AJOB does it, but seeing as how they accepted the article, I would assume that they had some peer review involved.

Q If you'll give me just one second, I'm trying to pull up the article and I'm having trouble. So I'm going to stop sharing and try to figure this out.

MR. BEATO: No problem. Take your time.

Q (By Ms. Dunn) All right. I apologize. I was having trouble opening the type of file.

(Document is displayed).

So this is a screenshot from the journal of your publication. And this here -- it lists this article as an open-peer commentary.

And so are you familiar with whether or not an open-peer commentary is peer-reviewed?

A Well, we were invited to offer a commentary, but I don't know that they're automatically accepted. So the process for accepting or not accepting, I would assume, involves some mechanism of review.

(Whereupon, Exhibit Number 9 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So I'm just going to share another document.

I'm sorry. So if we could mark that last exhibit, which is the article -- I'm sorry.

I realize I didn't mark the "Ebola, Epidemics, and Ethics" article. That should be Article -- or, I'm sorry, Exhibit 9.

(Whereupon, Exhibit Number 10 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) The "Beneficence in Utero," open-peer commentary, will be Exhibit 10.

(Whereupon, Exhibit Number 11 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'm now showing you an email which I'm going to mark as Exhibit 11.

So I will represent to you that this is an email that we sent to the editors of the American Journal of Bioethics. We asked them if open-peer commentaries are subject of peer review.

And their response was that open-peer commentaries are not peer-reviewed.

So can we agree that the open-peer commentary you provided that was marked as Exhibit 10 was not a peer-reviewed journal article?

A There you go. It says "Reviewed by our editorial team."

(Document is displayed).

Q All right. This article labeled as Number 8, "Physician Assistant Suicide in the Medical Profession," this was another Georgetown specific publication. It looks like perhaps a blog.
A Okay.
Q Is that correct?
A I assume.
Q Do you recall writing this publication?
A The publication, I probably did. The listing of these were all done by my secretary just when everything -- anything would be published.
Q And then Number 9 --
A As I recall, she didn't even list -- differentiate on these between peer-reviewed and not peer-reviewed, did she?
Q She didn't, so that's why we are asking these questions because we were unable to fully determine.
A Oh, okay.
Q And so Number 9, again, would be a blog post. That would not be a peer-reviewed article?
A I can't actually read that, so --
Q I'm sorry. Number 9 says -- is "PAS: Unwise, Uncontrollable, and Unnecessary," and then it lists an HTTP that appears to be a blog.

A Okay.
Q So that would not be a peer-reviewed article?
A I wouldn't think so.
Q And then Number 10 here, is this a book?
A Chapter.
Q A chapter in a book?
A Yes.
Q Do you recall what the name of the book?
Oh, I'm sorry, the book is "Palliative Care in Catholic Healthcare - Two Millennia of Caring for the Whole Person"; is that right?
A Right.
Q And this publication at Number 11 is "PAS" -- and I'm assuming that PAS -- and you correct me if I'm wrong -- is that the acronym for Physician Assistant Suicide?
A Correct.
Q Okay. "PAS: How should Catholic healthcare respond?"
And that article appeared in the Healthcare Ethics USA?
A Correct.
Q Are you aware that that Healthcare Ethics USA is a publication of the Catholic Health

Association?

A Yes.

Q And this article -- it's not a medical journal that's subject to peer review; is that right?

A It's an ethics journal.

Q Is it a peer-reviewed journal?

A I don't think it is. I think it's one like the other one, editorial reviewed.

Q Okay. Number 12 here, this is a book review you wrote?

A Yes.

Q And so that would not be a peer-reviewed article?

A No.

Q And 13, another article in the American Journal of Bioethics titled "How We Should Conceive of Creation: Natural Birth as an Ethical Guidepost for Neonatal Rescue."

Do you recall if that article was peer-reviewed?

A Well, I think that one was. I think that that was a -- I think Doug McAdams actually wanted to do that himself, but that may have been another one where they were responding to an AJOB article.

So the reason I wouldn't know is because I

wasn't the primary author on those. So if it was peer-reviewed and the comments from the reviewers come back, they come to the primary author.

(Whereupon, Exhibit Number 12 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I understand. So I'll just quickly show you the, I guess post -- I don't know, post -- or the journal page that references this article and we'll mark this as Plaintiffs' Exhibit 12.

So this article again is an open-peer commentary.

A Okay.

Q So we can agree that that is not a peer-reviewed article?

A It's been a learning experience for me. Thank you.

Q I'm going back to your CV.

(Document is displayed).

The next article is a publication, it looks like, in the Catholic Health Association.

Do you know what this -- whether this is a peer-reviewed journal?

A I would expect that's only reviewed by the

editors.

Q This article -- or this publication, "Reflections by a Christian Scholar," here at Line 18 -- or Number 18 is an "In Press Proceeding," but is this a lecture that was presented at a conference?

A That was -- it was.

Q Okay. And it will be published as such?

A Yes.

Q 19, there's an article that you co-authored with some other individuals that's called "Affirming Ethical Options for the Terminally Ill."

This was published in the Heritage Foundation publication; is that right?

A Apparently, right.

Q And the Heritage Foundation is not an academic medical journal?

A No.

Q Okay. Would this be a transcript of a lecture as well?

A I believe so.

Q Okay. And did you participate in that lecture, or in what capacity were you --

A I would have given it.

Q Would it have been at a Heritage Foundation event? Is that when that occurred?

A Yes.
Q Okay. The next article at Line -- at Paragraph 20, "The Deadly Advocacy of Doctor-Assisted Suicide."
This is a Washington Times article?
A Uh-huh. That looks requested.
Q Not a peer- --
A Not peer-reviewed.
Q Not peer-reviewed.
21 is an article you wrote with another individual called "Strangers in a Strange Land: How Our Founding Principles and a Bitter Pill Undo the Assimilation of U.S. Catholics."
This article was also in The Linacre Quarterly; is that right?
A Yes.
Q And as we've said, The Linacre Quarterly is the official publication of the Christian -- I'm sorry, the Catholic Medical Association?
A Peer-reviewed.
Q And this is peer-reviewed.
Do you know that this particular article was peer-reviewed?
A Yes.
Q So, to your knowledge, a commentary is

peer-reviewed?

A What are you talking about, Strangers in a Strange Land?

Q Yes.

A Well, they sent it back and forth to us. Did they look -- I don't know how they decide to list things in their journal, but I know that they required us to go through peer review.

Q So I guess I'm wondering, is there -- there is a distinction between "editorial review" and "peer review." Are you certain that this particular publication was peer-reviewed?

A Well, when they send it back -- and as I recall they sent it back with suggestions -- so that would have been peer-reviewed.

Q So --

A If you get messages from peer-reviewers, that means it's peer-reviewed.

Q Well, I do think there's a difference. I think the editors of the journal can give you comments and edits, but a peer-review process is different and requires practicing professionals who are your peers to provide comments and, you know, editorial sugg- -- or maybe not even editorial suggestions, but to provide comments.

So I do think there is a distinction, as noted in that email from American Journal of Bioethics, between editorial review and peer review.

So I'm just trying to determine if you are certain that that article was peer-reviewed or whether it could have just been subject to editorial review.

A To the best of my recollection, it was.

Q It was. Okay.

And would you say that that article, the "Strangers in a Strange Land," would that article be better described as empirical research or a learned opinion?

A More in the learned opinion category.

(Document is displayed).

Q Going back to your CV.

At 22 we have a document titled "Ethical Dilemmas in Pediatric Lipidology. Endotext Pediatrics."

Do you know if that -- is that a book or do you know what -- where that publication appeared?

A No, that -- that is done by the endocrinologist I was doing it with, Don Wilson, so he just told me that that was published.

Q Okay. So --

A And just for my permission and I said "Sure."
Q So is it a chap- -- I'm confused. Is it a chapter in a book or a publication?
A I believe it's a publication.
Q Okay. Number 23 here, this is another -- it's a chapter in, I think, the same book that we saw at the beginning, is that right, "Ethical Decision-Making in the Elderly"?
A No, that's the subsequent edition of --
Q So it's an update to that first entry on this publication list?
A Yeah, but it's already been published, so that hasn't been -- caught up yet. But, yes, that's now published.
Q Okay. 24, is this another -- your "CPR, DNR, and the Patient's Good," is this another book that you've contributed to?
A Yes.
Q And 25 would be similar. This "Ethical Issues in the Provision of Nutrition and Hydration" in Pellegrino's Compendium, that's, similarly, a book?
A Yes. They --
Q And 26 -- I'm sorry.

A They told us it will be published this fall.

Q Okay. And then 26, which is "Chapter 101 ethics in Prenatal/Neonatal Medicine," identified as the "Handbook in Neonatology," is that another book publication -- a book -- a publication related to a book?

A Yes.

Q Okay. And I believe that's the end of the publications that we have listed in your CV.

So you don't have any articles that you've published that underwent peer review where the topic was gender-affirming medical care; is that right?

A Yes. I've said that.

Q Okay. Well, I'm not sure we talked about publications. We talked about presentations and teaching, but I just want to confirm that you also haven't authored any publications that underwent peer review that were related to gender-affirming care.

A Correct.

Q You have been listed as an author on one article related to gender-affirming medical care; is that right?

A Yes.

Q And what article was that?
A That was the Laidlaw article.
Q And this article was an open-peer commentary; is that right?
A Correct.
(Document is displayed).
Q And this is the article we're talking about?
A Yes.
(Whereupon, Exhibit Number 13 was marked for identification purposes and made a part of the record.)
Q (By Ms. Dunn) All right. I will mark this as Plaintiffs' Exhibit 13.
So this article did not undergo peer review; is that right?
A Actually, you were the one who pointed out to me it underwent an editorial review, not a peer review.
Q Okay. Because it's in the American Journal of Bioethics and we looked at that email which clarified that?
A Right.
Q Okay. So this commentary argues that minors alone cannot consent to gender-affirming care

medical treatments; is that correct?

A Yes, that's correct. That minors should not be permitted to consent without the involvement of their parents to the gender-affirming care.

Q And so it's not suggesting that parents and legal guardians cannot provide informed consent?

A It was responding to an article that said, in fact, that if they don't perform -- or don't offer informed consent, they should be able to bypass the parent.

Q But this article itself isn't suggesting that parents can't provide informed consent for their children?

A No.

Q The article mentions -- so in the first paragraph the article states -- and I will -- I can highlight with my cursor. Actually, I can't. It won't let me.

But right here near where my cursor is, it states that, "Watchful waiting with support for gender-dysphoric children and adolescents up to the age of 16 years is the current standard of care worldwide, not gender-affirmative therapy."

What is "watchful waiting"?

A Okay. They were using the -- the term as

a -- as an approach to supporting children without puberty blockers or hormones.

Q And watchful waiting is not a type of care that you provided as a clinician; is that right?

A That's right.

Q And what evidence is relied on to support the contention that watchful waiting is the current standard of care?

A Well, he actually -- Dr. Laidlaw listed the -- the article right there, I believe.

Q So that's based on the de Vries and Cohen-Kettenis article published in 2012?

A Uh-huh. Yes.

Q So if we scroll down to the bibliography, that article is listed here. And I believe -- so it's called the "Clinical Management of Gender Dysphoria in Children and Adolescents. The Dutch Approach."

What supports the contention that the Dutch Approach is the worldwide standard of care?

A I think that he was talking about in places other than America.

Q But in what way does this article establish that the Dutch Approach is a worldwide standard of care?

A I think it's difficult to answer -- for anybody to answer what is the worldwide standard. Perhaps the Dutch Approach was certainly one that had been significant in the world and they were kind of leaders in the approach to children with transgender care.

Q Are there any sources cited that support what the standard of care in the United States would be?

A You mean within this article or elsewhere?

Q Within this article.

A I would have to go back and re-read it to answer that. I'm sorry.

Q And we've established today that your field of specialty is not pediatric endocrinology, correct?

A Correct.

Q Did you write any of the information in this commentary about puberty-blocking medications?

A No. No. My contribution was only on the ethical aspects.

Q Okay. So if we move further on in the article, this sentence here which provides opinions about GnRH analogues that suggest or assert that they cause infertility, what evidence was relied on in making this assertion?

A Once again, I wasn't writing the innercological (phonetic) parts of this.

Q So you're not familiar with any of the evidence that would suggest -- or any evidence that would suggest that GnRH analogues cause infertility?

A I have read this, yes.

Q Is that -- is it not -- I mean, is that fact, that the impact of GnRH analogues on fertility, is that not relevant to the bioethics opinions presented in this article?

A Yes.

Q So wouldn't it be important to be familiar with any such evidence?

A Yes.

Q Okay. So what evidence is being cited to support that contention?

A Once again, I'm going to have -- I haven't read this article in some time, so I would have to go back through it to see what evidence it cites.

Q There's about two paragraphs there. Would you -- would that help you to review to determine if there is evidence being cited to support that assertion?

I can zoom out, I can zoom in, whatever makes it easier.

A Which -- I'm sorry, where are we reading right now?

Q I believe the relevant text is in the section "Puberty-Blocking Agents and Infertility."

A Okay. I'm just reading along with you, I'm sure. "There are no randomized controlled studies for the use of puberty-blocking agents including safety for stopping normal puberty. Endocrine Society has published revised clinical guidelines in 2017, including adolescents. The" -- better scroll up. Let's see what else we've got.

-- "quality of evidence for PBA is noted to be low. In fact, all the evidence in the guidelines with regard to treating children/adolescents is low to very low because of the absence of proper studies. These same guidelines, however, recommend arresting normal puberty at Tanner Stage II. This is highly significant because it's the pubertal stage occurring before menarche in girls and before spermarche in boys. Continued suppression of pituitary gonadal axis by PBA will maintain a state of immaturity of the male and female gonads. As a result, though the child will likely grow in stature, the gonads and entire pelvic genitalia will remain stunted at Tanner 2. The condition of cross-sex hormones will

not change this condition. As a result, the patient will be infertile as an adult. The continued administration of cross-sex hormones may lead to permanent sterilization. Gonadectomy, of course, would also ensure sterility."

Is that what you were talking about?

Q No. I'm talking -- I'm asking. My question is, there's an assertion made here that as a result the patient will be infertile as an adult. And there's no citation provided.

So I'm asking what evidence is being relied on to support that assertion.

A Okay. And that's a very reasonable question, but I -- this is not the only place I have read that. It is not referenced in this short commentary.

Q So there's no evidence being provided to support the assertion that the administration of GRNH analogues leads to infertility as a result?

A The evidence is not, apparently, re-presented in this short commentary. I don't say that there's no evidence. I'm saying that the references don't seem to be listed for all the statements in the commentary.

Q But there's no evidence being cited in this

article to support that assertion?

MR. BEATO: Object to form.

Dr. Donovan, you can answer that question.

THE WITNESS: I think that you're probably right. Reminding you that absence of evidence is not evidence of absence.

Q (By Ms. Dunn) The article also suggests that puberty-blocking agents impair adults' sexual function. And I'll scroll down. There's a section here on this.

What evidence is provided in this article to support this assertion?

A Once again, I think that you're looking for the type of evidence that can be included in much longer articles. These are space-limited, so both the length of the article and the length of the references is not expansive. That doesn't mean that there haven't been multiple reports of either concerns or actual evidence that these things have occurred, they're just not all listed within this article.

Q Can you name a study that would support this assertion?

A I am certain that there are studies that have supported that assertion. I can't name you one

currently. It would take a little research.

Q Can you name any study that would support the assertion that the administration of GRN- -- GnRH analogues causes infertility?

A The same answer.

Q So your assertion is that providing the citation in the text would make this article too long to include. Is that what you're suggesting?

A No. No. It was clearly a matter of choice and it was not chosen to include all the references that could have conceivably been included.

Q Is it common in medical publications to make an assertion and not provide the evidence on which the author relies?

A It is common not to list every possible reference, of course. It is also common to list references. And some of the time you list references, depending on the type of article you're writing, whether it's an original article or a response article, whether it's an extensive article or a brief summary. So there will be variability.

Q Well, but this article, though, is discussing the fact that children should not be able to make decisions around medical transition and it relies specifically on these assertions of the

harmful impacts and yet it fails to cite any evidence to support those assertions. Is that not right?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: Yeah, I don't -- no, I don't think that's exactly right. Of course, it cites some evidence and you see that there are references listed, but there aren't references listed for everything.

Once again, how long is the article, how many references are listed will depend a lot on what you can put in there, how much that even the editors will allow.

Q (By Ms. Dunn) Well, there's ten articles listed, and not a single one assert -- not a single one of these articles supports the contentions about the harmful impacts that the authors are alleging.

MR. BEATO: I apologize. Is that a question?

Q (By Ms. Dunn) Well, you can strike that.

MR. BEATO: Counsel, would you mind if we take a five-minute break, or would you like to continue asking questions?

MS. DUNN: Let me just finish asking questions about this article and then I think it

would be a good time for a break.

MR. BEATO: Of course. Of course.

Q (By Ms. Dunn) So I'll move on to the section of the article that's more about an adolescent's ability to consent. I assume that that would be relevant to the bioethics contributions you made to this article?

A Yes.

Q And so here we -- in this section, the "Co-morbid Psychiatric Condition" section, on what's marked with the Bates number AHCA EXP 002078, it says that there's an "additional issue related to an adolescent's decision to take puberty-blocking agents without any parental involvement."

And then it cites to "associated psychological conditions."

So is this suggesting that because youth with gender dysphoria may have other psychiatric conditions, that that means that they're not able to assent to this type of treatment?

A Well, it certainly would be a reason for concern if someone had autism or schizophrenia or profound depression, all of which have been associated with transgender adolescence, that it might impair their ability to provide fully informed

consent.

Q Currently there are no -- the standards of care regarding the administration of this type of treatment to minors does require parental consent; isn't that right?

A Yes.

Q And there are protocols used by clinicians to obtain informed consent for patients who do not have capacity to consent for themselves in other circumstances; isn't that right?

A Yes.

Q So there are frequently situations where patients may have a psychiatric condition that can impact their ability to provide informed consent and there are protocols to -- that apply to those situations?

A But those protocols do not allow for the direct consent of the children. That is parental permission being sought.

Q Yeah, but there are situations where adults may not have capacity to consent because of psychiatric conditions and there are protocols in place where physicians are still able to obtain informed consent and provide treatment; isn't that right?

A That's a different situation altogether if we're talking about an adult. But you're also talking about an impaired adult who, therefore, their ability to provide an informed consent with full capacity would be questionable.

Q But what I'm saying is that there are standards and protocols that clinicians engage in in these types of situations; isn't that right?

A That's kind of a general statement that's hard to disagree with. There are situations and approaches to situations.

Q You published this article with Michael Laidlaw and Michelle Cretella; is that right?

A That's right. Correct.

Q Are you aware that Michelle Cretella is the executive director of the American College of Pediatrics?

A I have heard that. She was not at the time.

MS. DUNN: All right. I think that this is probably a good time for the break that you asked for, Michael.

MR. BEATO: Excellent.

(Lunch recess taken from 11:35 a.m. to 12:10 p.m.)

Q (By Ms. Dunn) So I wanted to just follow up on one thing we talked about before the break, and that was -- I asked about the affiliation of your co-author, Michelle Cretella.

And you stated that at the time of the article she wasn't affiliated with the American College of Pediatricians; is that right?

A No. You said she was executive director, and I think she just did that recently.

Q Okay. At the time that you all wrote the article together, was she affiliated with the American College of Pediatrics in any way?

A Probably.

Q Okay.

A But, however, I don't belong to the ACP, so I don't know. I mean, I think she was.

Q Do you know anything about that organization?

A Very little. I mean, it's pediatricians who didn't agree with the AAP on certain issues.

Q Sure. So I just -- I'm going to point you to a couple documents, so I'm going to share my screen.

(Document is displayed).

This is a document from the American

College of Pediatricians entitled "Homosexual Parenting: A Scientific Analysis."

Have you ever seen this document?

A No.

Q Okay. So this document is -- it's a policy statement of the American College of Pediatrics which states that, "There's sound evidence that children exposed to the homosexual lifestyle may be at increased risk for emotional, mental, and even physical harm."

You were not aware of the American College of Pediatrics' position on this issue when you --

A I've never seen this before, no.

Q So you were not aware of this policy position when you made the decision to co-author a publication with Michelle Cretella?

A No.

(Whereupon, Exhibit Number 14 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'm just going to mark that -- that exhibit that we just talked about, the American College of Pediatrics' policy statement on homosexual parenting as Exhibit 14.

And then I'm going to show you another

policy statement from the American College of Pediatricians.

Have you ever seen this policy statement?

A No.

(Whereupon, Exhibit Number 15 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Okay. So I'm going to mark this as Plaintiffs' Exhibit 15. This is a policy statement from the American College of Pediatrics stating that there's "No evidence that psychotherapy for unwanted homosexual attraction is any more or less harmful than the use of psychotherapy to treat any other unwanted psychological or behavioral adaptation."

You are not familiar with this policy statement?

A Correct.

Q And you were not aware of this policy statement when you made the decision to co-author the publication -- a publication with Michelle Cretella?

A First time I've seen it was today.

Q Would it have changed -- if you had known about this, would it have changed your decision to be an author on that publication?

A It didn't seem like those two really are directly connected to each other.

Q So would it have changed your decision to be an author --

A No.

Q -- on that publication?

A I don't know. I haven't read the article, so it's hard to say whether it would change or not change.

Q Well, I suppose, knowing that -- I mean, I -- just understanding what I -- what I read from this document, that it's a policy position issued by this organization of which your co-author plays a leadership role, that states that there's "No evidence that psychotherapy for unwanted homosexual attraction is any more or less harmful than the use of psychotherapy in other contacts," would knowing that that was a policy position of the American College of Pediatricians have changed your decision to co-author a publication with Michelle Cretella?

A I agreed to co-author based on the topic at hand and not anybody else's CV. So the answer would be I don't see how it would.

Q And same for the exhibit that we marked as Exhibit 14, the policy statement on homosexual

parenting.

If you had been aware of that policy statement, would it have changed your decision to co-author a publication with Michelle Cretella?

A Well, once again, it's speculative. I don't know exactly what it says, but I was -- I was part of the -- the effort on the other paper simply on the basis of that paper alone.

Q We also talked about a number of your publications appearing in The Linacre Quarterly, and that that is the official journal of the Catholic Medical Association; is that right?

A Yes.

Q Are you aware of -- actually, I'm just going to open -- one second. So I'm going to show you a document.

(Document is displayed).

(Whereupon, Exhibit Number 16 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So this is a cover page of Resolutions of the Catholic Medical Association. I will mark this exhibit as Plaintiffs' Exhibit 16.

Have you ever seen this -- these -- this is a printoff of a web page. So have you ever seen this

web page of the Catholic Medical Association?

A I don't think so.

Q So the website states that, "The following are resolutions accepted as positions at the Catholic Medical Association."

And we're going to jump to the resolutions that are listed in the topic of "Family and Sexual Education." Specifically I'm going to look at Resolution 8-12, which is a resolution on transgender treatments.

Resolution 8-12 reads that, "The Catholic Medical Association does not support the use of any hormones, hormone-blocking agents, or surgery in all human persons for the treatment of gender dysphoria."

Were you aware of this resolution of the Catholic Medical Association?

A No. As I've mentioned, I'm not a member of the Catholic Medical Association.

Q And if you --

A I wasn't aware of this.

Q You weren't aware of this?

A No.

Q If you had been aware of this, would it have changed your decision to publish in the Catholic Medical Association's official journal?

A Well, I -- I imagine that I would probably be pleased if anybody agrees with me.

Q So are your beliefs aligned with this resolution?

A I don't know because I haven't seen the full text of it. I just see a title there.

Q So this is the full text of the resolution. The title is "8-12: Resolution on Transgender Treatments." And then it says "Be it resolved."

A Well, then, that does sound reasonable.

Q Okay. And then if we move down to Resolution 8-13, which is the "Resolution on Gender Dysphoria," it reads, "Be it resolved that the Catholic Medical Association and its members reject all policies that condition all persons with gender dysphoria to accept as normal a life of chemical and surgical impersonation of the opposite sex. Further, that the use of puberty-blocking hormones and cross-sex hormones and surgical reassignment surgery be rejected."

Were you aware of this resolution of the Catholic Medical Association?

A No. Like I said, I've never seen this page before and I don't know if any of these were ever adopted.

Q These are on the website of the Catholic Medical Association as adopted resolutions.

A Okay.

Q I'll represent that to you. And so if you had been aware of this resolution, would it have impacted your decision to publish in The Linacre Quarterly, the Catholic Medical Association's official publication?

A No.

Q And are your beliefs around the treatment of gender dysphoria aligned with this Resolution 8-13?

A I would not have used this language, but I don't have severe disagreements with it.

Q Okay. At this point we're going to turn back to what has been marked as Plaintiffs' Exhibit 1. And that is your report, which is not on my screen anymore, so I'm going to have to stop that share again.

(Document is displayed).

This, we already identified, as the expert declaration that was provided, written by you and provided to plaintiffs by the defendants in the lawsuit that brings us here today, Dekker versus Weida.

You stated that you yourself drafted this report fully and completely?

A Yes.

Q And does this report comprise the totality of your opinions around the provision of gender-affirming care medical treatments?

A Well, when you say "totality," that would mean like I have no other thoughts or opinions, so that's probably not the best way to characterize it, but it certainly is my opinion.

Q Okay. So here you state that you "Have not testified as an expert in the past five years at any court hearing, trial or deposition."

So when we talked about the depositions that you participated in earlier in our conversation today, those all predated the last five years?

A That's right.

Q So you -- and we've talked a little bit about your position as the founding director of the Oklahoma Bioethics Center, which you reference here.

Does that organization still currently exist?

A I am not quite sure of its status. I think someone took it over from me and someone else took it over from him, and I don't know what involvement

she's having currently.

I know that there is still some bioethics education going on through the university, but I don't know if it's under the umbrella of the Bioethics Center or not.

Q In Paragraph 8 you mentioned that you "Have chaired the IRB, the Institutional Ethics Research Board, for 17 years at SFH."

What is "SFH"?

A That was one of the teaching hospitals. Saint Francis Hospital.

Q So "SFH" stands for Saint Francis Hospital?

A Correct.

Q And are you currently the chair of IRB and Saint Francis Hospital in Tulsa, Oklahoma?

A No.

Q So the way this is phrased it always seems present tense. When did you stop being the chair of the Institutional Research Ethics Board at SFH?

A Oh, when I left Tulsa.

Q And when was that?

A Or Georgetown.

Q So in 2012?

A Right.

Q Okay.

A So it was in the -- 17 years before that or -- yeah.

Q So scrolling down to Paragraph 10, you state that you "Have studied and consulted on issues surrounding transgender patients, both minors and adults, locally and nationally."

We just -- we discussed your background and your CV extensively and you weren't able to identify presentations, and other than one article, publications surrounding issues on transgender patients; isn't that right?

A No, I've not been writing about it but I've discussed it with people locally and nationally.

Q And in what context have you discussed it with people?

A Well, I'm not quite sure -- what context?

Q Well, in what -- who were you discussing these issues with?

A Oh, various colleagues.

Q Can you name those --

A Other bioethicists.

Q So let's start with nationally. Who nationally were you speaking about on issues surrounding transgender patients?

A I would be speaking to bioethicists, you

know, informally, not -- not for meetings or publication.

Q Can you name any of the bioethicists that you had these conversations with?

A I'm sure I can. I'm not sure if they want to be involved or not, so I'd want to clear it with them first.

Q Were these informal conversations that were occurring at meetings of some sort?

A Oh, boy, there hasn't been a meeting in, like, three years where people had the opportunity for informal conversation. So, no, these would be either locally or over the phone or Zoom or something.

Q So how many Zoom conversations would you say you've had with other national bioethicists on transgender issues in patients?

A I mean, the purpose of the -- well, no, that's not true. I was going to say the purpose wasn't specifically to talk about transgender issues, but you'd be talking about bioethical issues in general. But, no, we've had a couple conversations, either by phone or Zoom, maybe half a dozen times where the primary topic probably was transgender issues.

Q Now, you say "half a dozen." That means six -- like around six?
A Around that, yeah.
Q And --
A I mean, I don't keep track of them, so I'm just guessing at this point.
Q What time period were these conversations occurring?
A These would have been in the recent past because not many, many people were having these discussions over ten years ago.
Q So in the last ten years you would say you've had approximately six conversations by Zoom or by phone with other bioethicists around --
A Well, no. I mean, that's -- that's -- that's a little narrow. I know I've had a lot more conversations than that. You know, you asked me about by Zoom, so that would probably be no more than half a dozen, I suspect. By phone, more than that certainly, and even in person. So, I'm sorry, I didn't keep a tally. People call me, ask me my opinion, or if we're in a discussion and they ask me what do I think about such and such, then I'll tell them.
Q What you're referencing is kind of informal

consultations of your opinion on these things?

A Absolutely.

Q So I think I'll just say, going back to the ground rules we started with, I may be -- and this may be partially my fault -- occasionally maybe asking you a question too quickly and cutting you off. And so I just want to remind both of us to try not to interrupt each other and -- you know, if you try not to interrupt me with my question, I'll try not to interrupt your answer. I'll pause before I jump in with my -- with additional questions.

So this sentence says, "I've studied or been consulted on." So it seems like what we were just talking about was "been consulted on."

So what instances -- I guess, can you provide some context for this statement that you "have studied issues surrounding transgender patients locally and nationally"?

A Oh, yes. Yes, I've been reading up on the available literature and journals and other places, even in the popular press and in blogs and such.

Q So when you say "studied," you just mean reading up on the medical literature?

A Reading up on medical literature is studying, you betcha.

Q Sure. And I guess I'm wondering, like, how are you -- so in what way are you identifying the sources that you're studying?

A How do I --

Q How are they coming to your attention?

A Oh, well, through -- they're published journals, both online and paper.

Q Can you name any studies that have had significance with regard to your position -- or, I'm sorry, let me strike that and start again.

Can you name any specific studies that have been meaningful in your position on issues surrounding transgender patients?

A Not so easily that there would be any study or a couple of studies that would be meaningful. I take little bits from everything I read and form my own opinions.

Q What specific issues have you studied surrounding transgender adult patients?

A Okay. I'm having a little trouble --

Q Hearing me?

A No, I heard you, I just didn't understand you completely I'm afraid. What do you mean, "what issues"?

Q Well, you -- I'm just asking what you mean

by your terminology. So you say that you "have studied issues surrounding transgender patients." Specifically, what issues related to transgender patients have you studied?

A Well, I think that the things that I have read about and been concerned about exactly parallel those that you see in the younger patients, as well, in terms of the concept, the diagnosis and the treatment and the results.

Q So can you estimate how many times you've been consulted on issues specific to transgender patients?

A No. I mean, these are not formal consultations, these are discussions.

Q I'm sorry. So going back to your role providing ethical consultations, either -- I guess at Georgetown would have been primarily the period of time we're talking about. Can you estimate how many of those ethical consults would have related to transgender patients?

A None of the hospital consults related to transgender patients as transgender patients.

Q So you've not given an ethical consult with regard to patient care for a patient that was transgender?

A Not for an individual patient, no.
Q And that extends to both children and adults?
A Correct.
Q Moving on to Paragraph 11 where you say, "For ethical as well as medical reasons, I have never prescribed medications nor referred for surgery any patients that consider themselves transgender."
These medical reasons you reference -- going back to your specialty, you're a pediatric gastroenterologist. We've established that. That's right, right? Is that right?
A Yes.
Q Did any of your pediatric gastroenterology patients identify as transgender, to your knowledge?
A No --
Q To your knowledge --
A -- not to my knowledge.
Q Oh, I'm sorry, I cut you off again. I apologize.
What were you saying?
A I just said "not to my knowledge."
Q To your knowledge, have any of your pediatric gastroenterology patients been diagnosed with gender dysphoria?

A Not to my knowledge.
Q Have you ever prescribed a medication to a patient in your role as a bioethicist?
A That's not the role of a bioethicist.
Q Okay. I just wanted to confirm that.
Do bioethicists treat medical conditions with surgical referrals?
A That's not the role of the bioethicist.
Q Okay. When you -- so turning back to Paragraph 11, when you refer to ethical reasons that you don't prescribe medications, is that because your activities as a bioethicist are informed by your Catholic faith?
A No, it's because I think that it's unethical.
Q Do you think that it's unethical because it's not consistent with the ERDs that we talked about as Plaintiffs' Exhibit 4?
A No, I think it's unethical on the face of it. I don't think you have to be Catholic, Muslim, Jewish, or none of the above to come to the same conclusions.
Q In Paragraph 12 you say that, "None of your opinions are biased by professional income."
The entirety of your career in medicine

didn't involve patients who present to you for a gender dysphoria diagnosis; is that right?

A That's correct.

Q And none of your writings, presentations, or positions dealt with issues affecting trans people; is that right?

A Not entirely right, but mostly right.

Q And when you say "not entirely," are you referencing the one article we looked at before?

A No, I'm saying I'm very careful about absolutes.

Q Understood.

In Paragraph 14 you reference your review of the literature. Have you reviewed all of the literature pertaining to gender dysphoria?

A No one has reviewed all the literature pertaining to practically anything, including gender dysphoria.

Q Is the literature you've reviewed limited to -- or, I suppose, is the bibliography you provided a fair representation of the literature you've reviewed in preparing this expert report?

A It would have to be a representation, sure. Provided, it's -- I consider it fair, but it's not, you know, complete. There are many things that I

would look at that I didn't consider important enough to include in the bibliography, including the things that I look at and think, "Well, that's wrong, but it's good to know that that's how they feel."

Q So are there other sources that you considered in preparing this expert report?

A Sure. Many.

Q And are you able to list those sources?

A No.

Q And why not?

A Too many. There's just too many. And some of them I read in their entirety, and some of them I didn't, and some of them are just off of things like the CDC site, a WPATH site, and some of them aren't. It's just -- it's a whole gemish. Anybody who just reads an article and considers themselves an expert isn't working hard enough.

Q So when you prepare an expert report for submission in a case like this, we are entitled to know what your sources for your expert opinion are.

So, you know, I -- I -- I think we either need to understand that that bibliography is the list of sources you relied on exhaustive, or we're entitled to know what additional sources you considered and relied upon in writing this report.

Are you able to provide that list?

A I could probably -- no, I couldn't, really. I -- there's just -- there's too many things that I look at and read on a relatively frequent, if not constant, basis. And some of them I thought were pertinent and some of them not so pertinent. I thought the pertinent ones would be in the bibliography.

But I would be hesitant, like you saw when we were looking at other articles, to say that you have an exhaustive bibliography for any article. There's always more that could be added, but there are some practical limitations.

Q If a source is not listed in your bibliography, would that mean that you did not consider it pertinent to your report?

A No, I didn't say it wouldn't be pertinent but it may not be something I felt needed to be included.

As a for instance, all the regulations that govern human -- research with human subjects. Well, there's huge tomes that include all that. I don't think that that necessarily needs to be included in the brief bibliography that I submitted. You know, all the various statements from medical associations

about this one way or the other may have been things that I have read, but I don't see that they added much to my bibliography so I didn't include them.

I see something several times a week on this subject and I look at it and I read it and I see if it adds any new information or, you know, can alter my -- my perspective or sometimes reinforce my opinion, but that doesn't necessarily mean that it belongs in the bibliography.

Q To be clear, for your work as an expert you wrote a report, which is being submitted to a court of law.

Do you understand that?

A Yes.

Q This report is comprised of your opinions that are being presented to a judge as evidence in a court case.

Do you understand that?

A Yes.

Q Okay. And when we ask for the sources upon which you relied, we are provided with a bibliography that has been marked as Plaintiffs' Exhibit 2, which I will pull up, and I believe has approximately seven sources on it.

(Document is displayed).

So this was the bibliography we were provided. You've already confirmed that; is that correct?

A Yes.

Q In submitting that report, we -- so the Federal Rules of Civil Procedure require that an expert who provides a written report must disclose the facts or data that are considered by the witness in forming their opinions.

So we are entitled to know all facts and data that you relied upon in forming your opinions. And when we asked for that information, we were given this bibliography.

Are there additional sources that needed to be added to this bibliography that are facts or data that were considered by you in forming your opinions?

A I didn't feel that I needed to add anything else to the bibliography.

Q So this bibliography --

MR. BEATO: Chelsea -- I apologize. You can continue, Chelsea.

Q (By Ms. Dunn) So this bibliography is a complete document of the facts and data considered by you in forming your opinions in your expert report; is that correct?

A Well, I -- those are articles considered by me in forming my report.

Those are not the only things that I thought about, nor the only things that I read, nor the only things that have influenced me over the last decade, or over the last year, or over the last few months. You know, there's a lot of things that I have read. I thought these were pertinent to the report.

Q Dr. Donovan, I appreciate that these are the most pertinent, but you are required under the Federal Rules of Civil Procedure to provide a report that contains the facts and data that you considered in forming your opinions.

A These are facts and data that I considered in forming my opinion. It is not --

Q But is it a complete document of those facts and opinions?

A Of course not. It can't be because there's no way that I can tell you everything that has affected my thinking.

MR. BEATO: So, Dr. Donovan, let me -- let me step in.

For the studies that you reference in your bibliography, those are a sufficient and accurate

representation of the studies that you relied on when issuing your expert report; is that correct?

THE WITNESS: Yes, I believe so.

MR. BEATO: And if there are additional studies that you think of that could've -- well, strike that.

Okay. So you think it's a sufficient and accurate representation of the studies that you relied on for your expert report, correct?

THE WITNESS: I -- yes, with the provisos that I've already said. There are other things that I would consider important, but -- once again, all the CDC documents or -- now, those -- I didn't include those. Did I rely on them? Have they guided my understanding of, for instance, the requirements of appropriate human research? Well, sure.

Q (By Ms. Dunn) So setting aside various sources of background knowledge that you brought to this report, when you were writing this report, are these the specific sources you were referencing in writing your report?

A I don't know how to answer that any better than I have.

MR. BEATO: Then the answer would be "yes."

Q (By Ms. Dunn) Are these the only specific

sources you referenced in writing your report?

A Of course not.

MS. DUNN: I'm sorry, we need a short break, please.

MR. BEATO: Okay.

(Recess taken from 12:44 p.m. to 1:19 p.m.)

Q (By Ms. Dunn) So, Dr. Donovan, when we were talking before about the obligations that are associated with submitting an expert report to a federal court, I was referencing a rule which is the Federal Rule of Civil Procedure 26(a) -- I'm going to make sure I get this right -- (a)2(b). And this governs when someone who's been retained as an expert provides a written report to the Court. I'm going to read from that rule.

So that rule says: "Unless otherwise stipulated or ordered by the Court, this disclosure must be accompanied by a written report prepared and signed by the witness. If the witness is one retained or specially employed to provide expert testimony in the case or one whose duties as the party's employee regularly involve giving expert testimony.

"The report must contain, 1: A complete statement of all opinions the witness will express

and the basis and reasons for them.

"2: The facts or data considered by the witness informing them.

"3: Any exhibits that will be used to summarize or support them.

"4: The witness's qualification.

"5: A list of all other cases which the witness testified as an expert at trial or by deposition.

And, "6: A statement of the compensation to be paid for the study and testimony in this case."

Were you instructed that your report was required to contain all of the opinions that you intend to offer in this case?

A Yes, I believe I was, but I think perhaps, you know, when we're talking about the opinions that I intend to offer, I don't think that was the conversation you and I were having previously.

Q Well, I'm sorry, I'm just starting with the first subsection.

A Oh, okay.

Q So were you instructed that the report has to contain all of the opinions you intend to offer in this case?

A Yes.

Q And does your expert report that we've been referencing as Exhibit 1 contain all of the expert opinions you intend to offer in this case?

A Yes, I believe so.

Q Okay. Were you instructed that your expert report must contain the facts or data considered by you, the witness, in forming those opinions?

A Yes.

Q Okay. And did you provide all of the facts or data that you considered in forming your opinions, either in the report or in the bibliography that accompanies it?

A I would say, yes, in the report or the bibliography.

Q Okay. So turning back to your report. Give me a second.

MR. BEATO: No problem. No problem whatsoever.

Q (By Ms. Dunn) Okay. So back to your declaration. So here you say that you relied on your "years of experience as a physician and medical ethicist and your review of the literature as documented in your report."

So we should be able -- your report will demonstrate any literature that you relied upon in

forming your opinions; is that correct?

MR. BEATO: Dr. Donovan, you're muted.

THE WITNESS: It's hard to answer that way. Sorry.

Yes, I believe so.

Q (By Ms. Dunn) In Paragraph 15 you refer to yourself as an "unbiased observer." And you make comparisons to the fact that it's preferable to have unbiased observers make opinions on the diagnosis of brain death. But those unbiased observers still have to have qualifications in order to render opinions on these issues; is that correct?

A Yes.

Q And what are your qualifications to render opinions on the provision of gender-affirming care?

A Well, they would be, I think, analogous to rendering opinions on the diagnosis of brain death.

My perspective is that of an ethicist. I'm not a neurologist or a neurosurgeon or a transplant surgeon, but when you are talking about -- particularly in today's topic, you know, whether or not what we are doing constitutes appropriate informed consent and whether or not it is -- or should be considered research versus standard of care, yeah, I've had years of experience in

discussing these topics and -- and completely ready and able to render an opinion on it.

Q But you've never -- you haven't had any specialized -- well, you haven't been a -- participated in presentations or publications around the provision of gender-affirming care specifically?

A You mean, if I don't have a large public record on it? It certainly doesn't mean that you haven't been reading up on it, done some research and formed an opinion.

Q But you do have a large body of publications and presentations on issues such as physician assisted suicide or brain death; isn't that correct?

A Relatively large. Yeah, I've got those things. Those have been issues for many years now.

This case, for instance, is certainly less than a year old.

Q You reference, in Paragraph 17, a "diagnosis of transgenderism."

What is a diagnosis of transgenderism?

A Diagnosis of someone who is being transgender or that they believe that they are transgender.

Q Where does that diagnosis exist?

A Where does the diagnosis what? I'm sorry.
Q Exist. Where's that diagnosis provided for? Is that a medical diagnosis?
A You mean, who provides the diagnosis? Is that what you're asking me?
Q Well, no. Is that a medical diagnosis?
A Well, it certainly is supposed to be, yes.
Q Where is the criteria for that -- or where's the diagnostic criteria for transgenderism?
A Well, the diagnostic criteria for transgender patients is found in both DSM and WPATH.
Q And the what?
A W-P-A-T-H criteria.
Q But that diagnosis is gender dysphoria, not transgenderism; isn't that correct?
A Yes. But gender dysphoria only occurs in those who have identified as transgender.
Q But transgenderism is not a diagnosis that's reflected in the DSM-5 or in the WPATH standards of care, correct?
A Okay.
Q Is that correct?
A Yes, I believe so.
Q You refer here to a person presenting themselves as a -- or a person having a gender

identity that's different from the sex assignment at birth as an aberration. Is that fair to say?

A I think that's quite fair to say. You know, if you talk about the norm being what is predominant, then that would have to be statistically described as abnorm.

Q What is your basis for asserting that a person asserting their gender identity is akin to asserting a delusion that they are a chicken?

A Well, I think that if someone came in with something that seemed to define -- defy both the visual evidence and common sense, that you would not necessarily take that at face value.

Q Are you a licensed psychiatrist?

A No, I'm not a licensed psychiatrist, but I do know the difference between a person and a chicken.

Q Have you ever diagnosed any sort of mental health condition?

A I'm sure I have because I've had patients who had to be referred.

Q You've -- you have been the one to provide the diagnosis of a mental health condition?

A Well, when you suspect it, you refer it to someone to care for them, sure.

Q But is that providing a diagnosis for the patient or is that referring someone for a diagnosis?

A It's a presumptive diagnosis.

Q You then state that, "This is the approach now being taken by many psychiatrists and surgeons and endorsed by medical society."

Is the approach you're referring to in this sentence the approach of someone saying that they are a woman and someone else immediately clothing them in a dress?

A No. I'm saying that the -- the problem is that we are accepting the mis-diagnosis. Or not even a mis-diagnosis, but the mistreatment rather.

Q And what is the mistreatment you're referring to here?

A In terms of patients with gender dysphoria, I think it's not conceptually sound to say that you are a man or a person in a man's body but you think you're supposed to be in someone else's body or some other body or yourself or alter that body in order to look like that. Those are approaches that just don't really seem to fit with a common sense approach.

If we had a patient with anorexia nervosa and she had a dysmorphia and she said, "I am too fat," the last thing that I would recommend we do is

to help her body conform to her self-image.

Q So you're comparing gender dysphoria to anorexia nervosa?

A Well, they're both distortions of bodily image, yes.

Q But affirming a patient with anorexia desire to limit their calorie intake could lead to dehydration; is that correct?

A And worse.

Q And it could lead to starvation or even death?

A Yes.

Q Yes. And so your position is that it is mistreatment to affirm someone's gender identity if it's not aligned with their sex assigned at birth?

A I am saying that we don't have enough information to be certain of the correct approach and, therefore, to embark upon that approach without seeking that information is wrong.

Q And what particular types of medical treatment are you referencing?

Are you speaking of the administration of cross-sex hormones?

A Yes.

Q Are you speaking of gender-affirming

surgeries?

A Yes.

Q And are you speaking of the administration of puberty-blocking medications?

A Yes.

Q And so it is your opinion that affirming someone's gender identity, if it is not aligned with their sex assigned at birth, is mis- -- is medical mistreatment?

A I think it is fraught with problems because I think that it is probably applying a treatment that does not match the needs of the patient.

Q Earlier you said that you have given presumptive diagnoses for mental health conditions.

When you're licensed as a medical doctor -- or I guess you're a pediatric endo- -- I'm sorry.

Does your license allow you to diagnose mental health conditions?

A My license? Yes.

Q Okay. So you say that -- so going back to this approach. When you say "this is the approach," I just want to make sure that we're both talking about the same -- you know, what you are referring to as "this approach."

And you're talking about the approach of

providing medical care that affirms someone's gender identity when it doesn't match their sex assigned at birth. Is that accurate?

A Yes.

Q Okay. And you say that "many psychiatrists are taking this approach."

What is the basis to say that?

A Well, I -- I don't think that that's in contention that many psychiatrists are providing or endorsing gender-affirming care. I didn't specifically give you data on that, but I think that that's pretty widely known.

Q You then go on to say that, "Perhaps, as a result the number of individuals who identify as transgender has exploded over the past decade"; is that correct?

A It has certainly increased, it has.

Q And you said a number of 20 to -- to a factor of 20 to 40; is that right?

A That's right, that's what I've read.

Q Where did you get that information?

A Actually, the CDC had that information in their database.

Q So you didn't -- you cited to -- in your bibliography, which I'll quickly turn to -- I stopped

sharing. I could have just stayed where I was.

(Document is displayed).

So you cite to -- here on this first line there's a "CDC Youth Risk Behavior Survey" and then there's a link to the Williams Institute.

Is this the data you're using to make that 20- to 40-factor assertion?

A I believe that's where it came from.

Q And so the Williams report that's linked here -- I'll just quickly pull up that source, just so we can look at it together.

(Document is displayed).

So this is the Williams Institute report that is found at the end of that link.

Do you recognize this report?

A Not in that form, but I'm sure that must be it.

(Whereupon, Exhibit Number 17 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Okay. I'm going to mark this as Exhibit 17.

So this study -- I'll zoom in a little bit -- or this report cites to data from the CDC, a couple of different surveys, it looks like, the

Behavior Risk Factor Surveillance System, the Youth Risk Behavior Survey, and then some other survey data.

Is this the document where you got -- when you reference the CDC, is this the document where you got that information?

A I believe so, or links from it.

Q Okay. And do you know where in this report it cites a 20- to 40-factor increase?

A I'm sorry, I'd have to read the whole thing again to find that.

Q So here on this first -- on this first page it says, "Youth ages 13 to 17 comprise a larger share of the transgender-identified population than were previously estimated, currently comprising about 18 percent of the transgender-identified population in the U.S. up from 10 percent previously."

Is that relevant to how you determined there was a 20- to 40-factor increase?

A No, the 20 to 40 is actually what I read in the CDC survey, but I don't see it -- as a matter of fact, I can hardly see what you've got there at all, but that's okay.

Q Oh, I'm sorry.

A Small print.

Q I'm happy to share your screen.

So I'll just -- I guess what I'll represent to you is that we could not -- looking at your bibliography, we could not find the 2017 data that you were citing to. So are you saying that you received that information -- that information came directly from the CDC and not from this report?

This report is what was linked and we thought that that indicated that that's where it came from.

A Well, I -- I believe that that information may be there.

That's the executive summary, isn't it? Not the entire report?

Q Correct.

A Yeah.

Q All right. I will stop sharing this document and go back to your bibliography.

(Document is displayed).

So going back to your report, in Paragraph 19 you state that, "80 percent of young males who present early" -- and I assume that you mean by this present with a gender identity that's different than their sex assigned at birth. Is that what you're referencing?

A Yes.
Q Okay. So young males presenting early, that "80 percent of those young males would historically revert in their self-perception by the time they had completed puberty."
Where did -- what is your evidence of that statement?
A Oh, that -- that's been widely published and repeatedly published.
Q Can you name the study that that information comes from?
A I'm sure I could. It's more than one source, but, yeah.
Q Can you name those studies?
A Not right now, no.
Q Why didn't you cite to this -- the studies that you relied upon in formulating that assertion in this report?
A Once again, I had relied upon a large number of things. Not everything that was listed in the bibliography, as I mentioned before.
Q But you are aware that it was your obligation to provide the data and resources you relied upon in forming your opinions when you submitted this report?

A Well, I understood that I would present my opinion and/or the data in the bibliography. And my opinion has been formed by a much broader reading sources than -- than are involved even in this case. So --

Q I understand --

A -- my opinion, you know, was not strictly just a matter of -- of opinion on the -- on this particular case. And, in fact, you know, I have read these and somewhere have articles that do demonstrate that. So I thought that that was important.

I hadn't really seen anybody contesting that as a fact. Sometimes what people are doing is showing that it may be transition for females, but that -- that is a fact that had been clearly established in the past and I didn't think that that would be very controversial.

Q This fact was of significance to your opinion; is that right?

I mean, you cited it in your report so it has had some significance to your opinion.

A Okay.

Q Is that right?

A Yeah.

Q And you are under an obligation to provide

the data and evidence that you are relying upon to come to your opinions. We've discussed that already.

Do you understand that?

A I -- yes, we've discussed that.

Q And you haven't -- you are unable right now to provide the source of evidence on which you relied in making this statement.

A Well, you did say that you wouldn't accept anything more at this point. I could, if you want, go back through my files and find that.

Q You -- well, so perhaps I should ask it this way. You did not disclose the data or evidence you were relying upon in making this assertion when you submitted your report?

MR. BEATO: Counsel, I think we can agree that for this proposition there's not a citation to it and it's not involved in the bibliography. I think we've established that.

MS. DUNN: Well, I think the witness needs to say that, though, if you don't mind, Michael.

Q (By Ms. Dunn) So you did not disclose the data or evidence you relied upon in making this particular assertion when you submitted your report; is that correct?

A I did not. I did not list things in the

bibliography that supported every statement that I made.

Q Okay. You also say that, "We are now seeing a much larger number of females."

What is your source for this assertion?

A No one denies that. That data is available as well. And I believe you'll find it in the bibliography. I could go through the articles and bring that out for you, but, you know, I'd have to open up the articles and find them.

Q So if we turn to your bibliography, can you tell me in looking at it which of these articles would support that assertion?

A Not at this time.

Q And you did not specifically provide a citation for that source of -- I'm sorry, for the evidence or data upon which you make this assertion in your report?

A I didn't footnote the report itself.

Q You then say that, "The two leading explanations for this unexplained phenomenon are greater social acceptance or social contagion."

What sources do you rely upon in making that assertion?

A Actually, this was suggestions that have

been made that I do have listed in there.

But I'm -- like I said, the way I write, I read and then I write. But I wasn't asked to footnote these so I didn't. I could find them in the -- in the articles that you have, I'm sure, but it's going to take me some time to pull those out again.

Q So these are -- could be described as perhaps hypotheses? Is that what you're suggesting?

A Yes. Explanations could be hypotheses.

Q But as the literature stands, there's no scientific evidence that links social contagion as a cause of gender dysphoria?

A There has been, as you know, a description by Littman and all about the -- about gender dysphoria in young females being almost like a social contagion. And she had documented that. I didn't list that one in there, it's just -- I thought that was a worthwhile and interesting observation.

But, once again, it's an unexplained phenomenon with potential explanations. It's not data.

Q So just to be clear, are we referencing the Littman report that -- you did list this in your bibliography. Is that what you're referencing right

now, the rapid --
A Yes.
Q -- onset gender dysphoria?
A Yes.
Q And are you aware that there was a correction issued with regard to this article?
A I'm aware that she got a lot of flack about that in a subsequent article as well, yeah. It's -- it was not embraced by the community.
Q And so you're aware that there was a correction issued by the publication that featured her article?
A I had heard about that.
Q Have you read it?
A Nope.
(Document is displayed).
Q So what I'm showing you on the screen is the correction to the Littman article that you listed in your bibliography.
You have not seen this document before?
A I don't recall seeing this.
Q You said you don't recall seeing it?
A Nope.
(Whereupon, Exhibit Number 18 was marked for identification purposes and made a part of the

record.)

Q (By Ms. Dunn) And we will mark this as Plaintiffs' Exhibit 18.

And if you'll look at -- so here it says, "Emphasis that this is a study of parental observations which serves to develop hypotheses."

So this specifically says that, "Rapid-onset gender dysphoria is not a formal mental health diagnosis at this time. The report did not collect data from adolescents and young adults or clinicians and, therefore, does not validate the phenomenon."

Are you aware that this correction was issued with regard to this hypothesis?

A Well, this doesn't actually correct anything that I had just said, though, that you were reading to me because, in fact, I wasn't making a -- an argument so much about rapid-onset gender dysphoria, but also pointing out that we are seeing more females currently than in the past when male predominance was the usual or the norm.

And then I pointed out that there may be some potential explanations for that. That's all I did.

And this still says it's a "study of

parental observations and serve to develop hypotheses."

Q So this article --

A (Inaudible) hypotheses.

Q You would agree this article is hypothesis-generating rather than hypothesis testing or validating?

A That's all I was using it for.

Q Okay. Turning back to your report.

(Document is displayed).

You say that -- in Paragraph 20 you say that, "There's no biochemical, hormonal, radiological, or genetic basis for confirming a diagnosis of gender dysphoria"; is that correct?

A That's correct.

Q What is your evidence to make this assertion?

A Because there is no evidence. There is -- there is no biochemical, hormonal, radiological, or genetic. Nobody has held out that there is. I didn't really think that needed further explication. None of the people treating it say that they have a hormonal or a biochemical or a radiological or a genetic basis that they can point to.

Q So you're not aware of any studies that

demonstrate that genes or hormones might influence gender identity?

A I didn't say that. "Might"? Might is a different thing from diagnosing.

(Whereupon, Exhibit Number 19 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So I'm going to share an article titled "Neurobiology of Gender Identity and Sexual Orientation." This was published in the Journal of Neuroendocrinology in 2018.

We'll mark this as Plaintiffs' Exhibit 19.

Are you familiar with this study, Dr. Donovan?

A I am aware of it. I haven't read this article.

Q And so you were not aware that this article, on Page 4, states that, quote, "Several extensive reviews by Dick Swaab and coworkers elaborate the current evidence for an array of prenatal factors that influence gender identity, including genes and hormones."

A "And evidence of a genetic contribution to transsexuality is very limited." Yeah. I mean, this -- this basically is not diagnostic.

Q So my question is whether you were aware of this study when you made your assertion in your report.

A This study has nothing to do with what I said. It confirms what I said in that there is no genetic basis that allows us to diagnose it.

Are you saying that this is a genetic basis for the diagnosis of gender dysphoria?

Q I'm saying that there is evidence in the literature -- that this article notes that there is evidence in the literature that there are prenatal factors that could influence gender identity, including genes and hormones.

A There is -- there are suggestions. None of these are proven in humans. These are all hypotheses that I think are worth noting, but none of these are used to diagnose a child or an adult with gender dysphoria or as transgender.

Q But my point is that you had not read this study when you made your assertion in your report because you -- you told me when I opened this study that you had not read it; is that correct?

MR. BEATO: Object to form.

Dr. Donovan, you can answer the question.

THE WITNESS: I was aware of the study. I

had not read it. I didn't think it was particularly worth a great deal of time when they were unable to use their findings to form a diagnosis on individual patients, which was really what I was pointing to.

Q (By Ms. Dunn) Give me just one quick second. Not a break.

So, I guess, going back to the report -- and I'll just close this other exhibit to hopefully get there.

(Document is displayed).

When you say -- or when you take issue with the fact that self-report -- that there's no way to confirm a diagnosis other than self-report, are you suggesting that medical conditions that rely on self-support -- I'm sorry, that rely on self-report of symptoms are invalid? I mean, there are other conditions that rely on self-report.

A No, I didn't say that. And the term I used, by the way, was self-perception rather than just self-report --

Q And what's --

A -- because symptoms can be reported.

No, I said "self-perception." And all I would say with that is if that's all we have to go on, we should proceed cautiously.

Q Is there a difference between self-perception and self-report?
A Well, first you have to perceive in order to report.
Q You wouldn't agree that just because a diagnosis is based on self-report that it should go untreated?
A I'm sorry, please restate that so I'm clear.
Q So the mere fact that a diagnosis is based on self-report doesn't mean that the condition should go untreated?
A No, it shouldn't go untreated if there is a condition that a patient is reporting. It should be confirmed and the treatment should be conformed appropriately.
Q And that sort of confirmation is done by a clinician, according to diagnostic criteria; is that right?
A To the extent that you say it, yes.
Q So even in the case of patients with gender dysphoria, a clinician is confirming that diagnosis.
A Insofar as it can be confirmed, yes.
Q But you're not suggesting that there must be a biochemical, hormonal, radiological, or genetic

test to confirm every diagnosis?

A I don't think there's anyone who is trying to make that diagnosis who would not welcome some sort of confirmatory evidence. And that's what I'm saying. And we don't have that.

Q In Paragraph 22 you talk about a "treatment approach that is to provide puberty blockers for young prepubertal patients followed by cross-sex hormones followed by various levels of surgical reconstruction."

Are you aware that puberty blockers block puberty?

A Well, of course.

Q So in what context would a puberty blocker be given to a patient who is prepubertal?

A You can only block puberty if it hasn't occurred. So puberty blockers are for those who have not gone through puberty completely. They're not given after Tanner Stage 2.

Q But a patient receiving puberty blockers would be at Tanner Stage 2, so they would be beginning to move through the process of going through puberty?

A That's what they're supposed to block with those medications.

Q And just to confirm this, your clinical practice was not in endocrinology; is that correct?
A I was a pediatrician. All my patients were supposed to go through puberty eventually.
Q Understood. But your clinical practice was not in endocrinology --
A No.
Q -- is that correct?
A No.
Q And what evidence do you have to support your contention that any youth who receives puberty blockers goes on to cross-sex hormones?
A It's by far the norm.
Q What evidence do you have to support that assertion?
A It has been reported repeatedly, including by the people who are using the puberty blockers and cross-sex hormones. It's not in contention.
Q But what evidence are you relying on to make this statement?
A It's -- that's the multiplicity of sources.
Q Is there one source in your bibliography that you can point us to?
A I'm sure I can find that as well, yes.
Q If I were to show you your bibliography

right now --

A If I were to read the articles again. I don't even highlight them, typically, but I could find it for you.

Q But if I were to show you your bibliography today, you would not be able to identify to me which source contains the support for this assertion?

A I suspect it's in more than one.

Q But if I provided you with your bibliography today, you would not be able to point me to the -- any one of the specific sources that contain the information to support this assertion?

A Given enough time, I would.

MR. BEATO: Object to the form.

You can repeat that, Dr. Donovan.

THE WITNESS: Say what?

MR. BEATO: Could you repeat your answer? I made an objection, but could you repeat your answer?

THE WITNESS: I don't even remember the last answer. I'm sorry.

Q (By Ms. Dunn) Can you point me to which of these sources you rely on in making this assertion?

A I'm sure I could, given enough time.

Q Can you do it right now?

A Nope.
Q And then what evidence do you have to support the contention that any person who receives hormones goes on to have a surgery of some sort?
A I didn't say that.
Q Well, you summarized the treatment approach as being -- as moving from one of these types of treatment to the next.
A That's true.
Q And do you have any evidence to support the contention that a person who receives hormones then goes on to surgery?
A That is the sequence. That's not contentious. That's what WPATH -- I didn't say everyone did, I just said that's the sequence.
Q So you say that treatment -- here you say, "Treatment is determined by the patient."
What does that mean?
A I mean you can't have surgery unless the patient wills it.
Q But you also can't have surgery unless a clinician supports it; isn't that correct?
A Well, that's true, but that really isn't in contention here.
Q Well, this is -- you've framed in your

report that this is self-determined. And I -- I just want to be clear, you're not -- your opinion, you're not stating that this is something that happens without clinician approval, correct?

A I didn't say it would happen without clinician approval. Patients should not self-castrate.

Q In Paragraph 23 you say that, "The studies that support this approach have come under increased scrutiny, with international scientific and clinical bodies expressing concerns about the safety, efficacy, and scientific basis for the current interventions."

What international scientific bodies are you referring to?

A Those in Finland, Sweden, England, Australia, and New Zealand.

Q And what sources are you relying on in making that statement?

A Well, the -- and these are published sources as well.

Q Are they in your bibliography?

A They are in a bibliography. I think that they're in the one that we have for this as well.

Q I'm sorry, I don't understand that.

Are they in the bibliography that was provided with your expert report -- or after your expert report?

A Yes. Certainly the Abbruzzese one mentions that. I'm trying to think which others may have done that.

The Levine report may have, as well, and I think I could find it in the Clayton report, too, but I'd have to look.

Q Do you have any sources directly from these international scientific bodies, or you're relying on these -- these articles that you've referenced in your bibliography?

A No, they've published them.

Q I'm sorry, who's published them?

A No, no, the various medical associations in those countries have published their concerns. This isn't just from the articles itself.

Q And did you rely on those sources when you made this statement in your report?

A I also read those, yes.

Q And did you cite them in your bibliography to your report?

A Once again, I didn't cite everything that I read.

Q So you said that you think that this was mentioned in the Abbruzzese article?
A I believe it was, yes.
Q So I'm just -- I'm going to pull up this article for you -- for us. And this is the Abbruzzese article that's listed in your bibliography. Abbruzzese, Levine and Mason are the authors?
A Yes.
(Document is displayed).
Q I can -- is this --
A Oh, no, this isn't the one. They had -- it was an evaluation of the original Dutch studies involved, so it wouldn't be in there.
Q So this is the Abbruzzese article that is cited in your bibliography, so when you reference "Abbruzzese" in identifying a source where you would have received this information about the international bodies, you're not speaking of this article called "The Myth of Reliable Research in Pediatric Gender Medicine"?
A That's correct.
Q You're thinking of an article that's not listed in your bibliography?
A I can't say that.

(Whereupon, Exhibit Number 20 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Well, there's no other Abbruzzese article -- sorry.

Before I move on to there, I'd like to mark this as Plaintiffs' Exhibit 20.

So going back to your bibliography, there's no other Abbruzzese article that's listed here.

A Then we must assume that it was not the Abbruzzese article.

Q Okay. So you can't identify which of the source -- you said it might be in either the Levine or Clayton articles?

A I --

MR. BEATO: Object to form.

Dr. Donovan, you can answer that.

THE WITNESS: I believe so. Once again, this was not a controversial statement, so I didn't make a point of highlighting the reference for it.

Q (By Ms. Dunn) So did you just -- you decided not to reference anything that you found to be non-controversial?

A I didn't say that.

Q Just going back to the Abbruzzese study

that you did cite, in what way did you rely on this study in your report, do you recall? Or this -- I'm sorry, this article.

A Well, they were critiquing the original Dutch studies that talked about the diagnosis and -- and, therefore, the treatment protocols for gender dysphoria, only it wasn't called "gender dysphoria" at the time. It was also called the "gender-identity disorder," I think, at that time.

And it turns out the literature itself was so poorly done that it shouldn't have served for the -- for the development of the widespread treatment protocol for this condition.

Q Are you aware that one of the authors of this article is affiliated with the Society for Evidence-Based Gender Medicine?

A Well, it says that there.

Q Yeah. Are you familiar with the Society for Evidence-Based Gender Medicine?

A Not particularly, no. I've heard of it.

Q What do you know about it?

A That they have real problems with -- with the diagnosis and treatment of gender identity disorder.

Q Are you a member?

A No.
Q Have you done any work for Society for Evidence-Based Gender Medicine?
A No.
Q Do you know how they're funded?
A No.
Q In Paragraph 23 -- I'm sorry, I'll re-share your report so that we can be specific.
(Document is displayed).
In Paragraph 23 you say that, "Three European countries have begun to form more conservative and cautious treatment guidelines."
What countries are these?
A Well, Great Britain, you know, the Tavistock Clinic was closed and they re-did their approach.
And Finland has said that they are concerned about their own approach.
And so is Sweden.
I believe France has already done that, as well, too, but I haven't read up on that.
Q Did any of these countries ban this sort of medical treatment?
A To my knowledge, nobody has yet banned that approach.

Q And when you say that they --
A But have they expressed concerns? Yes. And re-evaluated, yes.
Q What evidence do you have that these countries have formed more conservative and cautious treatment guidelines?
A Well, the Brits themselves said that they -- they closed Tavistock in order to actually slow down their enthusiasm for gender affirmation and to spread it around to other clinics and hospitals in Great Britain who would take a more cautious approach.
Q What is your source for that?
A There's a report in the British literature.
Q Is that report cited in your bibliography?
A It's not.
Q And in England, the care is still being provided, just by local clinics instead of centralized clinic; is that right?
A Yes, that's my understanding.
Q In Paragraph 24 you assert that, "Initial psychological evaluations of the patient have often become minimal or almost non-existent."
What is your evidence for this assertion?
A The next line does point out what has been

reported. I thought that was also in the bibliography.

Planned Parenthood clinics have been reported by those going to them that they will give a prescription after a single visit, sometimes within the same day.

Q You're saying that that comes from patient reports?

A Uh-huh.

Q So the only source that we are given related to Planned Parenthoods from your -- I'm sorry, when we were provided with your sources, was a printoff of the Planned Parenthood of Texas.

Is that what you're referencing?

A I'm sorry, I'm not sure what you're referring to.

Q Okay. I'll pull it up.

(Document is displayed).

So this was provided to us when we asked for sources upon which you relied. And this was actually provided in response to your GAPMS report.

But is this what you were referencing when you say that hormones are provided after a single visit?

A Actually, scroll down. I think that may be

one of the places where they -- yeah. Well, I guess, "If you are eligible, Planned Parenthood staff may be able to start hormone therapy as early as the first visit."

Yeah, I'd say that was it.

Q Yeah, is this the only --

A At least one of them.

Q Is this the only evidence that you have of that?

A No.

Q What other evidence do you have of that assertion?

A There have been patients who have also described this, and that's been published in the lay literature.

Q And what literature is that published in?

A Online. I'd have to find it.

Q These aren't --

A But the fact that Planned Parenthood -- the fact that Planned Parenthood also says the same thing made me think that it was probably accurate.

Q Are these your patients that we're talking about?

A Of course not.

Q They're just anecdotes or reports that --

A Patients that have gone to Planned Parenthood and received hormonal treatment on the first day.

Q And these are things that you've read online?

A Yep.

Q Have you confirmed this information in any way?

A I think Planned Parenthood just confirmed it right in front of us.

Q Well, this actually says, "If you are eligible, Planned Parenthood may be able to start hormone therapy as early as the first visit."

Do you know what it means to be eligible?

A The patient said that they went in and said that they wanted it and they got it. That sounds like they were eligible.

Q But does it say that there are no psychological exams being provided? This report does not say that, correct?

A It would be difficult to follow the guidelines in a single day, seeing as how it's supposed to be over a prolonged period of time to confirm the diagnosis.

Q But you have not confirmed that Planned

Parenthood is doing -- the patient may have gotten a psychological exam elsewhere and then gone to Planned Parenthood.

How -- have you confirmed that that's not what's happening?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: You mean, have I visited the Planned Parenthood office and asked to see the psychological report that didn't exist? No.

Q (By Ms. Dunn) And so you're basing this assertion on reports that you've seen online and this statement from this website?

A And there are other reports for other locations. It's not just Planned Parenthood who have done this. But, yes, I think if a patient goes to Planned Parenthood, says they didn't bring a psychological report, that they were given their hormones on the first day. One of them said over the phone even. That seems like it's plausible. And nobody has come out to deny it.

Q But you haven't confirmed that this is actually the way the care is being provided?

A What sort of confirmation are you looking for?

Q Well, I guess I'm looking for evidence that's something more than just ambiguous printout of a website and, you know --

A And a patient statement?

Q -- things you've read online.

A I'm sorry. And the patient's statement doesn't count?

Q Well, unless you can point -- I think it -- without you identifying where online you've seen them, I think it's hard to assign credibility to that sort of statement.

And you're not able to identify to us where you read these patient reports?

MR. BEATO: Object to form.

Dr. Donovan, you can answer the question.

THE WITNESS: They could be found.

Q (By Ms. Dunn) Did you identify where you read these patient reports in your expert report?

A No.

Q And did you disclose that in your bibliography?

A Actually, I think that was touched on by one or two papers in the bibliography, as well. But, once again, you know, it wasn't the --

Q Can you tell us --

A -- sole topic of the paper, so I'd have to go through each one.

Q Can you identify right now to me which of these articles support that statement that there aren't psychological examinations being provided of patients with gender dysphoria?

A Not today.

Q Are you aware to do so would be inconsistent with the standard of care prescribed by WPATH?

A Absolutely.

Q You agree that that would be inconsistent with the standard of care?

A Yes.

Q And you agree that that would be inconsistent with the standard of care required by the Endocrine Society clinical guidelines?

A Yes.

Q Do you know of any instances of this happening in the state of Florida?

A No.

Q Do you know of any instances where someone was prescribed any sort of gender-affirming medical treatment without a psychological evaluation and that was covered by the Florida Agency for Medicaid?

A I don't know who's prescribing these in Florida.

Q But you're not aware of any instances where someone received a gender-affirming medical treatment without a psychological evaluation and that care was covered by Florida's Medicaid program?

A No.

MR. BEATO: Counsel, I think we've been going for about an hour. Would you mind if we take a break?

MS. DUNN: Absolutely. Let's take a break.

(Recess taken from 2:19 pm. to 2:27 p.m.)

(Whereupon, Exhibit Number 21 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So before the break we were looking at a PDF of a website of the Texas Planned Parenthood. I did not mark that as an exhibit and so I'd like to have that marked as Plaintiffs' Exhibit 21.

All right. So we'll go back to your report, Dr. Donovan. And in Paragraph 25, you reference that, quote, "With further study it has come to light that complications such as arrested maturation, physiological changes, fertility

challenges, hematological changes, and osteoporosis can all result from treatment with puberty blockers and may be irreversible."

You don't cite any evidence to support this statement in your report, correct?

A Within the report or in the bibliography are we saying now?

Q Well, so first of all there's no citation here to support this statement; is that correct?

A No, I -- like I said, I didn't use footnotes on this.

Q And which of the sources in your bibliography provide the evidence to support that assertion?

A I think you'll find it in the Levine and I think probably in Robbins as well. Probably in Clayton as well, too, because she was talking about the dangers.

Q I'm going to pull up the Clayton article that you reference.

A Okay.

(Document is displayed).

Q Do you recognize this document?

A Looks like -- yes.

Q And this is the Clayton article that's

included in your bibliography?

A Yes, looks like it.

(Whereupon, Exhibit Number 22 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'd like to mark this as Plaintiffs' Exhibit 22.

This article is a letter to the editor; is that correct?

A This looks like, yeah, the one -- the story about Rose. I don't know that they talked as much about the -- in this particular one about the adverse effects. I'd have to look on the next page.

(Document is displayed).

Okay. It's really hard for me to read this because the print is so small.

Oh, that's bigger. That's good. Thanks.

Okay. This, I think, concentrates more on the surgical problems than the hormonal problems. Is that right? Slide slowly.

Yeah, I think this is one on the -- bring it up a little bit more, if you would, Ms. Dunn.

Q Up this way?

A The other way, I think. Yeah.

Oh, I guess she did talk about hormonal

treatments there, but that wasn't really as pointed.

Let's go down to the next page. I think that this one was really better for the -- go ahead down.

Further down. Thanks.

Can you scroll down a little bit? I'm having trouble.

Well, she does mention irreversible and long-term adverse effects with the treatments on fertility and sexual function and bone, brain, cardiovascular functioning.

So, yeah, she -- this wasn't the highlight of it but she certainly does go into it as well.

Q Just to be clear, though she may reference those things, this is a letter to the editor, correct?

A Yes.

Q And letters to the editor are not peer-reviewed?

A No.

Q And Ms. Clayton is actually, it appears, a student at the University of Melbourne when she wrote this?

A If you say so.

Q Well, her email address indicates that

she's a student. Do you know otherwise?
A No.
Q And she --
A (Inaudible).
Q I'm sorry?
A No. I see that now.
Q And she is a -- at the School of Historical and Philosophical Studies at the University of Melbourne; is that right?
A That's what it says there.
Q She's not a medical doctor?
A No.
Q You also referenced the Robbins article that you cite in your bibliography.
A Yeah. Let's look there. I thought that was pretty good, too.
Q Is that -- can you read that or should I zoom in more. I'm trying to -- oh, wait, I haven't shared my screen. I apologize.
(Document is displayed).
Can you read this or should I zoom in more? I'm trying to balance getting --
A That's okay. I can see some of that.
Q Is this the Robbins article that you were referencing in your bibliography?

A I believe so. Looks like it, yes. July '19, yes. Okay.

(Whereupon, Exhibit Number 23 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'd like to mark this as Plaintiffs' Exhibit 23.

This is not an article in a peer review research publication, correct?

A Neither was the Planned Parenthood thing. I mean, no, I'm just looking for reports. Right.

Go ahead.

Q So you said that this supported your contention of the harmful effects of puberty blockers that you cite in your report; is that correct?

A I'm sorry. Say that again.

Q When I asked -- and I'll go back to your report. When I asked what supported your assertion that complications can result from puberty blockers, you said that you believed the Robbins article may provide that information; is that right?

A I said that or the Levine. Like I said, I'd have to look, so --

Q But I just want to clarify --

A -- I'm going to look with you.

Q I'm sorry?
A Yeah. Yeah. I said I'm perfectly willing to look through these with you.
Q Sure. But my question is, this is not an article in a peer-reviewed journal?
MR. BEATO: Object to form.
Dr. Donovan, you can answer.
THE WITNESS: I don't know that this is peer-reviewed.
Q (By Ms. Dunn) If we go back to your bibliography, it looks like this is published on a website called thepublicdiscourse.com.
A I doubt that's peer-reviewed, then.
Q And, in fact, it appears -- and correct me if I'm wrong, but it appears that this article merely summarizes another article; is that correct?
A It refers to the Levine article a lot, yeah.
Q Okay.
A This was not so much to establish the side effects, which had already been reported, but actually to talk about what I thought was interesting which was why informed consent then was difficult, given what we know and mostly what we don't know.
Q So, I'm sorry, I don't believe I'd asked a

question, so if you can just limit yourself to responding to the questions I ask, I would appreciate it.

A I thought I was responding, why we were using something -- why we were using this article.

Q That's not what I -- I just asked whether that article was summarizing another article.

A Okay.

Q So, then, you also stated that it's possible that you were relying on the Levine article, which you cited in your bibliography. And I will pull that up.

(Document is displayed).

Is this the article you were referencing?

A Uh-huh.

Q Or you referenced.

A Yes.

(Whereupon, Exhibit Number 24 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'll ask that this be marked as Plaintiffs' Exhibit 24.

So do you know where in this article that the complications associated with puberty blockers are discussed?

A Let's scroll through it.
Q Please tell me if I'm going too fast.
A We may have to go back, but keep going.
Let's go down further, more so toward the -- keep going.
Keep going. Let's go down to see if we can't find a section on the harms as well.
Keep going.
Q Should I keep going or --
A Sure. Sure. Whoa, slow down.
Go back a little. Thank you.
Okay. Let's go down a little further. Okay. Now, you do see -- I'm sorry, I assumed you saw some of those. No, that was --
Q I'm sorry?
A Nevermind. It's hard to do it this way.
Just keep scrolling down, let's see if we get to the prepubertal part again because he's kind of switching back and forth.
Oh, those are the social risks for children being considered for puberty block A, not the physiological risks.
I think we've passed it, but keep going down, why don't you.
Scroll it. Keep going.

No, keep going because you're on the social.

No, you're still in the social area. Keep going. I think it's probably above us.

Okay. Keep going.

Keep going down.

Keep going down, please.

Oh, go up. Way up where we were talking about the --

Q Is this --

A Let's go above the --

Q -- what you're referencing?

A Huh?

Q Is this what you're referencing or --

A Possibly. Let me -- I think that there was even more than that, so I think he covered it.

Okay. Sorry. Let's go back down. Too quick. Too quick. I can't read that fast.

Q Sorry, did you not want me to go the whole way down?

A Well, no, I wanted to see -- I think it --

Okay. Scroll up a little bit.

Scroll up a little bit.

And up a little bit.

Up a little bit.

Okay. Up a little bit.

Okay. Go on.

And I think this is a really good article, but I think it is also focusing more on the informed consent thing than the -- than the puberty-blocking hormone issues.

Q So you're not able to identify a place in this article that --

A Let's go up a little bit more. Sorry. Let's go --

Okay. Not seeing it there.

Q Okay. So you're not able to identify where in this article is any evidence to support the assertions you made about complications associated with puberty blockers?

A Not in this article.

Q Okay. And we looked at the other two articles that you said from your bibliography might contain that information and you weren't able to identify where in those articles?

A That's two.

Q I'm going to go back to your report.

(Document is displayed).

So in addition to listing these complications, you say that they may be irreversible.

Do you -- can you cite to any evidence for that assertion?

A It's a maybe. The problem, of course, is that what we need is evidence-based answers with this. And it's not just that, you know, we're citing the wrong articles today, but for many of these the evidence is pretty thin or non-existent at this point.

Q But I'm just asking whether you have evidence cited to support your assertion that these complications may be irreversible?

A They may be.

Q But you have not provided any --

A That doesn't make them --

Q I'm sorry. My question is whether you have provided any citation in your report that supports the assertion that these complications may be irreversible?

A No, not on this bibliography.

Q Okay. So no citations in the report and no sources you can point to on the bibliography; is that correct?

A The citations -- none of the citations were in the report. That's (inaudible) footnotes.

Q So then in Paragraph 26 you say, "In any

medical condition where the cause is unknown, the treatment's uncertain, and the adverse effects of intervention are not fully elucidated, a proposed course of therapy would have to be seen as experimental."

So you say "cause unknown."

Do causes of medical conditions have to be known in order to treat them?

A That's not what it says, but it's certainly helpful. If you know what the cause is, then your treatments can be modeled to the cause more certainly.

Q Sure. But does every medical condition have to have an identified cause in order to be treated?

A Nope. Advantageous but not necessary.

Q Aren't there many medical diagnoses for which a cause is unknown but there is a clearly established treatment protocol?

A Yes. I think those are preferable.

Q But there are medical diagnoses for which a cause is unknown but there is still a clearly established treatment protocol?

A And I said that that would be preferable, yes.

Q What does it mean that treatments are uncertain?

A It means that we don't really have a good idea of whether or not these are the proper treatments or the proper diagnosis with a proper risk-to-benefit ratio and good outcomes over the long term.

Q Is that a scientific phrase that you're using?

A Which one?

Q That treatment's uncertain.

A It's not unscientific.

Q You say that, "As a result of this, that the cause is unknown, the treatments are uncertain, and the adverse effects are not fully elucidated, that the treatment must be seen as experimental."

Is your definition of whether treatment is experimental guided by the same standards that Florida's Agency for Healthcare Administration uses to determine if a treatment is experimental?

A I would imagine they are very close.

Q Did you consider evidence-based clinical practice guidelines in determining -- or in coming to your opinion that a treatment is experimental?

A If clinical practice guidelines are truly

evidence based, then they should be considered. I don't think we have those.

Q Do you consider -- do you know what standards the Agency for Healthcare Administration is required by regulation to use in determining that a type of treatment is experimental?

A I don't know their regulations.

Q So your opinion that this treatment is experimental does not reflect --

A Is my --

Q So your opinion that it's experimental, it doesn't reflect the agency's standards?

A They were asking my opinion, so I gave them my opinion.

Q But not based on their standards, based on your own standards?

A Yes.

Q But you don't offer an opinion about whether gender-affirming medical care is consistent with the standards AHCA uses to determine that treatment is experimental?

A Well, I would see their standards and be able to answer that more accurately. I would strongly assume that they use the same sort of care and precision in deciding these things.

Q But in formulating the opinions that are contained in this report, you did not -- you had not referenced the standards used by AHCA to determine whether medical care is experimental?

A I was using more generalized standards. Widely accepted.

Q Does your opinion that the treatments for -- of gender -- I'm sorry -- gender-affirming medical treatments are experimental apply to all medical treatments for gender dysphoria?

A Could you rephrase that?

Q Yes. So just more clear -- a point -- like -- excuse me -- to provide more clarification.

This paragraph follows some discussion of puberty blockers.

Is your opinion regarding a, quote, "proposed course of therapy as experimental" referencing specifically puberty blockers or is it referencing the other sorts of gender-affirming care we have been discussing today?

A I think it should apply to the entire sequence of interventions that we've been discussing.

Q So including -- so puberty blockers, cross-sex hormones, and gender-affirming surgeries?

A Correct.

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil

No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME XII OF XXI

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

Counsel for Defendants-Appellants

INDEX TO APPENDIX

Volume	Tab	Title
1	Dkt	Docket Sheet
1	Doc.1	Complaint
1-3	Doc.11	Motion for Preliminary Injunction
3-4	Doc.49	Redacted Defendants' Response in Opposition to Motion for Preliminary Injunction
4-7	Doc 49-1	Redacted Appendix to Defendants' Response in Opposition to Motion for Preliminary Injunction
7-8	Doc.58	Reply to Defendants' Response in Opposition to Motion for Preliminary Injunction
8	Doc.60	Notice of Scrivener's Error and Filing of Supplemental Declaration to Correct Error re: Motion for Preliminary Injunction
8	Doc.64	Order Denying Preliminary Injunction
8	Doc.65	Answer to Complaint
8	Doc.108	Preliminary Injunction Motion Hearing Transcript
8	Doc.118	Order Allowing Mr. Weida's Deposition
8-9	Doc.120	Motion for Summary Judgment
9	Doc.120-27	Attachment to Motion for Summary Judgment: Dr. Edmiston Expert Report
9	Doc.120-36	Attachment to Motion for Summary Judgment: Dr. Edmiston Deposition
9	Doc.233	Amended Complaint
9-12	Doc.235	Plaintiffs' Deposition Designations
12	Doc.246	Final Order
12	Doc.247	Clerk's Judgment
12-13	Doc.248	Notice of Appeal
13-14	Doc.221	Trial Transcript, Day One
14-15	Doc.224	Trial Transcript, Day Two
15-16	Doc.225	Trial Transcript, Day Three
16-17	Doc.229	Trial Transcript, Day Four
17	Doc.232	Trial Transcript, Day Five
17-18	Doc.234	Trial Transcript, Day Six
18	Doc.241	Trial Transcript, Day Seven
18	Doc.193-1, DX1	U.S. Health and Human Services Notice and Guidance on Care

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Gary Perko
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 Appellants-Defendants

Q Your report doesn't list any complications attendant to cross-sex hormones; is that right?

A It doesn't list them. There were other people actually, as I understood it, listing all the things that you've been asking about, including that. I didn't feel it was necessary to -- to reiterate all that, seeing how what we were really talking about was the ethical implications of informed consent and the --

Q Well --

A -- and the standards for research versus clinical care.

Q So today we're just talking about your report. And so my question is just whether you listed any complications attendant to cross -- the administration of cross-sex hormones.

And you did not -- your report does not list such complications; is that right?

A That's correct, I believe.

Q You also don't offer an opinion about complications related to gender-confirming surgeries; is that correct?

A About their complications, I didn't get into that. That's not to say there aren't complications, I just didn't feel the need to iterate

them.

Q Your report doesn't list those complications?

A No need.

Q But it does say that those treatments are experimental; is that right?

A Yes.

Q And you're aware that these types of treatment have all been provided in the clinical context for years and even decades. Are you aware of that?

A Of course.

Q So gender-confirming surgeries were first performed in the 1930s; is that right?

A The first one I knew about was Christine Jorgensen in Sweden.

Q Which was in the 1930s; is that correct?

A No. I think she was more in the '50s or '60s.

Q Cross-sex hormones became available in the 1930s as well; isn't that right?

A Well, no. The hormones have been available, but -- for this use? Is that what you're talking about?

Q Yeah. I'm sorry. Cross-sex hormones were

first used for this type of treatment in the 1930s?

A These things have been used for a long time. Only recently have they become popular and widely applied.

Q Do you think the use of puberty-delaying medications to treat gender dysphoria in adolescents was first referenced in medical literature around 25 years ago? Isn't that right?

A Sounds right.

Q In the next paragraph, Paragraph 27, you're responding to Dr. Karasic's report and you suggest that, "Healthcare providers treating patients for gender dysphoria should include protocols for de-transitioning."

Do you have any evidence to support the contention that that is not happening?

A I didn't say it wasn't happening. He was concerned about his patient's -- or some patient's de-transitioning.

And I said, in that case, you know, protocols to manage that are appropriate.

Q But he was referencing the fact that patients were being forced to de-transition by the fact that their medical care would no longer be covered by Florida's Medicaid system, correct?

A And I -- I'm assuming that he himself was assuming that's their only source for the ongoing treatment, which I wouldn't know, but he did say that.

Q Well, Medicaid is health insurance coverage for individuals who cannot afford to pay for their own healthcare, is it not?

A That's true.

Q So it's safe to assume that many individuals who have lost coverage for this type of care are unable to access it elsewhere, correct?

A There's a fair presumption.

Q You reference a, quote, "idea" of a quote, "conveyor belt of treatment."

Do you know of any Medicaid patients in Florida that were on a conveyor belt of treatment who were unable to stop receiving gender-affirming treatment if they wanted?

A I don't think Dr. Karasic or myself were referring to any individual patients, so, no.

Q But you would agree that having to stop receiving gender-affirming medical treatment because you can't afford the treatment is different than voluntarily deciding to stop the treatments, right?

A Different in what way?

Q Well, it's different for a patient to no longer be able to afford a treatment versus choosing to stop a treatment; is that correct?

A Well, there would be differences, but the differences might be financial. The differences probably wouldn't be the effect on the withdrawal from the medications. I think those would probably be about the same.

So would there be some differences? Probably.

Would there be similarities? Undoubtedly.

Q No, I'm sorry, I'm not referencing the impacts of discontinuing that treatment, I'm saying that as a factual matter, it is different for someone to no longer be able to afford a type of medical care than that they choose to stop that medical care. Those are the two different circumstances that should not be treated identically.

A Well, those would be the financial impacts that I think you were referring to.

Q So when we were talking about the conveyor belt of treatment, I just want to confirm because I think your answer was a little bit ambiguous.

You do not know of any patients in Florida who have not been able to stop receiving

gender-affirming treatment if they so chose?

A My exchange with Dr. Karasic was not about any specific Florida patients, that's correct.

Q You're not aware of that actually happening?

A No.

Q You say that, "To begin treatment of such patients without knowing how to successfully discontinue such treatment, and to not warn patients of this issue in advance, again reflects unfavorably on the issue of informed consent for the treatment of patients identifying as transgender."

What basis do you have to believe that patients and clinicians don't know how to continue -- discontinue that treatment?

A Dr. Karasic was talking about those who would suddenly have to de-transition.

I was talking about the need to be able to plan for that.

Q But are you --

A If you don't plan for that, then what I was saying about it being a medical failure on the practitioner's part would come into play.

It is not just a loss of funding, which I'm sure has occurred in other circumstances for

patients, but other circumstances as well that might cause them to be forced into de-transition or a decision about that.

Q But do you have any knowledge or evidence upon which to suggest that clinicians and patients aren't able to thoughtfully discontinue that treatment?

A I'm advocating that they thoughtfully discontinue the treatment.

Q And I'm saying, do you have any evidence to believe that's not happening?

A I was responding to Dr. Karasic's concern. I wasn't concerned that that wasn't going to happen.

Q In your conclusion on Paragraph 28 -- I'm sorry, Paragraph 29 of your conclusion, you compare gender-affirming care to a lobotomy.

Are you aware that nearly all lobotomies were performed without informed consent from patients and guardians?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: I wouldn't know how to know that all lobotomies were performed without informed consent. I believe that, in fact, the single case that I did cite was with informed consent.

Q (By Ms. Dunn) You cited a case?
A Yes, President Kennedy's sister.
Q Were you aware that lobotomy was not supported by major medical associations?
A Yeah. It was considered innovative surgery at the time for psychiatric problems. It didn't last long enough to seek widespread support from medical association.
Q So you cited a single case with regard to the informed consent. Do you have evidence to demonstrate whether or not the care was being provided without informed consent in any other case?
A No, no. You're the one who was asking about informed consent for these. I was just pointing out that they did exist and they were a mistake.
Q Of course, but you have likened it to gender-affirming care, so I'm just trying to determine whether these -- to your knowledge, these procedures were being done without informed consent.
A You are correct that they could not be done with informed consent, seeing as how people had no clear idea of what the long-term consequences would be but proceeded anyway.
And to that extent it's very similar to

what we're seeing with the treatment for gender dysphoria currently.

Q Well, but lobotomies were also not supported by major medical associations at the time.

A I don't think the issue in the lobotomy was whether or not there was a major medical association that supported it or not, I think it was actually the procedure itself, and the consequences known or unknown, and the ability to give informed consent for that procedure. That's where you actually find the strongest parallels.

Q So just to be clear, the case that you've cited, the sister of President John F. Kennedy, she did not consent to that treatment; is that correct?

A I --

Q She did not provide informed consent for that treatment?

A I don't know.

Q When you cited it as --

A I don't see how she could.

Q -- a case where --

A I don't see how she could.

Q Okay. But in gender-affirming care situations, there are protocols for informed consent?

A A protocol for informed consent is not the

same as obtaining informed consent. Only if it's followed, and it has to be followed by providing all the elements of informed consent.

Those elements include the capacity to understand what's going on; the absence of coercion in the decision-making process, either positive or negative; the comprehension so that you can understand all the risks, benefits and alternatives that are presented to you.

But when those things are not even available, then the possibility of informed consent is reduced or absent.

Q What evidence do you have that that isn't happening, that that information is not being provided in this context?

A Because the information is not available, according to even the people who are providing it.

For instance, Robert Garofalo, who is the chief of adolescent medicine at Lurie Children's Hospital in Chicago, told a podcast interviewer last year that the evidence base remained a challenge. It's a discipline where the evidence base is now being assembled and it's truly lagging behind clinical practice. He said it's -- he thinks it's being done safely.

But now I think we're really beginning to do the type of research where we're looking at short, medium, and long-term outcomes of the care that we are providing in a way that I think hopefully will be reassuring to institutions and families and patients, or will also shed a light on the things that we could be doing better.

Q Did you cite that podcast in your report?

A No, I'm just telling you.

Q Did you rely on --

A In response to your question. You said, you know, why would I think that.

Q Well, saying that there's room for there to be more research and to improve the evidence base for the treatments is different from saying that people are not being fully informed of the risk of which we are aware.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: We first have to be aware of the risks and the benefits. Neither of those are clearly elucidated in the present day.

Q (By Ms. Dunn) Well, these treatments have been provided for decades at this point, and so there's some --

A Provision --
Q -- information --
A I'm sorry.
Q There is information about the risks. And the standards of care and clinical guidelines that are applicable to this care require that that information be disclosed to the patients and their -- and in the case of minors, to the patients and their guardians; isn't that correct?
A No, not entirely.
Should they be required? Yes.
Is it? But the problem is, of course, even when things are done for decades, if they are not well documented, done in an orderly fashion where the risk, benefits, alternatives, and outcomes can be clearly delineated, then, in fact, you can't give informed consent because you don't have the information to give.
Q What evidence do you have to suggest that the informed consent process that's being engaged in is not sufficient?
A The fact that they can't tell what's going to happen to children and adolescents and young adults ten years from now or 15 years from now or 20 years from now because the data is so sloppy the

information isn't there.

Q What evidence do you have to support that statement?

A There is evidence to support that statement. There is evidence from many sources.

Q What evidence -- can you please cite to the evidence that you rely upon in making that statement?

A I -- I can, but, you know, I -- I turned in a lot of different reports with citations and giving you that answer right today will be difficult, but certainly not impossible if you're willing to receive it.

Q Well, I'm asking if you, right now, can cite to me the data and information upon which you are presenting this opinion?

MR. BEATO: Object to form. I also think that Dr. Donovan's answers speak for themselves.

But, Dr. Donovan, if you want to provide another answer --

THE WITNESS: I don't have any other answer. I think I've answered it.

Q (By Ms. Dunn) Okay. I think at this point I will stop sharing your expert declaration and we will move on to look at the report you provided in support of Florida's GAPMS process. So let me just

pull that up.

(Document is displayed).

Do you recognize this document, Dr. Donovan?

A Yes.

Q And what is it?

A The title reads: "Florida's Medicaid Project: Treatment for Transgender Children Medical Experimentation Without Informed Consent: An Ethicist's View of Transgender Treatment for Children."

Q And this is the report you provided to the Agency of Healthcare Administration in Florida in the course of their process to determine whether or not gender-affirming care was experimental?

A Yes.

(Whereupon, Exhibit Number 25 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'm going to mark this as Plaintiffs' Exhibit 25.

How did you become involved in preparing this report?

A I was contacted and asked if I would be willing to help.

Q And do you recall the names of any of the individuals who you spoke with from the agency in your work with them?
A I'm sorry, I don't.
Q Did anyone assist you in preparing this report?
A No.
Q Did you draft the report solely on your own?
A Yes.
Q Did you consult with anyone in preparing the report?
A No, not really.
Q Did you consult with anyone not at the agency, any other bioethicist or any other medical professionals?
A No.
Q Okay. So going into the substance of the report itself. I'm on Page 1 of the report, which is also, in this version of the document, marked as Appendix 237. Just give me one quick second.
In the second paragraph here, the second sentence says that, "Currently less than half of state Medicaid programs provide gender-affirming care."

Do you see that reference?
A Yes.
Q And that cites to a Williams Institute report from 2019?
A Yes.
Q When you say "less than half provide," are you referring just to those states that have affirmatively included coverage for gender-affirming care?
A I'm not quite sure what the question means.
Q So when you say that "less than half of states cover," does that mean that less than half the states have policies that exclusively provide for coverage?
A All that I know is what I read, that less than half the state Medicaid programs provide gender-affirming care.
Q So I'm going to pull up the Williams report that you've referenced.
Do you recognize this report? Is this what you were relying on? I can scroll down to the executive summary if it helps.
Is this the report that you relied on?
A It's not on the screen.
Q Oh, I'm sorry. Thank you. This is me

getting a little tired.

(Document is displayed).

Is this the Williams report that you referenced?

A I don't know. It doesn't look like the way I saw it, but it probably is. Sure.

(Whereupon, Exhibit Number 26 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'll mark this as Plaintiffs' Exhibit 26.

So this report actually splits the states into three different categories.

One is those states that have affirmative coverage for gender-affirming care. And in that category are 18 states and D.C.

Then after listing all those states, it notes that 20 states have no express statute or policy addressing coverage. And so in these states coverage for gender-affirming medical treatments may be covered, but there's not an affirmative coverage policy.

And then the last category is the 12 states that have express bans on coverage.

Is this the information that you reviewed

in making the statement in your report that "less than half the states cover gender-affirming care"?

A Yes.

Q And would you agree that even fewer than half the states, so closer to 25 percent of states, only 12 states explicitly exclude gender-affirming care. Is that accurate?

A That's what it says, 12 have expressed bans, 18 have expressed coverage.

Q And the other 20 states may cover gender-affirming care; is that correct?

A It's -- the law is silent, it says, so --

Q But you don't have any information that one of those states do or do not cover gender-affirming medical treatments?

A I'm sorry, you faded out there. Try again.

Q I'm sorry. You don't have any information as to whether or not those 20 states in fact do cover gender-affirming medical treatment?

A It just says that they -- okay. They're silent. I will remain silent myself.

Q I'm just saying you don't have any information to confirm that they do not cover it?

A Okay. Nothing --

Q It's possible that they do.

A Nothing beyond the report itself.
Q You reference the Belmont report providing ethical requirements for medical research and informed consent; is that correct?
A Correct.
MR. BEATO: Chelsea, the GAPMS report is not on the screen.
MS. DUNN: Yeah. Thank you. I'll pull it up.
(Document is displayed).
Q (By Ms. Dunn) So now we're on Page 2 of your report, which is labeled as Appendix 238. And here you reference the Belmont report regarding informed consent for research; is that right?
A Yes.
Q The Belmont report governs biomedical and behavioral research involving human subjects; is that right?
A Yes.
Q Those guidelines apply to research being done when human beings are the subjects of that research; is that correct?
A Yes.
Q The Belmont report does not apply in providing clinical care in clinical settings; is that

right?

A Well, the way you state it, you have to understand that, first off, the Belmont report was an expert opinion. It was not a law or a regulation itself. It did talk about clinical research. So it will involve human beings in clinical setting.

Q Sure. But providing gender-affirming medical treatment in the clinical setting is different than biomedical and behavioral research involving human subjects, right?

A I am sad to report that, yes, that's true.

Q So these ethical principles don't apply to the type of clinical care that the plaintiffs in this case were receiving?

A Absolutely wrong.

Q Well, I mean, are you offering an opinion about the clinical care that our plaintiffs have received?

A No. You just said that the principles as enumerated in the Belmont report don't apply to clinical care. But, of course, they do. They talk about, you know, the principles of autonomy, beneficence, justice, non-maleficence, and fully informed consent, and all of those apply to clinical care whenever it should be delivered.

Q Your opinion, your report, states that, "There are deficiencies in each of these categories in the current approach to treating minors with gender dysphoria."

How do you know that?

A I think it's kind of spelled out in the report itself.

Q Well, what is your evidence, though, for saying that there are deficiencies in the clinical care that's being provided?

A By the nature of the care and the inability to give informed consent because of the things that are not known, that are not included in an adequate evidence base.

Q Aren't there always unknown risks to medical treatments?

A Yes, but we should minimize those to the extent possible. That's the point of doing research on innovative therapies in order to get evidence-based data.

Q But the way that you're framing it, someone could never provide informed consent because a doctor could never explain every single possible unknown risk.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: Actually, now you're sounding -- no offense -- a little like a lawyer because, in fact, that's often what is brought up. Of course, physicians can't tell you every unknown risk. How can anyone tell you what's unknown?

What they can do is strive mightily to determine what the risks, outcomes, and benefits are through carefully constructed trials that are then widely reported through the -- to the world so that they can then be applied.

MR. BEATO: Here's a question, Counsel. Would you mind if we take a five-minute break or do you have related questions that you would like to ask Mr. Donovan?

MS. DUNN: No. I was about to pull up the Belmont report, so we can take a break now. It's a fine time.

(Recess taken from 3:21 p.m. to 3:26 p.m.)

Q (By Ms. Dunn) So, Dr. Donovan, before we broke we were talking about informed consent. Is it your position that nobody can ever provide informed consent to gender-affirming care?

A Well, I told you before I'm not fond of absolutes, but I think that there are deficiencies in

the body of knowledge about what is termed "gender-affirming care" that prevent fully informed consent from being available.

Q Which suggests that there's no way that gender-affirming care can be provided with fully informed consent. Is that your opinion?

A I will accept your suggestion.

Q Well, I guess, are there circumstances -- any circumstances where a patient can provide fully informed consent to gender-affirming care?

A I think that's what we answered the first time. I think that we have some serious knowledge gaps. We have embarked on a program of what's termed "gender-affirming care" for a diagnosis of gender identity disorder, now gender dysphoria, that actually started without us knowing all the risks, benefits, alternatives, and long-term outcomes. And I don't think we've made great progress in that regard, even though it's been going on, as you pointed out, for years.

Q But the end result of that is that because of these unknowns that you cite, you don't believe that any -- that a patient can provide fully informed consent to any of the gender-affirming medical treatments we're discussing today?

A Informed consent can't be obtained without information. That's the informed part. And I think we have an information gap.

Q So it's your opinion that a patient can't provide fully informed consent to any of the gender-affirming medical treatments we've been discussing today?

MR. BEATO: Object to form.

But, Dr. Donovan, you can answer that.

THE WITNESS: You're saying to any of them, and they can certainly, you know, consent to certain aspects of them because certain aspects they'll be able to say, you know, "If I do a mastectomy, what are the risks, benefits, alternatives?"

How that relates to, you know, gender dysphoria is still problematic, but the surgery itself, it's been done a lot.

Q (By Ms. Dunn) Well, so --

A In other circumstances, I mean.

Q I guess, if a patient can provide informed consent, what is -- I'm -- are you saying the patient can provide informed consent about these treatments or that they cannot?

A Well, you were the one who said that -- kind of made it an absolute, they couldn't do it to

any aspect of them.

And I was pointing out that there are aspects of them in which they can be informed.

If I were to offer -- if I were a surgeon and offered a patient a mastectomy, I could tell them the risks, benefits, the alternatives to a mastectomy and the expected outcomes. But I couldn't tell them how that would affect their diagnosis of gender dysphoria with certainty.

Q So you're saying the treatments themselves might be able to have gender-affirming care, but the treatments for the purposes of the treatment of gender dysphoria cannot be made with fully informed consent?

A Yeah, that one was a little jumbled. Can you try again --

Q Right.

A -- please?

Q So you're saying that the procedures themselves may be -- people may be able to provide fully informed consent to the procedures themselves, but they can't provide fully informed consent to the use of those procedures to treat gender dysphoria?

A That would be partially true. And that's going to be more true for, for instance, surgical

procedures which have been done and would be done again in very much the same mode.

You know, using puberty-blocking agents or cross-sex hormones for these indications would be much more difficult, even though we know how those -- how those apply in other diagnoses and other indications. So there you have a problem.

Q I'm just going to go back to your report.

(Document is displayed).

You make a reference in the third paragraph that, "The rules for their involvement" -- which is referencing the involvement of children in research studies -- or vulnerable subjects in research studies, are set out in the, quote, "Code of Federal Regulations 46 CFR 401 through 409."

So when we looked up this reference we found a section of the U.S. Code that appears to be on shipping.

A No, I don't think that was mistyped. I can go right behind me and find that. I mean, the CFR has the rules about informed consent in children on the shelf behind me. I'm pretty sure those are the right numbers. 46: 401-409.

Do you want me to go look?

Q Well, no, I'll pull up --

MR. BEATO: Dr. Donovan, it's --

Q (By Ms. Dunn) I'm going to pull it up in one moment.

(Document is displayed).

So if you see here in the Code of Federal Regulations, we have Title 46, Part 401 to 40 -- here it's just 404, but it appears to be about shipping regulations. I can zoom in, I think.

A No, no, no, no, no. You're not in the ICH Guidelines.

Q What's different about the citation?

A Well, it's the Code of Federal Regulations and ICH Guidelines, Title 21, Good Clinical Practice.

Q Title 21?

A Uh-huh.

Q Okay. So you listed Title 46.

A No, no. The -- I think it was Part 46, wasn't it? Yeah, Part 46, "The Protection of Human Subjects."

Q Well --

A Under Title 45, Part 46.

Q I'm sorry, I'm a little confused. So if we could just take it -- so you've listed --

A IR -- this is fairly standard and widely available. These are the IRB Clinical Investigator

Reference Guides put out by -- you know, by the -- well, the NIH and the ICH Guidelines by the FDA because this is FDA regulated.

And you're looking for IRB Clinical Investigator Reference Guide, which should be under, I guess, Title 45. Part 46 is "Protection of Human Subjects."

Q All right. So maybe this is a citation discrepancy. I'm not sure. What I'm trying to just identify is how we would identi- -- how we would find what you're citing to.

So 46 CFR, in legal citation, means Title 46 of the Code of Federal Regulations.

What title of the Code of Federal Regulations are you intending to reference?

A It's Title 45, Part 46.

Q Okay. And is it Sections 401 through 409? Is that correct?

A Let me double check and make sure. Yep.

Q Okay. Thank you for that clarification.

A Sure.

Q All right. I'm scrolling down in your report to Page 3, which is marked as Appendix 239.

And here we talk about -- you talk about the various interventions, which I'm assuming you use

that word to reference the medical treatments or procedures we've been talking about today.

And so first you reference "surgeries." You say that, "The semantic shift from sex change operations to gender-affirming surgeries is important."

What do you mean by this?

A I'm looking for the context.

Q The first paragraph under "Surgery," the very last sentence.

A Oh, okay. I'm sorry, what's the question there?

Q What do you mean when you say "the semantics shift is important"?

A It's basically what I was trying to point out with the rest of the paper, that, you know, we -- we have switched from calling -- from differentiating gender from sex, to begin with, and then we've started calling it affirming surgery. We don't call it just a mastectomy or a penectomy anymore.

So, you know, when you say that I am going to do an affirming surgery for you, that's a very positive connotation when a patient first hears it as well.

If you said I'm going to do a mastectomy or

penectomy, I think that that probably wouldn't sound as appealing.

Q Do you have reason to believe that clinicians are not using the name for the procedure with their patients?

A I didn't say that. I just said that they are referring to it now as a "gender-affirming surgery," as you know.

Q Well, gender-affirming surgery is the category, but I'm just -- do you have any evidence to believe that the term -- the word penectomy or mastectomy is not being used in individual consultations when someone is seeking that type of surgery?

A I have good evidence that they're using gender-affirming surgeries, but I think that that's really kind of the point I was trying to make.

Q What evidence are you citing?

A Well, they are using "gender-affirming surgery." You used "gender-affirming surgeries." We all hear that.

Q Well, we use -- of course we use that term to describe multiple surgeries that are for the purposes of treating gender dysphoria.

What I'm asking is whether you have any

evidence to support the notion that a clinician isn't using the actual name of the procedure with the patient, i.e., a penectomy or a mastectomy.

A No.

Q Okay. The shift in terminology -- the goal of that shift in terminology was for there to be less stigma associated with the condition.

Is that problematic?

A Well, what we have done, then, is to take a gender identity disorder and say that that is no longer a disorder. It's only a disorder if you're unhappy with it.

The fact that you are a physical male who believes he is or should be a female is normal or should be treated as normal, according to the shift in the terminology and the shift in the approach. I think a lot of people are having some difficulty with that shift.

Q What do you mean "a lot of people are having difficulty with that shift"?

A I think that people are finding it difficult to just believe the concept, that this man is actually a female gender or this woman is actually a male gender. I think that part of the evidence for that, because you like evidence, is that we're

involved in a lawsuit over that right now.

Q But who are the people that are having trouble with that change in semantics or that shift?

A Well, I think it's a wide number of people, if you just look at things that are being discussed, but I'm sure the people you're suing would fall in that category as well.

Q Do you think this shift is problematic for the individuals experiencing gender dysphoria?

A I do.

Q Why?

A Because I think that -- I think that we are taking a psychological problem and applying a medical/surgical solution to it, which doesn't probably -- no, forget "probably" -- doesn't really directly address the underlying problem.

Q What is the underlying problem?

A I think the underlying problem is that we have men who assert that they are in a -- that they are females in a male body and the reverse.

Q Do you have any evidence to cite to to support the assertion that the medical treatments we're discussing today are not effective in addressing the diagnosis?

A I don't think we have evidence one way or

the other, but I think that the -- it is highly unlikely if, in fact, the basic underlying problem is psychiatric or psychological.

Q But are you -- do you have any evidence to cite, with regard to your assertion that surgeries and medical treatments are not effective in treating the condition of gender dysphoria?

A Well, I really think that's what we've been discussing all day is the absence of this evidence, that it is effective.

Q But you have not provided any citation to support the fact that it is not effective.

A Nor have I seen sufficient proof that it is. So I think that, in this case, when you don't have evidence that what you're doing is good, it's difficult to have evidence that what you're doing is not good because we don't have the long-term outcomes being clearly delineated.

I mean, we -- you've pointed out that we've been doing this for over a decade on a larger scale, but for a couple of decades and more on a smaller scale and yet we really don't have -- I can't tell you the number of people who have claimed benefit after 20 years or what that's done to their suicide rate. We do know that in adults the suicide rate has

gone up, not down after ten years. But these are important questions that need to be answered and we really should be answering those.

Q So my question is not -- my question was specific to whether or not you have provided evidence or citation in your report to support the contention that gender-affirming medical treatments are not effective to treat gender dysphoria.

A And my response --

Q Have you cited an evidence or citation?

I mean, just look at your report, Dr. Donovan. I'm just asking, is there a citation or evidence to support that contention?

A And what I'm trying to explain is that in the absence of evidence, you know, that isn't evidence of absence.

What we're dealing with right now is an entire situation that is evidence-deficient.

Q But I'm not asking about the situation. I'm asking a yes or no question as to whether or not there is a citation or evidence -- a source of evidence cited in your report.

MR. BEATO: Object to the form.

THE WITNESS: And I not only answered that, but I also gave you a reason why there is no answer

for that.

Q (By Ms. Dunn) I don't believe I've heard -- it's a yes or no question and I don't believe I've heard a yes or a no.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: There is no sufficient evidence as to the outcomes.

Q (By Ms. Dunn) So is that a no, that you have not provided a citation to a source of evidence to support the contention that gender-affirming surgeries and medical treatments are not effective to treat gender dysphoria?

MR. BEATO: Counsel, I think the report speaks for itself and I think Dr. Donovan's answer speaks for itself.

MS. DUNN: Michael, if you have an objection, you're welcome to state it, but I'm asking a yes or no question and I'm not being given a yes or no answer.

THE WITNESS: You're not being given a yes or no answer by me because a yes or no answer would be inappropriate. I could give you a yes or no answer, but it would not actually help clarify the truth, it would obfuscate it.

Q (By Ms. Dunn) I'm merely asking whether you provided a source of evidence to support your contention that gender-affirming medical treatments are not effective to treat gender dysphoria.

If you -- that is a yes or no question.

A It is a yes or no question, but a yes or no answer is inappropriate when there is no such evidence. It's like asking for evidence of aliens.

You know, have I proven that there is no evidence? Proving the negative is much harder than affirming the positive, as you know.

Q But I haven't asked you to prove, I've merely asked if you cited evidence in your report.

MR. BEATO: Object to form.

THE WITNESS: Evidence to do what?

Q (By Ms. Dunn) To support the contention that gender-affirming medical treatments are not effective to treat gender dysphoria.

A And how is "support" and "prove" different because I'm confused now.

Q A supporting citation just demonstrates that you relied on some sort of evidence. And I'm merely asking if you have cited any such evidence in your report.

A There is no such evidence to cite.

Q And, similarly, you haven't cited any such evidence in your bibliography?

A And there is no such evidence to prove that it is effective long term.

Q Back to your report. I just want to make sure I'm in the right place.

So you state that, "The lack of sexual maturity in younger patients, especially previously delayed by puberty-blocking agents, makes the sparse tissue more difficult to work with and outcomes less favorable with problems such as wound rupture are more likely."

What is your evidence to support this assertion?

A This is information that I have received from surgeons. This is not personal experience.

Q How did you receive this evidence from surgeons?

A This was in reading their reports.

Q And are those reports cited here?

A No.

Q Are they cited in your bibliography?

A Everything that's cited here is cited within the body of the thing. This doesn't have a separate bibliography, to my recollection. No, it

doesn't.

Q Okay. I'm sorry, but it wouldn't be a source that would be cited in the bibliography you provided with your expert report?

A This was stated by surgeons who do this surgery, so I don't think it's controversial enough to need a separate citation.

Q Well, this is evidence that you're relying on. I'm just asking if you have cited a source for that evidence.

A And, no, I didn't, because I didn't think this was anything controversial, seeing as how the surgeons themselves have mentioned this.

Q You then say that, "These are challenges that are not routinely described to minors at the beginning of their treatment progression."

What is your evidence to support that contention?

A Simply because it -- I don't think it's even widely known by people.

Q Do you have a source of evidence that you can cite to for that assertion?

A Are we talking about the same assertion or something --

Q No, the assertion that these challenges are

not routinely described. I'm just asking how --

A I certainly haven't been able to find them as part of the routine description anywhere in surgery for adolescents, but if I'm wrong, I'd be happy to be corrected.

Q Other than this one -- this issue identified with individuals who begin their treatment with puberty blockers, you don't describe any other ethical issues or complications related to gender-affirming surgeries in this part of the report; is that right?

A Everything I described is -- is there.

Q What do you mean by that?

A Well, what did you mean by that? This is --

Q Well, I'm asking if there are other ethical issues that you've identified with gender-affirming surgeries.

A I think the fact that they're being done is the ethical issue, actually. We're talking in this report on -- not on adults, but on children.

Q So now we'll move on to this section that's called "Hormonal Treatment." It's on the same page, Page 3 of your report marked as Appendix 239.

Here you again cite to "80 percent of

minors who identify as transgender will reverse this identity by the time they reach their mid 20s."

Do you cite any evidence in this report to support this assertion?

A Actually, I think we found that in the other reference, but I don't have a specific citation on that paragraph, no.

Q Are you saying that this source was included in your bibliography?

A Yeah. I thought we found that 80 percent when we were looking through there.

Q To my recollection, you were not able to identify that source from your bibliography.

A Okay.

Q Is that inconsistent with your recollection?

A It's been a long day, Counselor. I'm not sure.

Q But there's no citation here to support that assertion?

A That's right.

Q You say that, "Sex hormones have an important and lasting effect on brain development and adolescent psychology."

That's right here right before the end of

this paragraph.

There's no citation or source of evidence for this assertion in your report; is that correct?

A That's correct, I don't have citations for every statement.

Q Do you know of any studies that show the administration of cross-sex hormones to be harmful to brain development?

A What I said was they have an important and lasting effect. And I think that, yes, those studies do exist.

I think that most people recognize that if they have ever been an adolescent, or had one in the family, it's -- didn't seem like it was that controversial a concept to require a separate citation. But, yes, there is evidence for that, you're right.

Q There's evidence for what?

A For the fact that there are important effects and lasting effects on brain development and adolescent psychology.

Q But you did not cite any research or studies to support this assertion?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: What you see is what you get. Everything that I cited is right there. And if it's not there, then it wasn't cited in this paper.

Q (By Ms. Dunn) And in your report you don't describe other ethical issues related to the administration of cross-sex hormones?

A I didn't cite any. That doesn't mean there aren't any.

Q Specific to this report, there are no other ethical issues related to the administration of cross-sex hormones addressed.

A Okay. Not specifically.

Q And I'm just -- I see you flipping through papers. Are you just looking at the same report that I have on the screen?

A Yes, it's easier to read.

Q That's absolutely fine, I just wanted to confirm that's what you're looking at.

And if you're looking at a different section than me at some point, if you're referencing it, if you'll just please direct me to that section.

A Sure.

Q So the next section addresses "Puberty Blockers." You state that, "Children and parents are only told that this is a benign intervention whose

effects are easily reversible and that potential effect on the development of bone density may be mentioned."

What evidence do you have that this is the exhaustive information provided to children and their parents?

A Actually the people who provide them have written this in their own papers. It is not cited --

Q Well, who --

A It is not cited there, but those people who have written papers about transitioning have frequently said on their websites, you know, what I'm saying there.

Q Can you direct us to those sources?

A It can be done.

Q Can you do that right now today?

A No.

Q You go on to discuss a case of a child in Sweden. Where did you get this information?

A I'm trying to read where you are.

Q I'm sorry, it's just the next sentence, I think.

A Oh. I'm sorry, that was reported. I didn't cite the -- the location of the report, but it was reported publicly in the literature.

Q There's no cite, though, in your report?
A Once again, Counselor, if you don't see it right there, you're right, it's not a specific citation.
Q You go on to note that, "Sweden changed its guidelines for gender-affirming care to reflect that GnRH analogues should only be used in exceptional cases."
Do you know what the criteria in those Swedish guidelines is?
A No.
Q So I'm going to pull up the Swedish Guidelines for the Treatment of Gender Dysphoria.
(Document is displayed).
Do you recognize -- have you ever seen this document, Dr. Donovan?
A Is that the one from February of last year?
Q Let's see if there's a date on it. I don't see a date on it.
Do you recognize the document itself, though?
A No, I don't. I said I hadn't seen that. And maybe this preexisted the changes, do you think?
Q Let's just -- if you want to take a -- oh, I'm sorry. Here if you look at this paragraph this

references "2022," so this must be a recent document.

A Okay. Let me read then.

Q Sure.

A "A systemic review published in 2022 by the Swedish Agency for Health Technology Assessment and Assessment of Social Services shows the state of knowledge largely remains unchanged compared to 2015. High quality trials such as RCTs are still lacking."

Q I'm sorry, I don't need you to read --

A "The evidence on treatment" --

Q Sir?

A -- "efficacy and safety is still" --

Q Dr. Donovan?

A I think what I'm looking for is in here.

Q Okay.

A -- "is still insufficient and inconclusive."

Q Yeah, I'm not asking you to read from the document. I'm sorry. I was just asking -- I wasn't able to confirm a date, but I think based on this sentence we can both agree that it was published sometime after -- sometime in 2022 or 2023.

A Okay.

Q So do you know the criteria that's used to determine if a case is so-called "exceptional" for

the purposes of the provision of GnRH analogues?
Are you familiar with the criteria?
A Well, it's saying here, to minimize the risk it should offer more closely to those used in the Dutch protocol.
Q And so that requires "early onset of gender incongruence, persistence of gender incongruence until puberty, and a marked psychological strain in response to pubertal development is among the recommended criteria."
Is that accurate?
A That's what that says, yes.
Q Is this significantly different than, for example, the Endocrine Society guidelines?
A I will defer to your knowledge.
Q So you are not -- you are not aware whether the new Swedish guidelines are significantly different from the clinical guidelines for endocrine treatment that are used here in the U.S.?
A I haven't even had a chance to read this in its entirety, so I can't answer that. I'm sorry.
Q Well, but -- so I guess the reason I'm asking is just because you reference that this case should only be provided in exceptional cases, to suggest that it's more restrictive than the criteria

for this care here in America.

Do you know for a fact that that is correct?

A All I know is what the National Board of Health and Welfare from Sweden said that, "The risks of puberty-suppressing treatment with GnRH analogues and gender-affirming hormonal treatment currently outweigh the possible benefits. The treatment should be offered only in exceptional cases."

Q But these --

A That was a quote --

Q These guides -- I'm sorry.

A That was a quote from the Swedish source and I don't know that that quote --

Q Again, I'm not asking you to read the document. I'm asking about the --

A But you are -- you are giving me this as the source of it, but I'm not certain that you're actually giving me the proper source.

Q You don't think that this publication from the National Board of Health and Welfare is an accurate reflection --

A The one that contains that quote, I don't think that it -- it -- necessarily. I'd have to read the whole thing to know that that's where the quote

came from.

Q What quote? I'm sorry. What are you talking about?

A The quote that says that "The risks currently outweigh the possible benefits and treatment should be offered in exceptional cases."

Q You're saying that you --

A Puberty blockers. From the Swedes.

Q Are you saying that this isn't the source that you got your quotation from?

A I'm not recognizing what you're showing me here. I'm sorry.

Q So that -- understanding that, what I'm asking is that you --

A It says, "Until a research study is in place, the NBHW deems that the treatment" --

Q Dr. Donovan, I'm sorry, I'm not asking you to read from this document.

A -- "may be given in exceptional cases."

Q If you can wait until I've posed a --

MS. DUNN: I think we might need to take a break.

MR. BEATO: That's fine. We can take a five-minute break.

(Recess taken from 4:02 p.m. to 4:08 p.m.)

(Whereupon, Exhibit Number 27 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So, again, I have to clear up my sloppiness around labeling exhibits. So the Swedish guidelines we just looked at will be marked as Plaintiffs' Exhibit 27.

So I'm just going to go back to your report again, Dr. Donovan, and move on to the section that you reference, quote, "The Fundamental Flaw," which is on Appendix 240.

(Document is displayed).

So in this section you say, in the second sentence of this paragraph, that "After close scrutiny, it can only be seen as off-label experimental."

And by that you're referencing -- the "it" you're referencing is gender-affirming care, as we -- we discussed already, the hormonal treatments, the gender-confirming surgeries and the puberty-blocking medications; is that right?

A Yes.

Q And so this seems to associate off-label medications with experimentation. Is that the suggestion you're making?

A No, not exactly.
Q So what do you mean by "off-label experimentation"?
A Well, that's two different phrases. One is "off label," the other is "experimentation."
Experimentation is when you are -- sometimes it's also referred to as innovative practice, but when you're doing things that are trials in which the outcomes have not been sufficiently determined or documented.
The --
Q Just to be clear --
A -- "off label" part is referring to the FDA approval, which is useful if it's for a specific indication, but is not necessary for --
Q So -- I'm sorry. I didn't mean to cut you off.
So just to be clear, those terms are interchangeable --
A No.
Q -- off label and experimental?
A No. No, they're not interchangeable.
Q So a medication -- just because a medication is used off label doesn't mean that that medication is necessarily experimental?

A I have used medications off label for indications that were clearly documented but never had sought FDA approval.

Q In this paragraph you talk a little bit more about what we discussed earlier with, "The change in terminology in the DSM-5 led to a shift from seeking to correct the underlying cause of the dysphoria to instead focusing on transitioning to one's affirmed gender."

Is that a fair -- is that what you're writing about here in this report?

A That is a quote, yes.

Q Okay. And what do you rely on in this discussion around the impact of the change in semantics?

A I was quoting. I was quoting the people who put out the DSM-5 and the American Psychiatric Association. You know, those are quotes.

Q Do you have any other -- was there any other source you relied on in your discussion of this change of semantics?

A I mean, this was the APA's rationale. I thought that they would be reliable in terms of what they were intending.

Q And perhaps to be more specific, in your

bibliography -- which I'll flip over to very quickly --

(Document is displayed).

-- you cite a source that's named "Gender dysphoria in the DSM-5: The change in terminology." That's "HLI.org/resources/DSM-5-gender-dysphoria/."

A Well, no, I wasn't using --

Q Is --

A I'm sorry, I didn't mean to interrupt. I thought that was -- that was not what I used in this report.

Q So you did not -- in talking about that change in semantics, you didn't rely on that Human Life International article?

A True.

Q Do you know how it was used in your expert report?

A I don't know. We could go back through it, I suppose.

Q Well, we can table that momentarily.

Do you believe that this shift in semantics in changing the diagnosis to gender dysphoria, do you believe that change was harmful?

A Well, I think it shifted the focus away from the patients presenting with what they describe

as "being in the wrong body" as saying that that is somehow normal and not a disorder.

Q Do you believe that the best course of treatment for a person experiencing gender dysphoria is to help that person understand they're not trapped in the wrong body?

A I think that that probably would be the best approach and I think that it should have been compared to what is being done.

Q You say that -- and I think it's going to be in the next paragraph, so let me just find where I'm referencing so I can point you directly.

In this second paragraph on this page, we're currently on Page 5 of your report marked as Appendix 241, you say -- the third sentence in this second paragraph you say, "Self-diagnosing psychiatric conditions is always fraught with the possibility of error."

You aren't a psychiatrist by -- in your practice; is that right?

A That's correct.

Q You're also not a licensed mental health professional; is that correct?

A Correct.

Q How often during your time as a clinician

did you provide mental health diagnoses when you were a pediatric gastroenterologist?

A I'm sorry, I lost you there.

Q Oh, I'm sorry.

A Can you repeat that?

Q Yes, of course. I think the Internet is getting a little buggy.

So you testified that there were occasions where you would give presumptive mental health diagnoses to patients in your --

A Yes.

Q -- pediatric gastroenterology practice; is that right? I'm sorry, did you --

A Yes.

Q Yeah. The answer to that was yes?

A I said "Yes."

Q I'm sorry, I think I lost you then, so I apologize.

Can you estimate how many patients --

A Okay. I think you're right. We're having some problems.

Q Yeah. I apologize for that. I don't know if it's our Internet, but let's try to do the best we can.

Can you estimate how many patients during

your time as a clinician you provided a mental health diagnosis for?

A No.

Q You can't even give an estimate of that?

A No. I mean, no. I was in practice for 30, 40 years. I couldn't begin to guess accurately.

Q Was it common for you to be providing mental health diagnoses for your pediatric patients?

A Oh, no, I wouldn't be providing them, I would be suspecting them and referring them.

Q So, I guess, was that a common instance that happened frequently?

A No, because the psychiatric diseases in children aren't that common compared to the other types of diseases.

Q And so, again, you weren't actually providing these diagnoses, you suspected diagnoses and were making referrals to mental health clinicians?

A Correct.

Q So what basis do you have to support a statement that self-diagnosing psychiatric conditions is always fraught with the probability of error?

A I said "possibility of error." And I -- I don't see that as terribly controversial. I don't

see anyone in psychiatry disagreeing with that.

I would find any patient whose self-diagnosis always fraught with the possibility of error. And not just in psychiatry, in medicine in general.

Q How do we -- what conditions are self-diagnosing?

A Well, the way it applies in this particular case is when there's no confirmatory evidence in -- like we've talked about before, in lab, in X-rays, and in other tests --

Q But that's --

A -- that could confirm it. That would be -- that means, basically, the patient comes in with their own diagnosis. And I -- you know, I assume, if somebody overruled that diagnosis, you know, that that would fall in the same category as well. But that wouldn't be my job.

Q Are all psychiatric conditions based on self-reported symptoms?

A No.

Q They can't be -- they can be -- there are psychiatric conditions that are confirmed by lab tests?

A No. But they're not all self-diagnosed. I

don't think most schizophrenics come in and say, "I'm schizophrenic."

Q Well, I guess, what evidence do you have that individuals who are diagnosed with gender dysphoria are self-diagnosing?

A You understand what we've been talking about. This is how they present. They come in and say, "I am a woman. This is a male body." They are the ones who determine that.

Q They're reporting symptoms. But it's a clinician who makes --

A That's not a symptom, ma'am.

Q What -- I -- what evidence do you have that patients experiencing gender dysphoria are self-diagnosing?

A The patients are the ones who claim that they are in the wrong body.

Other people are not walking up to them and saying, "You know, you look just like a man but I think you're a woman." That doesn't happen.

Q But the clinician provides the diagnosis.

A Only after the patient has presented themselves as a woman in a man's body. Okay? You could say they're confirming it, but that doesn't necessarily equate to providing it because it's

already been provided when they enter the room.

Q Have you cited any evidence in your report that individuals experiencing gender dysphoria are self-diagnosing their psychiatric condition?

A I -- this is -- I mean, it's in the definition of "gender dysphoria."

Q I'm sorry, I -- can you provide a citation for that?

A No.

Q The third paragraph on this page you say that, "The claim of urgency, coupled with an impulse towards nonjudgmental empathy, for the disturbed patients has led to a frantic insistence on a single approach."

What is the single -- I'm sorry.

Is the single approach that you're referring to "providing gender-affirming care"?

A Yes.

Q And you call this approach "cult-like"?

A It seems like that to some people and I see why it does.

Q Well, and your source for this statement is two articles that are cited here; is that correct?

A Uh-huh. Yes.

Q One of these articles was from The Daily

Signal; is that right?
A Yes.
Q And were you aware that The Daily Signal is the Heritage Foundation's news organization?
A No.
Q And one was from The Daily Mail Online; is that correct?
A Yes.
Q The Daily Mail Online is a British tabloid?
A Yes. These were reports from parents directly, so they would not appear in the academic literature.
Q But these are your sources for your suggestion that this single approach is cult-like?
A Made the parents feel like, yes, because that's what they said.
Q You say that, "Love-bombing wrongly encourages children to be transgender."
What is your citation for this proposition?
A I'm trying to remember if that was with the same -- the next citation or something else. No, that's a separate citation. I have it in my files, but I don't have it cited here.
Q So there's no citation provided for that statement here?

A That it's the result of overenthusiastic acceptance? I think overenthusiastic acceptance is a reality, but you could also see it as an opinion, you know, is the glass half full or half empty?

I would say that the -- the rush to be affirming is overenthusiastic acceptance.

So perhaps I'm the authority there, because this is an opinion after all.

Q Are you -- do you have personal experience with this so-called love-bombing or overenthusiastic acceptance?

A No, no. These are the opinions that I've formed from reading the experience of others.

Q And are these -- the experiences of others, are they primarily in news articles or what sources are you reading these --

A I think it's very hard to live in today's world without realizing there is a strong urge in schools, in medical circles, and in the general environment to be affirming and only be affirming to someone who presents with a -- with a feeling that they are in the wrong body. I don't think that that's really very controversial or difficult to perceive.

Q Is it your opinion that this is

problematic?

A Absolutely.

Q You say -- I think going down to -- I'm sorry, I'm trying to find a reference here.

So you also discuss an issue that arose in Virginia where a sexual assault was -- well, as you put it, was committed by a, quote, "Self-described trans female."

Do you see that section?

A Yes.

Q And you quote -- or, I'm sorry, you cite to an article here that was published in the Washington Examiner?

A Uh-huh.

Q I'm going to show you that article.

(Document is displayed).

Is this the article that you were citing to?

A Probably.

(Whereupon, Exhibit Number 28 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to -- I will mark this as Plaintiffs' Exhibit 28.

A Can you enlarge it?

Q Of course. Can you tell me where you got the information that this person who committed this sexual assault was a, quote, "Self-described trans female"?

A There was more than one article about this. This is only one that I cited.

Q And here it just says there was "a male perpetrator who was wearing a skirt."

This article, which is the one you cited in your report, doesn't identify this individual as a trans person -- transgender person?

A Oh, no, there have been several reports. I cited one, but this, you know, was clearly reported in the news.

And, yes, the reason he was in the girls bathroom was because he had felt proclaimed to be transgender. I think that that self-diagnosis might be questionable. I don't think that people who truly feel they're transgender are at risk for sexual assaults opposite their biologic sex.

Q I'm just -- at this point I'm just asking about your citation here. So you have described the person who committed this assault as a "self-described trans female," and then you cited this article.

And I just want to confirm that this article does not refer to this person as a self-described trans female.

A Well, this is -- this is a reference to the article, but it looks like -- that does say he was wearing a skirt.

There are a couple of links there. Do they also mention that he had described himself as transgender? Because he had. And we can find it. Do you want to look?

Q Well --

A Can you click those links about "sexual assault" or "May 21 sexual assault"?

Q Dr. Donovan, I'm not asking you to read from the report, respectfully.

I am asking -- you cited this article in your assertion that this individual was a trans female. So I'm just asking -- in looking at this document, it does not state that the individual who committed this assault was a self-described trans female; is that correct?

A And I was saying I think it may be contained in those links about the same incidents.

Q Well, then -- but you did not provide a citation to those particular articles when you wrote

your report?

A I just provided this citation.

Q And I'm going to pull up one more article on this issue.

(Document is displayed).

So this is a CNN article that's about this same sexual assault in Virginia.

Have you ever seen this article, Dr. Donovan?

A I don't recall seeing it.

(Whereupon, Exhibit Number 29 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to mark this as Plaintiffs' Exhibit 29.

So CNN looked into this issue and they report here on this page that they "could not find evidence substantiating that the student identified as transgender or gender-fluid."

Were you aware that that report had not been substantiated by other news sources?

A I don't know how they failed to find it. I don't -- I don't know what this refers to. I don't know if they interviewed him or somebody else. I mean, this tells me nothing.

Q I'm just asking if you were aware that competing news sources were not able to substantiate the claim that this person was a trans female?

A I -- I actually would -- it's easier to say yes or no on this one rather than go into the details, but I'll accept that.

Q So you were not aware that other sources were unable to substantiate that claim?

A An unsubstantiated claim doesn't mean a false claim. That's all I'm trying to indicate here.

But, yes, I -- I don't know anybody who's interviewed the guy directly. The thing was -- it was very difficult to get information on the details. He was in a girl's bathroom wearing a skirt. You know, whether or not he had been diagnosed by himself or someone else as transgender is completely unknown to me. I would doubt the diagnosis that he gave.

Q But you cited to one article, and I'm just asking if you were aware of this other information from another news source.

A And I said "no."

Q You're not aware?

A Not this news source.

Q Thank you.

On Page 6 of your report, which I'll pull

up in just one moment.

(Document is displayed).

You cite to an article by Abigail Schrier. Are you familiar with this article?

A Yes.

Q Do you know where this article was published?

A Oh, there, "Top Trans Doctors Blow the Whistle on Sloppy Care."

Q And where was this article published?

A Says "Emmaus Road Ministries, 5 October 2021."

Q And is that a peer-reviewed source?

A You're not going to find very many discussions about these things in peer-reviewed sources. They basically, you know, have one orientation.

No, this, I don't think, would be a peer-reviewed source either.

Q Moving on to Page 7. We'll go to the second paragraph. So this is Page 7, Appendix 243. The second paragraph.

I'm sorry, I'm having trouble. I think I have a different version of the report pulled up than one of my colleagues, so I'm trying to identify

where --

A Okay. Well, whatever you have is what I'm looking at as well.

Q Okay. Simone was looking at the actual pages in the PDF and not the numbered pages and that's why we had some confusion, so that's my fault. Okay. I'm wondering why I was so confused and now I understand. All right. I apologize in wasting your time in trying to figure that out.

So we're going back up to Page 5, which is Appendix 241. And you say, "The rate of suicide among post-operative transgender adults in a study from Sweden found an incidence 20 times greater than that of the general population."

What study are you citing here?

A I don't see it. I don't even see the -- what you're reading to me.

Q Oh, I'm sorry. It's --

A Which paragraph?

Q -- the second paragraph. I'm looking at the second to last sentence in that paragraph.

A Oh, okay. Yeah. Yes, I do remember reading that. I didn't cite the article there.

Q Can you provide us with a name of that study here today?

A Not off the top of my head, no.
Q Slightly before this, the third to last sentence of that paragraph you say, "Studies have shown that adult transgender persons continue to have evidence of depression and suicidality following treatment."
What studies are you referencing there?
A Actually, I don't know. That may even be the -- among others, may be the same study, but I don't have the reference down there.
Q So there's no citation provided in your report --
A Right.
Q Regarding either of these two studies?
A That's true.
Q Are you aware of any studies that found there were positive mental health outcomes among transgender adolescents and young adults after receiving gender-affirming care?
A Well, there have been positive results reported.
Q And did you consider those studies when you were preparing your opinions in this report?
A Of course.
Q Do you reference any of those studies in

this report?

A If you're going to ask me for citation saying that there's -- on supportive ones, no, I didn't put that in there either.

One of the problems is that so many of these studies have been criticized because of the form in which they were done, how the questions were asked, and how they were reported, who was asked and who wasn't asked, you know, and who refused to ask.

So, yes, I know that they had been reported. I don't know that they are any more convincing evidence.

Q What evidence do you have with regard to those criticisms?

What evidence do you have of those criticisms? What are you referring to?

A Oh, you mean are there criticisms of some of the transgender reports or satisfaction surveys or something?

Q I'm asking what criticisms. I'm asking --

A Yeah. I don't even --

Q -- if you --

A -- have that stated here, so, no, I don't have a citation for that. I didn't even use that citation, seeing as how if it was sloppy work I

didn't think I'd want to cite that.

Q So I'm going to move down again to Page 6. This is marked as Appendix 242. So you reference two phenomena that may be associated with -- you say "this," and I -- I think we're maybe referring to this idea of overenthusiastic affirmation or love-bombing. Is that correct that that's what you're referring to?

A A strong affirmation for the diagnosis and treatment.

Q So you say here that, "It may not only be easier to identify as transgender in today's environment, it may be more difficult to turn one's back on that diagnosis."

What evidence do you have to support this statement?

A I said it "may." That's my opinion, that it may be more difficult to turn one's back if you're being strongly affirmed in any direction.

Q Have you cited any data to support that assertion?

A Well, I think maybe the subsequent lines about re-transitioning and de-transitioning and switching back and forth may be supportive of that.

Q But you're suggesting that because a recent

study found that fewer youth re-transitioned, that that is because it's more difficult to turn one's back on a diagnosis of gender dysphoria?

A Yes.

Q Why -- how can -- I guess, what evidence do you have that the lower rate of re-transition is caused by the fact that it's harder to turn one's back on the diagnosis?

A I'm sorry, I misunderstood your previous question, I'm afraid.

No, I think that enthusiasm and support for the diagnosis may be making it harder for people to then change their minds about their condition.

Q But then when I asked what evidence you had to support that, you cited to the evidence that follows in that paragraph, which is evidence that -- it's a study where the rate of re-transition, where someone changed their gender identity back, is -- is significantly lower than it was in earlier studies.

Does that data support your contention that it's harder to turn one's back on a diagnosis?

A I think that if you are being strongly affirmed, yes, you will be less likely to say, "I change my mind."

Q But what evidence do you have of that, that

that's what's happening?

A It's really kind of what we had just discussed, I think, that, you know, in fact, if you see stronger affirmation you may see fewer people saying that they no longer feel that way compared to historic data.

Q But merely citing a study which says that rates of re-transition have decreased does not necessarily mean that it's because of the cause -- the -- the hypothetis- -- I mean, you hypothesize that there are two phenomena that may be, you know, related to this, but those statistics about lower rates of re-transition don't necessarily prove that that was caused by these phenomena that you identify; isn't that correct?

A It says it may be an explanation.

Q But you have no evidence to demonstrate causation?

A That's why you say things like "it may be an explanation."

Q So here at the top of Page 7, Appendix 243, you say that, "All of this leads to the conclusion that we must ask if this represents a shift towards being trapped in the wrong diagnosis rather than a child being trapped in the wrong body."

What diagnosis would be right in this situation?

A The wrong diagnosis, I think, is when we are saying that your gender identity is both correct and the cause of all your problems.

Q So what diagnosis would be the right diagnosis in that situation?

A Perhaps what used to be thought of as gender identity disorder would be closer to accuracy.

Q And going further down on this page, in the second paragraph about midway through, you say that, "We may be making a fundamental mistake in approaching transgender phenomena, not as a disease or disorder but as a dysphoria that is a cause for affirmation."

So you believe that being transgender should be treated as a disease or disorder?

A It was a disorder until most recently. And I think that the transition to a dysphoria does not serve the interest of the patient.

Q So you believe that the medical community should return to a time when being a transgender person was a mental health condition that was treated only with psychotherapy?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: I think that it would be a very appropriate thing to do to test that theory. It hasn't been.

Q (By Ms. Dunn) So is it your opinion that the most appropriate treatment for gender dysphoria is psychotherapy with a goal of re-aligning a person's gender identity with their sex assigned at birth?

A That's not what I said, no. I said that both of those approaches are essentially untested hypotheses.

The purely psychiatric or psychological approach has fallen into great disfavor and the affirming approach is the predominant one with, in many cases, a nod towards some psychological discussions. But, in reality, that's not been used as a exclusive approach, nor has it been tested against gender-affirming therapy as it has now been practiced.

Q What is -- what evidence do you rely on to say that gender-affirming care is an untested hypothesis?

A Well, I think that we've kind of covered the fact that the long-term studies have been rather

deficient in testing the results of the therapy.

Q Is there a specific source in your report that supports that the impacts of gender-affirming treatment are unknown?

A Well, I didn't actually say they were totally unknown. I said that what is known is insufficient.

Q And what studies are you relying on to make that assertion?

A Well --

MR. BEATO: Object to the form.

Dr. Donovan, you can answer the question.

THE WITNESS: Okay. I think that what you -- what you have to understand is what I'm saying is that there are -- there's an absence of studies. You can't rely on studies that don't exist.

And in terms of good, scientifically designed and carried out programs with sufficient numbers of patients to actually test a theory, you don't find those.

Q (By Ms. Dunn) But can you cite to any one study that supports this assertion?

A You're asking about a study that supports that there aren't studies?

Q No, a study that supports the fact that

there are unknown risks that are of such a concern that this care should not be provided.

A I'm sorry, that doesn't completely compute. Try that again, if you would be so kind.

Q Well, you're making the assertion that we don't know enough about the impacts of this care in order for it to be provided.

A Yes. And that would be by definition of unknown risk. So you really can't have a study of the unknown risks --

Q So there's no --

A -- because they haven't been able to determine the risks.

Q But what evidence of these unknown risks are you relying on in formulating your opinions about whether the care should be provided?

A Ms. Dunn, there have been suggestions that there could be risks that they've shown up in individuals, but we don't know in how many individuals or how long or how -- whatever. But that is, by definition, an unknown risk.

And by definition, you can't know the unknown risks until you have done the studies that could reveal them.

Q So are you relying on anecdotal, you know,

examples of these risks?

I'm just trying to understand where the information of these unknown risks that keep being referenced -- I just want to -- I'm trying to figure out where that information is coming from, where we can look to to help understand that.

A You are actually giving a good definition for the need to do careful, large, controlled studies because that's how you find unknown risks. Nobody will find an unknown risk without that. At least not be able to document it in large numbers.

Has it been documented in individuals? Of course. This is why people are calling for the studies.

Q But there are always unknown risks in providing medical care. I'm just trying to determine what information you're relying on in saying that this type of care is associated with such a risk that it should not have been provided.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: Actually, I did say that if you were going to provide this care, it should be done in a controlled, experimental venue where you were also comparing it to something else that might

be effective without the risks of surgery or hormones or whatnot. That was actually my contention all along.

Q (By Ms. Dunn) Have you reviewed any studies that demonstrate that gender-affirming care is both -- is safe?

A Safe for what?

Q That it's a safe method of medical treatment.

A Well, I think this is what we've been talking about.

First off, there's no medical treatment that's completely safe. You know, that's just a truism.

But if you're talking about, you know, do we have the studies that demonstrate sufficient safety to overcome concerns about, you know, potential harms, that's exactly what I'm asking for.

Q Have you read any studies that demonstrate that gender-affirming medical treatments are safe and effective?

A Nothing that should be considered definitive or reliable, no. That's why I think the studies need to be done.

Q But there are no studies showing the safety

or efficacy of gender-affirming care that you find credible to rely on?

A I don't think that they have been done carefully in a large enough series of patients for a long enough period of time and conducted in an appropriate manner to be able to answer that question.

Q And what are these studies that you're referring to that are unreliable?

A I haven't found any that should fit the reliability category that we're discussing here, in terms of sufficient numbers, sufficient duration, sufficient design.

You know, and it depends on which kind of question you're trying to ask. So, I mean, are you talking about their psychological benefits or their physical harms or -- you know, basically we just don't have enough to -- to rely on at this stage.

Q So I guess what I'm asking, though, is can you name a single study that you have read that you determined was not reliable?

These studies we're talking about that are not sufficiently reliable, can you name a single one?

A I have read studies and I can't name any that are reliable, so I certainly couldn't name the

ones that aren't.

Q Okay. I'm going to show you a document, Dr. Donovan.

(Document is displayed).

Do you recognize this document?

A I actually don't recognize it, but it's got my name on it, so I believe it.

Q So you don't recall sending this email?

A When was that done? May 12th? No, I sure don't.

(Whereupon, Exhibit Number 30 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to mark this as Plaintiffs' Exhibit 30.

Do you recall that Devona Pickle and Jason Weida and Andrew Sheeran were the individuals at the Agency for Healthcare Administration that you worked with?

A That sounds right.

Q Do you recall the draft of the report that you were preparing that was attached to this email?

A No, definitely not.

Q I'm going to pull up a draft of your report so we can see if it might be that one.

(Document is displayed).

Do you recall seeing this draft of your report?

A No.

(Whereupon, Exhibit Number 31 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Okay. So if we could mark this as Plaintiffs' Exhibit 31.

I'm just going to scroll down to --

A Pardon me. Just to clarify, this is not something I submitted finally; is that right?

Q I believe this was a draft. This wasn't what was publicly released with the GAPMS memo, but this is a draft of that same report, as far as I can tell, that has some, you know, redline edits in it. They're actually green or blue on this copy, but --

A Okay. I can't see any edits at all, but I'll trust you.

Q So I'll just show you. So right here do you see these redlines? Or they're not red, they appear to be green.

But you don't recognize this?

A Not really, no.

Q Well, I'm just going to ask you about a

specific statement in this particular report.

So one difference between this report and the report that we were just reviewing that was the final report, that was publicly released with the GAPMS -- during the GAPMS process is the sentence that's bolded here.

It says, "It should be noted that none of my observations and criticisms are based on any so-called religious objections."

Why did you feel the need to include that statement in this draft of the report?

A Probably hoping to skip the first two hours of this deposition.

Q Is there a reason -- was anyone concerned that your opinions would be viewed as based on religious objections?

A Well, we did seem to spend an inordinate amount of time talking about various religious connections this morning. And I just wasn't -- they were irrelevant to what I was writing, so I thought I would put that in. But it didn't even show up in the last one. Maybe they didn't want to tempt anyone beyond their ability to resist.

Q Do you know why it was removed?

A I don't.

Q Do you know if anyone internal to AHCA, so anyone at the agency, expressed concern that your opinions might be considered to be religious?

A Oh, no, that didn't come from anybody else. That was all me.

Q So today we've reviewed the sources you relied upon in formulating your opinions in the case; is that correct?

A Correct.

Q We've discussed that kind of ad nauseam.

And I'm going to pull up your bibliography just one last time.

(Document is displayed).

Which of these articles are peer-reviewed articles, journal articles that you relied on for your -- your expert report?

A I will have to tell you that I did not rely on exclusively peer-reviewed articles because peer-reviewed articles are extremely difficult to come by in -- on this topic unless you're in favor of gender-affirming care. There is such a strong urge towards supporting it that anything negative is very difficult to get published.

Q Can you identify whether any of these articles were -- are peer-reviewed journal articles?

A I think -- looks like the Clayton one and the Levine one are. And the Abbruzzese one looks like it is. And the DSM is not peer-reviewed, it's just what it is.

Q Well, I'm sorry, so if we can just go a little bit more slowly --

A I'm going from the bottom to the top. Sorry.

Q That's okay. So Clayton we looked at, and I'm happy to pull it up again, but that was a letter to the editor.

A Oh, was it? Well, okay, that wouldn't have been peer-reviewed. That would have been published literature but not peer-reviewed.

So, basically, I think we have been through them all. I don't have anything to change on that then.

Q And you didn't cite to the DSM-5, in fact, you cited to a Human Life International --

A Oh, okay.

Q -- article -- online article on gender dysphoria in the DSM-5. Is that not correct?

A That looks right.

MS. DUNN: I am done with my questions on direct. So at this point I'll turn it over to see if

your attorney has any questions for you. Or not your attorney, I'm sorry, the defense attorney -- defendants' attorney.

MR. BEATO: Sure. And thank you for your testimony, Dr. Donovan. I know it's been a long day, but I just have four questions to ask you.

THE WITNESS: Okay.

CROSS-EXAMINATION

BY MR. BEATO:

Q So we established that you submitted a report attached to the GAPMS report, correct?

A Correct.

Q Did AHCA, the defendant in this case, did AHCA ask you to opine on treatments for gender dysphoria as an experienced ethicist?

A Only as an ethicist.

Q Okay. We reviewed your report attached to the GAPMS report. Do you today stand by the conclusions that you made in your report?

A I do.

Q Dr. Donovan, do you think that treatment for gender dysphoria is a controversial subject matter?

A Yes.

Q And my question is, why wade into this

controversial subject matter?

A Why did I or why do others?

Q Why do you. Why do you specifically.

A Simply because my entire life has been in serving the needs of children and being concerned about the ethical aspects of those treatments, and I thought that there were people reluctant to speak up about this, so I felt somewhat obligated when asked.

MR. BEATO: No further questions.

MS. DUNN: May I just have one brief second? I won't be long, I promise, and then I think we'll be all done.

MR. BEATO: Absolutely.

(Recess taken from 5:02 p.m. to 5:04 p.m.)

MS. DUNN: Thank you for your time today, Dr. Donovan. Plaintiffs are done with their questioning as well.

THE WITNESS: Thank you, Ms. Dunn. I'm happy to hear that you are done.

MR. BEATO: Okay. He will read.

Dr. Donovan, in reading you get to look over the transcript, and if there's any changes you want to make there's a sheet for them.

THE WITNESS: Fine.

MS. DUNN: Plaintiffs will order the

deposition transcript and we'd like it expedited, please.

MR. BEATO: We would like the transcript, too. Not expedited.

(Deposition adjourned at 5:05 p.m. CST)

* * * * * *

J U R A T P A G E

I, G. KEVIN DONOVAN, M.D., M.A., do hereby state under oath that I have read the above and foregoing videotaped deposition in its entirety and that the same is a full, true and correct transcript of my testimony so given at said time and place, except for the corrections noted.

_____

G. KEVIN DONOVAN, M.D., M.A.

Subscribed and sworn to before me, the undersigned Notary Public in and for the State of Oklahoma, by said witness _____, on this the _____ day of _____, 2023.

_____

Notary Public

My Commission Expires: _____

JH

C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Jana C. Hazelbaker, Certified Shorthand Reporter within and for the State of Oklahoma, do hereby certify that G. KEVIN DONOVAN, M.D., M.A., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, in the case aforesaid; that the above and foregoing videoconference deposition was by me taken in shorthand and thereafter transcribed; that the same was taken on MARCH 22, 2023, located in SAND SPRINGS, Oklahoma; that I am not an attorney for nor relative of any of said parties or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 27th day of March, 2023.

<%8249,Signature%>
Jana C. Hazelbaker, CSR
State of Oklahoma CSR No. 1506

G. Kevin Donovan, M.D. c/o Michael Beato, Esq.
mbeato@holtzmanvogel.com

March 28th, 2023

RE: Dekker, August, Et Al. v. Weida, Jason, Et Al.
3/22/2023, G. Kevin Donovan, M.D., M.A. (#5815158)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at transcripts-fl@veritext.com

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

Dekker, August, Et Al. v. Weida, Jason, Et Al.

G. Kevin Donovan, M.D., M.A. (#5815158)

E R R A T A S H E E T

PAGE 32 LINE 22 CHANGE teleological

REASON NOT ideological

PAGE 56 LINE 1 CHANGE patients

REASON NOT patience

PAGE 104 LINE 2 CHANGE endocrinological

REASON

PAGE LINE CHANGE

REASON

PAGE LINE CHANGE

REASON

PAGE LINE CHANGE

REASON

G Kevin Donovan 4/07/23

G. Kevin Donovan, M.D., M.A. Date

Dekker, August, Et Al. v. Weida, Jason, Et Al.

G. Kevin Donovan, M.D., M.A. (#5815158)

ACKNOWLEDGEMENT OF DEPONENT

I, G. Kevin Donovan, M.D., M.A., do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

G Kevin Donovan _____ 4/7/2023

G. Kevin Donovan, M.D., M.A. Date

*If notary is required

SUBSCRIBED AND SWORN TO BEFORE ME THIS

_____ DAY OF _____, 20___.

_____

NOTARY PUBLIC

&

& 2:17

0

002078 110:11
00325 1:6

1

1 2:12 4:3 12:22 13:1 14:10,22 18:14 46:19 64:15 85:18 120:17 138:24 140:2 211:19
10 4:15 21:3 89:4,8,21 91:5 123:3 150:17
100 4:19
101 99:3
105 2:12
10:31 72:10
11 4:16 67:15 89:9,13 91:14 129:5 130:10
114 4:21
115 4:22
117 4:23
119 2:18
11:35 112:24
12 4:3,17 5:19 92:9 93:4,11 130:23 213:23 214:6,8
1229 2:5
125th 2:5
12:10 112:25
12:44 138:6
12th 276:9
13 4:4,19 92:15 100:10,14 150:13
14 4:20 81:25 114:18,24 116:25 131:13
149 5:4
15 4:22 21:3 83:10,11,13 84:13 115:5,9 141:6 208:24
150 31:9,11
1506 285:22
157 5:5
15th 12:4
16 4:23 83:25 101:22 117:18 117:23
160 5:7
17 5:4 72:23 73:1 83:12 84:23 122:8 123:1 142:19 149:18,22 150:13
171 5:8
18 5:5 94:4,4 150:16 157:24 158:3 213:16 214:9
181 5:9
183 5:10
186 5:11
188 5:12
19 5:6 94:9 151:21 160:5,12 186:2
1930s 198:14,17 198:21 199:1
1970 27:17
1974 27:17,23
1977 27:23 28:2
1979 28:2,8
1980 28:8
1980s 68:12
1982 68:3
1991 70:18
1993 70:16
1994 28:11
1997 70:10
1:19 138:6

2

2 4:4 13:14 14:13 79:5 80:3 85:21 105:25 134:22 138:12 139:2 164:19,21 215:11
20 5:8 84:17 95:3 148:18,19 149:7 150:9,19 150:20 159:11 171:1,7 208:24 213:18 214:10 214:18 229:24 263:13 288:15
2004 68:4
2007 4:11 77:5
2008 68:12
2009 68:12,22
2012 30:1 45:25 52:21 53:15 102:12 122:23
2015 241:7
2017 105:10 151:4
2018 31:2 46:5 160:11
2019 212:4
2020 30:1 42:10
2021 262:12
2022 5:19 241:1 241:4,22
2023 1:16 6:6 12:5 241:22 284:16 285:13 285:18 286:2
20s 236:2
21 5:9 95:10 181:13,20 223:13,14 259:13
210 5:13
213 5:15
22 1:16 5:10 6:6 97:17 164:6 183:3,7 285:13
23 5:11 98:6 168:8 173:7,10 186:3,7

236-244 5:13
237 211:21
238 215:12
239 224:23 235:24
24 5:12 98:16 174:21 188:18 188:22
240 245:11
241 249:15 263:11
242 266:3
243 262:21 268:21
245 5:16
25 5:13 45:5 67:21 98:20 181:22 199:7 210:17,21 214:5
257 5:17
26 5:14 68:10 98:25 99:3 138:11 192:25 213:7,11
260 5:18
27 4:5 5:16 199:10 245:1,7
270-5938 2:19
271-8890 2:6
276 5:19
277 5:20
27th 285:18
28 5:17 203:14 257:20,24
281 3:6
284 3:7
286 3:8
28th 286:2
29 5:18 203:15 260:11,15
2:19 181:12
2:27 181:12

3

3 4:5 27:9,13 38:23 39:1 46:17,21 73:13 74:22 80:10 85:21 139:4 224:23 235:24
3/22/2023 286:5
30 5:19 251:5 276:11,15 286:17
30030 2:13
31 5:20 277:5,9
32301 2:19
32601 2:6
34 4:6
35 31:19
362 2:6
38 4:8
3:21 218:19
3:26 218:19

4

4 4:6 34:4,9 38:20 43:11 80:14 85:24 86:4 130:18 139:6 160:18
4-5 3:3
40 31:19 148:19 149:7 150:9,19 150:20 223:6 251:6
401 222:15 223:6 224:17
401-409 222:23
404 2:13 223:7
409 222:15 224:17
45 223:21 224:6 224:16
46 222:15,23 223:6,16,17,18 223:21 224:6,12 224:13,16
4:02 244:25
4:08 244:25
4:22 1:6

5

5 4:7 34:25 38:13,18 74:1 80:22 86:19 139:7 143:19 247:6,17 248:5 248:6 249:14 262:11 263:10 280:18,22
500 2:18
50s 198:18
538 36:25
56 4:10
5815158 286:5 287:2 288:2
5:02 282:14
5:04 282:14
5:05 283:5

6

6 3:4 4:9 36:25 56:12,16 139:10 261:25 266:2
60 72:13
60s 198:19

7

7 3:5 4:11 76:18 76:19 262:20,21 268:21
76 4:11,13
78 85:8

8

8 4:12 76:25 77:4 81:7,17,24 90:2 122:6
8-12 118:9,11 119:8
8-13 119:12 120:12
80 151:21 152:3 235:25 236:10
8249 285:21
850 2:19
88 4:14
89 4:15,16
897-1880 2:13

9

9 4:14 34:24 35:11 39:2 88:19 89:3 90:12,20,23
93 4:18
9:03 7:2

a

a.m. 7:2 72:10 72:11 112:24
aap 73:13,15 74:2 81:21 113:20
abbreviation 66:18
abbreviations 16:17
abbruzzese 5:8 169:4 170:2,6,7 170:15,17 171:5 171:9,11,25 280:2
aberration 144:2
abigail 262:3
ability 9:7 110:5 110:25 111:14 112:4 205:9 278:23
able 22:23 56:5 75:11 101:9 108:23 110:19 111:23 123:8 132:8 133:1 140:24 142:2 166:6,10 176:3 177:12 179:12 191:7,12,19 195:23 201:2,15 201:25 202:18 203:6 220:13 221:11,20 235:2 236:12 241:20 261:2 272:12 273:11 275:6
abnorm 144:6
abortionists 83:25
above 130:21 190:4,11 284:4 285:10 286:6 288:7
absence 105:15 107:5,6 206:5 229:9 230:15,16 271:15
absent 206:12
absolute 220:25
absolutely 126:2 180:11 181:11 216:15 238:17 257:2 282:13
absolutes 131:11 218:25
abstracted 54:24
academic 94:16 255:11
academy 74:8 76:4 81:8 82:8 82:19,20,21
accept 36:9 119:16 154:8 219:7 261:6
acceptance 155:22 256:2,2 256:6,11
accepted 16:11 16:19 82:13,14 82:16,16,19 87:24 88:16 118:4 196:6
accepting 88:16 88:17 145:12
access 200:11
accompanied 138:18
accompanies 140:12
accuracy 269:9 286:9
accurate 27:5 46:24 57:18 136:25 137:8 148:3 176:21 214:7 242:11 243:22
accurately 195:23 251:6
acknowledge... 288:3
acknowledgm... 286:12
acp 113:15
acquired 29:12 31:3
acronym 91:16
acronyms 17:4
action 285:16
active 34:21 47:20 48:22 53:5 57:21,24 58:3
actively 30:21 48:20
activities 29:24 30:6,7,8 40:21 130:12
actual 60:4 73:22 107:19 227:2 263:4
actually 19:17 20:12 21:20 25:8 55:17 58:18,24 63:20 66:22 70:10 76:14 84:21 90:22 92:22 100:17 101:17 102:9 117:14 148:22 150:20 155:25 158:15 174:8 175:21,25 177:11 178:23 179:22 184:21 187:22 197:4 202:4 205:7,10 213:12 218:2

219:16 227:23 227:23 231:24 235:20 236:5 239:7 243:19 251:16 261:4 264:8 271:5,19 273:7,22 274:2 276:6 277:17
ad 279:10
adaptation 115:15
add 135:17
added 133:12 134:2 135:15
addition 191:24
additional 28:4 110:12 126:11 132:24 135:14 137:4
additionally 28:10
additions 288:6
address 184:25 228:16
addressed 63:15 63:23 66:2,7 238:11
addresses 238:23
addressing 213:19 228:24
adds 134:6
adequate 217:13
adhere 35:14,24 36:2 67:6
adherence 35:3
adjourned 283:5
administration 10:9 16:13,21 16:23 18:17 35:6 106:3,18 108:3 111:3 146:22 147:3 194:19 195:4 197:16 210:13 237:7 238:6,10 276:18
adolescence 110:24
adolescent 206:19 236:24 237:13,21
adolescent's 110:5,13
adolescents 101:21 102:17 105:10,14 158:10 199:6 208:23 235:4 264:18
adopt 35:2
adopted 119:25 120:2
adult 68:15 106:2,9 112:2,3 127:19 161:17 264:4
adults 107:8 111:20 123:6 129:3 158:10 208:24 229:25 235:21 263:12 264:18
advance 10:18 202:10
advanced 66:22
advantageous 193:16
adverse 183:12 184:9 193:2 194:15
advice 53:24
advisements 34:13
advisory 56:19 58:11
advocacy 39:19 95:3
advocating 203:8
affect 9:7,11 68:25 69:7 221:8
affected 136:21
affecting 131:5
affiliated 57:12 113:6,11 172:15
affiliation 57:18 57:20 113:3
affirm 146:14
affirmation 174:9 266:6,9 268:4 269:15
affirmative 101:23 213:14 213:21
affirmatively 212:8
affirmed 247:9 266:19 267:23
affirming 5:15 10:4,7 11:3,5,14 16:8 47:14,15 61:4,14 62:8 63:7 64:6 68:7 72:3,6 94:10 99:13,19,23 100:25 101:4 121:6 141:15 142:6 146:6,25 147:6 148:10 180:23 181:4 195:19 196:8,19 196:24 200:17 200:22 202:1 203:16 204:18 205:23 210:15 211:24 212:8,17 213:15,20 214:2 214:6,11,14,19 216:7 218:23 219:2,5,10,14 219:24 220:6 221:11 225:5,19 225:22 226:7,9 226:16,19,20 230:7 231:11

232:3,11,17 235:10,17 240:6 243:7 245:18 254:17 256:6,20 256:20 264:19 270:15,19,22 271:3 274:5,20 275:1 279:21
affirms 148:1
afford 200:6,23 201:2,15
aforesaid 285:10
afraid 66:21 127:23 267:10
age 101:22
agency 16:12,21 16:23,24 17:23 18:17 180:25 194:19 195:4 210:13 211:2,15 241:5 276:18 279:2
agency's 195:12
agents 105:4,7 107:8 110:13 118:13 222:3 233:9
ages 150:13
ago 15:8 55:20 63:1 70:18 84:17,17 125:11 199:8
agree 37:14 89:20 93:15 113:20 154:15 159:5 163:5 180:12,15 200:21 214:4 241:21
agreed 6:2,10 116:21
agrees 119:2
ahca 16:22 17:8 17:17 110:11 195:20 196:3 279:1 281:13,14
ahead 12:16 184:3 186:12
ajob 87:19,23 92:24
akin 144:8
al 1:4,7 7:10 286:4,4 287:1,1 288:1,1
aliens 232:8
aligned 36:7,11 37:17,22 43:3 119:3 120:11 146:15 147:7
aligning 270:7
alleging 109:17
allotted 286:20
allow 109:13 111:17 147:17
allows 161:6
alter 134:7 145:20
alternatives 206:8 208:15 219:17 220:14 221:6
altogether 112:1
ambiguous 179:2 201:23
america 102:22 243:1
american 59:9 59:11,14,18 74:8 76:4 81:8 82:8,20 87:11 89:15 92:15 97:2 100:20 112:16 113:6,12 113:25 114:6,11 114:23 115:1,10 116:18 247:17
amount 278:18
analogous 141:16
analogues 103:23 104:5,8 106:19 108:4 240:7 242:1 243:6
analysis 4:21 114:2
andrew 276:17
anecdotal 272:25
anecdotes 176:25
annually 31:10 31:12
anorexia 145:23 146:3,6
answer 8:13,22 9:7,18 39:10,13 103:1,2,13 107:3 108:5 109:4 116:22 126:10 137:22 137:24 141:3 161:24 166:17 166:19,21 171:17 178:7 179:15 187:7 195:23 201:23 203:21 207:19 209:10,19,21 218:1 220:9 230:25 231:6,15 231:20,22,22,24 232:7 237:25 242:21 250:15 270:1 271:12 273:21 275:6
answered 209:21 219:11 230:2,24
answering 8:6,8 8:14,16,19 230:3
answers 8:1 9:21 192:4 209:17
antonnaria 20:4
anybody 103:2 116:22 119:2

132:15 153:12 261:11 279:4
anymore 48:12 52:10 81:2 120:18 225:20
anyway 204:24
apa's 247:22
apologize 17:14 71:9 88:6 109:18 129:20 135:20 185:19 250:18,22 263:8
app 5:13
apparently 54:22 79:20 94:14 106:20
appealing 226:2
appear 73:6,8 79:1 255:11 277:22
appeared 85:13 91:21 97:21
appearing 2:2 117:10
appears 68:11 90:25 184:21 187:14,15 222:17 223:7
appended 288:7
appendix 211:21 215:12 224:23 235:24 245:11 249:15 262:21 263:11 266:3 268:21
applicable 208:6 286:8
application 11:20
applied 199:4 218:11
applies 252:8
apply 43:12 111:15 196:9,21 215:20,24 216:12,20,24 222:6
applying 147:11 228:13
appointed 56:18 56:24 58:12
appointment 58:16,22 59:3
appointments 45:12
appreciate 7:15 136:10 188:2
approach 11:10 11:11,13 32:15 32:18 58:18 69:18 102:1,18 102:20,24 103:3 103:5 145:4,7,8 145:22 146:17 146:18 147:21 147:21,24,25 148:6 164:7 167:6 168:9 173:16,18,25 174:12 217:3 227:16 249:8 254:14,16,19 255:14 270:14 270:15,18
approached 58:21 59:5,6 69:6
approaches 32:21 69:11 112:11 145:21 270:11
approaching 269:13
appropriate 35:5 137:16 141:22 199:21 270:3,6 275:6
appropriately 163:16
approval 168:4 168:6 246:14 247:3
approximately 24:9 31:17,19 31:21 77:9 125:13 134:23
area 52:12 190:3
argues 100:24
argument 158:18
arose 257:5
arrange 45:1
arrangements 44:8
array 160:20
arrested 181:24
arresting 105:16
arrival 80:9
arrived 31:3
article 4:19 5:8 5:10,11,12,17 5:18 18:25 21:21 22:5 36:18,24 37:1,2 37:5 38:8 73:17 73:23,23,24 74:5,13,20,22 74:24 76:8,9,12 76:17,22,23 77:3,5,11,18,22 78:18 79:1,5,5,6 79:14,18 80:3 80:14 81:17 83:16,25 84:9 84:11,14 85:16 85:25 86:3,7,12 86:13,14,19 87:7,10,13,18 87:22,24 88:2 88:11,25 89:2,3 89:22 90:1,21 91:3,21 92:3,13 92:15,19,24 93:10,12,16,21 94:2,9 95:2,5,10 95:14,22 97:5 97:10,11 99:23 100:1,2,3,7,15

101:7,11,15,16
102:10,12,15,23
103:10,11,22
104:10,18 107:1
107:7,11,16,21
108:7,18,19,20
108:20,22
109:10,25 110:4
110:7 112:12
113:6,11 116:7
123:9 131:9
132:16 133:11
157:6,8,12,18
159:3,5 160:9
160:16,18
161:10 170:2,5
170:6,15,20,23
171:5,9,11
172:3,15 182:19
182:25 183:8
185:13,24 186:8
186:20 187:5,15
187:16,17 188:5
188:7,7,10,14
188:23 191:3,8
191:13,16
248:14 257:12
257:15,17 258:5
258:9,25 259:2
259:5,16 260:3
260:6,8 261:18
262:3,4,6,10
263:23 280:21
280:21

articles 14:25
18:5,20,21,23
19:7,9 73:2,7
75:25 76:5,6
77:14 78:20
83:9 84:21 85:2
85:2,12,14
99:11 107:15
109:14,16
133:10 136:1
153:10 155:8,10
155:12 156:5
166:2 169:12,18
171:14 180:4
191:18,20 192:6
254:23,25
256:15 259:25
279:14,15,15,18
279:19,25,25

aside 71:23
137:17

asked 10:22,23
10:25 28:15
29:2 38:16
57:14 59:4 70:1
84:13 89:16
112:21 113:3
125:17 135:12
156:3 175:19
178:9 186:17,18
187:25 188:6
210:24 232:12
232:13 265:8,8
265:9 267:14
282:8

asking 15:19
27:14 90:16
106:7,11 109:23
109:24 126:6
127:25 143:5
192:9 195:13
197:5 204:13
209:13 226:25
230:12,19,20
231:18 232:1,8
232:23 234:9
235:1,16 241:18
241:19 242:23
243:15,16
244:14,17
258:21 259:14
259:16,18 261:1
261:19 265:20
265:20 271:23
274:18 275:19

aspect 221:1

aspects 64:9
103:20 220:12
220:12 221:3
282:6

assault 257:6
258:3,23 259:13
259:13,20 260:7

assaults 258:20

assembled
206:23

assent 110:20

assert 103:23
109:15 174:21
228:19

asserting 144:7
144:8,9

assertion
103:25 104:23
106:8,12,18
107:1,12,23,25
108:3,6,13
149:7 152:17
154:13,23 155:5
155:13,17,24
159:17 161:2,20
165:15 166:7,12
166:23 174:24
176:12 178:12
182:14 186:18
192:2,10,17
228:22 229:5
233:14 234:22
234:23,25 236:4
236:20 237:3,23
259:17 266:21
271:9,22 272:5

assertions
108:25 109:2
191:14

assess 33:15

assessment
241:5,6

assign 179:10

assigned 66:12
146:15 147:8
148:2 151:24
270:8

assignment
144:1

assimilation 95:13
assist 211:5
assistance 52:6
assistant 90:2 91:17
assisted 95:3 142:13
assisting 33:8
associate 57:17 58:1 245:23
associated 24:15 110:15,24 138:9 188:24 191:14 227:7 266:4 273:18
association 4:10 52:24 55:9,12 55:15 56:9,23 57:3,6 78:4,8,15 79:4 84:7 92:1 93:22 95:19 117:12,22 118:1 118:5,12,16,18 119:14,22 120:2 204:8 205:6 247:18
association's 118:25 120:7
associations 49:22 133:25 169:16 204:4 205:4
assume 51:2,12 51:13 54:17 58:6 70:11 87:24 88:17 90:7 110:5 151:22 171:10 195:24 200:9 252:15
assumed 83:24 189:13
assuming 91:15 200:1,2 224:25
attached 276:22 281:11,17 286:11
attachment 16:10
attempted 79:14
attendant 197:2 197:15
attention 127:5
attorney 7:9 8:18 21:5 281:1 281:2,2,3 285:14 286:13
attorney's 19:20
attorneys 6:3,11 13:7,11 21:4
attraction 4:22 115:12 116:16
august 1:4 286:4 287:1 288:1
australia 168:17
author 73:2,5,9 73:11,20 74:1,6 74:11,13 75:6,8 75:19 76:3 80:11 81:10,20 82:1 93:1,3 99:22 108:14 113:4 114:15 115:20,25 116:4 116:13,20,21 117:4
authored 94:9 99:18
authority 256:7
authors 73:15 75:1 109:17 170:8 172:14
autism 110:22
automatically 88:16
autonomy 216:22
available 65:20 126:20 155:6 198:20,23 206:11,16 219:3 223:25 286:6
avenue 2:5
avoiding 69:14
award 50:13
awards 49:22 50:3
aware 11:22 15:6 32:15 83:21 87:16 91:24 112:15 114:11,14 115:19 117:2,14 118:15,20,21,23 119:21 120:5 152:22 157:5,7 157:10 158:13 159:25 160:15 160:17 161:1,25 164:11 172:14 180:8 181:3 198:8,10 202:4 203:17 204:3 207:17,20 242:16 255:3 260:20 261:1,7 261:19,22 264:16
axis 105:21

b

b 138:12
babies 52:7
back 15:13 20:11 39:24 46:18,19 75:21 75:23 78:25 82:13 86:16 93:3,19 96:5,13 96:14 97:16 103:12 104:19 120:16 126:3 128:15 129:10 130:9 140:15,19 147:20 151:18 151:20 154:10 159:9 162:7 171:8,25 181:21 186:17 187:10

189:3,11,19 190:17 191:22 222:8 233:5 245:8 248:18 263:10 266:14 266:18,24 267:3 267:8,18,21
background 21:11 24:14 33:14 123:7 137:18
balance 185:22
ban 173:22
banned 173:24
bans 213:24 214:9
barantorchinsky 2:17
base 206:21,22 207:14 217:14
based 102:11 116:21 163:6,10 172:16,19 173:3 192:4 194:22 195:1,15,15 217:20 241:20 252:19 278:8,15
basic 229:2
basically 30:5 52:13 64:4 66:12 160:25 225:15 252:14 262:16 275:17 280:15
basing 178:11
basis 117:8 133:5 139:1 144:7 148:7 159:13,24 161:6 161:7 168:12 202:13 251:21
bates 110:11
bathroom 258:16 261:14
baylor 27:20
beato 2:16 3:6 13:13 15:24 26:15 36:20 39:9 55:22 56:2 88:5 107:2 109:3,18,21 110:2 112:23 135:20 136:22 137:4,24 138:5 140:17 141:2 154:15 161:23 166:14,17 171:16 178:6 179:14 181:8 187:6 203:20 207:18 209:16 215:6 217:25 218:12 220:8 223:1 230:23 231:5,14 232:14 237:24 244:23 269:25 271:11 273:20 281:4,9 282:9,13,20
283:3 286:1
began 28:25
beginning 98:8 164:22 207:1 234:16
begun 173:11
behalf 1:15 6:5
behavior 149:4 150:1,2
behavioral 115:14 215:17 216:9
beings 215:21 216:6
beliefs 119:3 120:10
believe 11:12 12:6 15:18 16:14 17:9 27:8 36:20 45:6 57:19 58:10 59:4,16 61:2 71:3,8 74:21 78:2 79:9 80:19 81:1,3,4 84:8 86:8 94:20 98:5 99:9 102:10,15 105:3 134:23 137:3 139:15 140:4 141:5 142:23 143:23 149:8 150:7 151:11 155:7 170:3 171:18 173:20 186:1
187:25 197:19 202:13 203:11 203:24 219:22 226:3,11 227:22 231:2,3 248:21 248:23 249:3 269:16,21 276:7 277:13
believed 186:20
believes 227:14
belmont 215:2 215:13,16,24 216:3,20 218:17
belong 113:15
belongs 134:9
belt 200:14,16 201:22
beneficence 4:15 87:7 89:7 216:23
benefit 76:15 194:6 229:23
benefits 206:8 207:21 208:15 218:8 219:17 220:14 221:6 243:8 244:5 275:16
benign 238:25
best 29:19 59:7 82:9 97:8 121:9 249:3,8 250:23
betcha 126:25
better 97:12 105:10 137:22

184:3 207:7
beyond 215:1 278:23
biased 130:24
bibliography 4:4 13:19 14:5,6 14:8 15:4 102:14 131:20 132:2,22 133:8 133:11,15,24 134:3,9,21 135:1,13,15,18 135:19,22 136:25 140:11 140:14 148:25 151:4,18 152:21 153:2 154:17 155:1,8,11 156:25 157:19 165:22,25 166:5 166:10 168:22 168:23 169:1,13 169:22 170:7,16 170:24 171:8 174:15 175:2 179:21,23 182:6 182:13 183:1 185:14,25 187:11 188:11 191:18 192:19 192:21 233:2,22 233:25 234:3 236:9,13 248:1 279:11
bigger 183:17
bio 76:10
biochemical 159:12,19,23 163:25
bioethical 124:21
bioethicist 37:4 47:9 130:3,4,8 130:12 211:15
bioethicists 30:16 123:21,25 124:3,16 125:14 130:6
bioethics 4:16 28:11,14 29:14 29:18,20 30:13 32:4,12 34:14 41:19,22 43:15 44:4,10 45:12 62:16 66:13 68:10,13,23 72:24 73:14,16 73:19 74:2,8,23 75:3,5,6,10,10 75:20 76:4 77:14 80:12 81:11,21 82:2 83:14,19 84:21 85:22 87:11 89:16 92:16 97:3 100:21 104:9 110:6 121:20 122:2,5
biography 58:4
biologic 258:20
biomedical 215:16 216:9
birth 38:3 92:17 144:2 146:15 147:8 148:3 151:24 270:9
birthright 52:4 52:23
bishops 43:10
bit 9:25 29:11 33:5 45:9 49:22 72:5 84:18 121:18 149:24 183:22 184:6 190:22,23,24,25 191:1,9 201:23 247:4 280:6
bits 127:16
bitter 95:12
blind 78:11
block 19:6 164:11,16,24 189:21
blocker 164:14
blockers 61:8 102:2 164:7,11 164:17,20 165:12,17 182:2 186:14,19 188:24 191:15 196:15,18,23 235:8 238:24 244:8
blocking 10:11 61:18 103:18 105:4,7 107:8 110:13 118:13 119:18 147:4 191:5 222:3 233:9 245:21
blog 90:4,20,25
blogs 126:21
blood 69:14
blow 262:8
blue 277:17
bmj 19:4 21:21
board 49:2 52:3 52:8 56:19,25 122:8,19 243:4 243:21
boards 82:24
bodies 168:11 168:14 169:11 170:19
bodily 146:4
body 142:11 145:18,19,20,20 146:1 219:1 228:20 233:24 249:1,6 253:8 253:17,23 256:22 268:25
bolded 278:6
bombing 255:17 256:10 266:7
bone 184:10 239:2

book 85:19,20 91:5,7,9,10 92:9 97:20 98:4,7,17 98:23 99:5,6,7
books 85:17
bottom 280:7
bouillon 50:15
bound 35:19
boy 124:10
boys 105:20
brain 54:7 69:19 141:10,17 142:13 184:10 236:23 237:8,20
branch 28:6
break 8:13,15 8:17 67:13 70:25 72:9 109:22 110:1 112:21 113:2 138:4 162:6 181:10,11,16 218:13,17 244:22,24
brief 108:21 133:24 282:10
briefly 20:18 39:24 56:17
bring 155:9 178:17 183:21
brings 120:24
britain 173:14 174:11
british 18:23 22:5 51:10 174:14 255:9
brits 174:7
broad 45:16
broader 153:3
broke 218:21
brought 23:6 137:18 218:4
buggy 250:7
busy 31:4
bypass 101:9

c

c 1:18 2:1 3:1 6:7 16:22 285:1 285:1,5,22 286:1
cace 66:18,20
call 32:16 125:21 225:19 254:19
called 32:19 54:3,5 68:24 74:2,24 94:10 95:11 102:16 170:20 172:7,8 187:12 235:23 241:25 256:10 278:9
calling 225:17 225:19 273:13
calorie 146:7
campus 42:24
capacities 48:18
capacity 26:2 47:13 69:24 94:22 111:9,21 112:5 206:4
cardiovascular 184:11
care 4:7 5:15 10:4,7 11:3,5,14 24:8,11,11,16 32:17 33:2,9 36:7,11 37:10 37:17,20 43:1 43:21 44:2 47:15,15 48:17 50:16 52:15,15 62:8 63:7 64:6 68:7 69:1,7 72:4 72:6 91:10 99:13,20,23 100:25 101:4,22 102:3,8,20,25 103:6,8 111:3 121:6 128:24 141:15,25 142:6 143:20 144:25 148:1,10 174:17 178:23 180:9,13 180:16 181:5 195:19,24 196:4 196:19 197:12 199:24 200:11 201:15,16 203:16 204:11 204:18 205:23 207:3 208:5,6 210:15 211:25 212:9,17 213:15 214:2,7,11 215:25 216:13 216:17,21,25 217:10,11 218:23 219:2,5 219:10,14 221:11 240:6 243:1 245:18 254:17 262:9 264:19 270:22 272:2,6,16 273:16,18,23 274:5 275:1 279:21
career 51:1,12 130:25
careful 8:7 37:8 131:10 273:8
carefully 218:9 275:4
caring 91:11
carl 2:10
carried 271:18
case 10:1,14,18 10:22 15:7,20 16:25 20:6 25:18,21,24 73:9 74:10 132:19 134:17 138:21 139:11 139:14,24 140:3 142:17 153:4,9 163:21 199:20 203:24 204:1,9 204:12 205:12 205:21 208:8

216:14 229:14 239:18 241:25 242:23 252:9 279:8 281:13 285:9
cases 24:7,9,17 24:24 25:1,3,7 30:22 33:16 49:13 68:18 139:7 240:8 242:24 243:9 244:6,19 270:16
castrate 168:7
casuistry 32:21
catalog 66:15
categories 213:13 217:2
category 31:25 81:23 84:22 97:14 213:16,23 226:10 228:7 252:17 275:11
catholic 4:10 32:6,13 33:18 34:2 35:1,12 36:6 37:7,17 38:9 39:17 43:3 43:10 47:2 53:3 53:18,23 54:15 55:2,5,9,11,14 56:8,22 57:3,6 70:3,9,14 78:4,8 78:15 79:3 83:15 84:6 91:11,19,25 93:22 95:19 117:11,22 118:1 118:4,11,16,18 118:24 119:14 119:22 120:1,7 130:13,20
catholics 95:13
caught 98:14
causation 268:18
cause 23:24 103:24 104:5 156:13 193:1,6 193:10,11,14,18 193:22 194:14 203:2 247:7 268:9 269:5,14
caused 267:7 268:14
causes 108:4 193:7
cautious 173:12 174:5,11
cautiously 162:25
ccharles 2:14
cdc 132:14 137:13 148:22 149:4,24 150:5 150:21 151:7
center 29:14,17 29:25 30:4,6,21 31:1,7,11,15 32:3 33:3,8,17 34:10,14,22 35:9,18,19,23 35:24 40:3,15 40:25 41:10 42:1,5,22 43:15 43:23 44:4,10 63:3 64:21 68:24 121:20 122:5
centralized 174:19
certain 38:4 39:3 96:11 97:5 107:24 113:20 146:17 220:11 220:12 243:18
certainly 17:6 19:9 39:14 103:3 110:21 121:10 125:20 142:8,17 143:7 148:17 169:4 184:13 193:9,12 209:11 220:11 235:2 275:25
certainty 221:9
certificate 3:8
certified 6:7 285:5
certify 285:7
cfr 222:15,20 224:12
chair 28:15 29:2 122:14,18
chaired 122:7
chairman 45:4 45:5 52:3,8
challenge 206:21
challenges 33:2 33:9 182:1 234:14,25
chance 242:20
change 106:1 116:8,9 225:4 228:3 247:6,14 247:21 248:5,13 248:23 267:13 267:24 280:16 287:4,7,10,13 287:16,19
changed 86:22 115:23,24 116:3 116:19 117:3 118:24 240:5 267:18
changes 181:25 182:1 240:23 282:22 286:10 288:6
changing 248:22
chap 98:3
chapter 85:18 91:6,7 98:4,7 99:3
chapters 85:17
characterize 52:25 121:9

characterized 29:19
charities 48:15
charles 2:10
check 224:19
chelsea 2:4 7:8 135:20,21 215:6
chelsea.dunn 2:7
chemical 119:16
chicago 206:20
chicken 144:9 144:17
chief 45:21 206:19
child 105:23 161:17 239:18 268:25
childhood 45:19
children 21:19 74:4 87:10 101:13,21 102:1 102:17 103:5 105:14 108:23 111:18 114:7 129:2 189:20 208:23 210:8,11 222:12,21 235:21 238:24 239:5 251:14 255:18 282:5
children's 206:19
choice 40:11 108:9
choose 201:16
choosing 201:2
chose 202:1
chosen 47:17 108:10
chriss 2:4
christian 70:20 83:14,19,23 94:3 95:18
christine 198:15
chronological 53:10
church 69:21,22 69:25
circles 256:19
circumstances 23:14 36:13 49:8 53:23 111:10 201:17 202:25 203:1 219:8,9 220:19
citation 106:10 108:7 154:16 155:16 182:8 192:16 223:11 224:8,12 229:11 230:6,10,12,21 231:10 232:21 234:7 236:6,19 237:2,16 240:4 254:7 255:19,21 255:22,24 258:22 259:25 260:2 264:11 265:2,24,25
citations 192:20 192:23,23 209:9 237:4
cite 109:1 149:3 152:16 169:22 169:24 172:1 182:4 185:14 186:15 192:1 203:25 207:8 209:6,14 219:22 228:21 229:5 232:25 234:22 235:25 236:3 237:22 238:7 239:24 240:1 248:4 257:11 262:3 263:23 266:1 271:21 280:18
cited 103:7 104:15,22 106:25 148:24 153:20 170:16 174:15 188:11 192:10 204:1,9 205:13,19 230:10,22 232:13,23 233:1 233:20,22,23,23 234:3,9 238:2,3 239:8,10 254:2 254:23 255:23 258:6,9,13,24 259:16 261:18 266:20 267:15 280:19
cites 104:19 109:6 110:15 149:24 150:9 212:3
citing 151:5 192:5 224:11 226:18 257:17 263:15 268:7
civil 135:6 136:12 138:11
claim 253:16 254:11 261:3,8 261:9,10
claimed 229:23
claims 26:11
clarification 17:5 71:15 196:13 224:20
clarified 100:22
clarify 18:25 186:24 231:24 277:11
clarity 13:8
class 63:24
classes 40:25 41:3,10,11,12 41:12,18
clayton 5:10 169:8 171:14 182:17,19,25 184:21 280:1,9
clear 68:19 124:6 134:10 156:23 163:9

168:2 184:14 196:12 204:23 205:12 245:4 246:12,18
clearly 108:9 153:15 193:18 193:22 207:22 208:16 229:18 247:2 258:13
click 259:12
clinic 173:15 174:19
clinical 29:14,17 30:24 32:5 34:14 42:4,19 44:13 45:10 59:23 60:23 62:17,24 66:22 81:7 83:1,7 102:16 105:9 165:1,5 168:10 180:17 194:22 194:25 197:12 198:9 206:24 208:5 215:25,25 216:5,6,8,13,17 216:21,24 217:9 223:13,25 224:4 242:18
clinician 48:12 48:22 102:4 163:18,22 167:22 168:4,6 227:1 249:25 251:1 253:11,21
clinicians 111:7 112:7 158:11 202:14 203:5 226:4 251:19
clinics 174:10 174:18 175:3
close 22:18 32:1 162:8 194:21 245:14
closed 173:15 174:8
closely 242:4
closer 214:5 269:9
clothing 145:9
cma 4:23 78:2
cnn 5:18 260:6 260:16
code 222:14,17 223:5,12 224:13 224:14
coercion 206:5
cohen 102:12
colleagues 40:22 123:19 262:25
collect 158:10
college 27:21 59:9,11,15,18 112:16 113:7,12 114:1,6,11,23 115:1,10 116:19
combined 84:18
come 21:21 22:25 54:10 93:3,3 130:21 154:2 168:9 178:21 181:24 202:23 253:1,7 279:4,20
comes 152:11 175:7 252:14
comfortable 10:5
coming 127:5 194:23 273:5
commentaries 89:17,19
commentary 87:17,19 88:11 88:13,15 89:8 89:21 93:13 95:25 100:4,24 103:18 106:16 106:21,24
comments 93:2 96:21,23,25
commission 284:21
commitment 35:16
committed 257:7 258:2,23 259:20
committee 28:16 29:3 44:20 58:11 73:13,16,19 74:2,8 75:2,5,6 75:10,10,20 76:4 80:12 81:11,13,15,21 82:2
common 35:17 74:12 108:12,15 108:16 144:12 145:22 251:7,11 251:14
commonly 10:1 34:2
community 54:21 157:9 269:21
compare 203:15
compared 241:7 249:9 251:14 268:5
comparing 146:2 273:25
comparisons 141:8
compatible 64:10
compendium 98:22
compensation 139:10
competing 261:2
compiled 23:4
complete 8:23 9:21 27:5 131:25 135:23 136:17 138:24 288:8

completed 27:20 28:25 152:5 286:17
completely 121:2 127:23 142:1 164:18 261:16 272:3 274:13
complication 49:10
complications 181:24 186:19 188:24 191:14 191:25 192:11 192:17 197:1,15 197:18,21,23,25 198:3 235:9
compose 19:10
comprehension 206:7
comprise 121:4 150:13
comprised 134:15
comprising 150:15
compute 272:3
conceivably 108:11
conceive 4:17 92:16
concentrates 183:18
concept 11:18 11:20 78:11 128:8 227:22 237:15
conceptually 145:17
concern 54:7 110:22 203:12 272:1 279:2
concerned 128:6 173:18 199:18 203:13 278:14 282:5
concerns 45:18 107:19 168:11 169:17 174:2 274:17
conclusion 203:14,15 268:22
conclusions 130:22 281:19
condition 35:4 39:4 105:25 106:1 110:10 111:13 119:15 144:19,23 163:11,14 172:13 193:1,13 227:7 229:7 254:4 267:13 269:23
conditions 30:11 39:7 110:16,19 111:22 130:6 147:14,18 162:14,17 193:7 249:17 251:22 252:6,19,23
conducted 59:24 61:3,7,10 61:13 275:5
conducting 83:6
conference 43:10 44:20 68:23 94:5
conferences 44:23,23 45:1
confirm 12:8,19 99:17 130:5 162:13 164:1 165:1 177:24 201:22 214:23 238:18 241:20 252:13 259:1
confirmation 163:17 178:24
confirmatory 164:4 252:9
confirmed 135:2 163:15,23 177:7,9,25 178:4,22 252:23
confirming 10:10 159:13 163:22 197:21 198:13 245:20 253:24
confirms 161:5
conform 146:1
conformed 163:15
confused 98:3 223:22 232:20 263:7
confusion 7:23 263:6
connected 116:2
connections 278:19
connotation 225:23
consent 72:3,5 100:25 101:3,6 101:9,12 110:5 111:1,5,8,9,14 111:18,21,24 112:4 141:23 187:23 191:5 197:8 202:11 203:18,24,25 204:10,12,14,20 204:22 205:9,14 205:16,24,25 206:1,3,11 208:17,20 210:9 215:4,14 216:24 217:12,22 218:21,23 219:3 219:6,10,24 220:1,5,11,21 220:22 221:14 221:21,22 222:21

consequences 204:23 205:8
conservative 173:12 174:5
consid 37:18
consider 46:23 83:2 129:8 131:24 132:1 133:16 137:12 194:22 195:3 264:22
considered 14:9 39:15 84:10 132:6,25 135:8 135:16,23 136:1 136:13,15 139:2 140:6,10 141:24 189:21 195:1 204:5 274:22 279:3
considers 132:16
consistent 64:12 130:17 195:19
constant 133:5
constitutes 141:22
constructed 218:9
consult 128:23 211:11,14
consultant 34:21 42:5 53:3 54:12
consultants 33:8 44:1
consultation 29:23 30:8 42:11
consultations 30:15,17 31:6 31:16,19 34:13 42:8 44:13 126:1 128:14,16 226:13
consulted 123:4 126:13,14 128:11
consulting 30:21
consults 31:10 31:11,23 128:19 128:21
contact 17:24
contacted 15:12 15:17 16:2 17:7 210:24
contacts 116:17
contagion 155:22 156:12 156:17
contain 138:24 139:13,23 140:2 140:6 166:12 191:19
contained 196:2 259:23
contains 136:13 166:7 243:23
contention 102:7,19 104:16 148:9 165:11,18 167:3,11,24 186:14 199:16 230:6,13 231:11 232:3,16 234:18 267:20 274:2
contentions 109:16
contentious 167:14
contesting 153:12
context 63:18 123:14,16 126:16 164:14 198:10 206:15 225:8
continue 109:23 135:21 202:14 264:4
continued 105:20 106:2
continuing 29:10
contraceptive 38:3,6
contraceptives 37:25 38:1
contribute 13:2 51:20 73:22
contributed 46:2 73:20 74:12 98:18
contribution 73:17 103:19 160:23
contributions 51:23 83:22 110:6
control 38:3
controlled 105:6 273:8,24
controversial 153:17 171:19 171:23 234:6,12 237:15 251:25 256:23 281:22 282:1
convenient 22:23
conversation 8:4,5 121:15 124:12 139:18
conversations 124:4,8,15,22 125:7,13,17
conveyor 200:14,16 201:21
convincing 265:12
cooperate 26:14
copies 286:14
copy 74:19 277:17
correct 8:25 12:5 14:16 24:19 25:16

27:18,24 28:12
35:25 36:3
38:12 44:15
45:14,15 47:8
47:11,12,19
48:5 52:22
61:15 63:4,8,11
71:3,7 72:1 77:6
85:20 86:15
90:6 91:15,18
91:23 99:21
100:5 101:1,2
103:15,16
112:14 115:18
122:13 129:4
131:3 135:3,25
137:2,9 141:1
141:12 142:14
143:15,20,22
146:8,17 148:16
151:15 154:24
158:15 159:14
159:15 161:22
165:2,8 167:22
168:4 170:22
177:20 182:5,9
183:9 184:16
186:9,15 187:14
187:16 192:22
196:25 197:19
197:22 198:17
199:25 200:11
201:3 202:3
204:21 205:14
208:9 214:11
215:4,5,22
224:18 237:3,4
243:3 247:7
249:21,23,24
251:20 254:23
255:7 259:21
266:7 268:15
269:4 279:8,9
280:22 281:11
281:12 284:6
288:8

corrected 235:5

correction 5:5
157:6,11,18
158:13

corrections
284:8 288:6

cough 17:15

could've 137:5

counsel 2:5 7:12
14:18 109:21
154:15 181:8
218:12 231:14
286:14

counselor
236:17 240:2

count 179:7

countries
169:17 173:11
173:13,22 174:5

county 285:3

couple 7:21
16:15 31:22
62:15 68:20
69:20 70:24
71:10 113:22
124:22 127:15
149:25 229:21
259:7

coupled 254:11

course 19:20
33:6 41:5,15,20
41:23 63:12
65:4,9,11,20
66:2,3,6,9,13,19
69:10 71:23
106:4 108:16
109:6 110:2,2
136:19 138:2
164:13 176:24
192:3 193:4
196:17 198:12
204:17 208:12
210:14 216:21
218:5 226:22
249:3 250:6
258:1 264:24
273:13

courses 46:12
63:16,19 64:19
66:4

court 1:1 2:12
7:24 9:13,15
10:17 26:4,7
76:15 121:13
134:11,17
138:10,14,17

cover 117:21
212:12 214:2,10
214:14,18,23

coverage 5:14
16:7 200:5,10
212:8,14 213:15
213:19,20,21,24
214:9

covered 180:25
181:6 190:16
199:25 213:21
270:24

coworkers
160:19

cpr 98:16

creation 4:18
92:17

credibility
179:10

credible 275:2

cretella 4:19
112:13,15 113:4
114:16 115:21
116:20 117:4

criteria 143:8,9
143:10,13
163:18 240:9
241:24 242:2,10
242:25

criticisms
265:14,16,17,20
278:8

criticized 265:6

critiquing 172:4

cross 3:6 10:9
50:6 61:11 65:9
65:10 105:25
106:3 119:19

146:23 164:8 165:12,18 196:24 197:2,15 197:16 198:20 198:25 222:4 237:7 238:6,11 281:8
crusades 50:15
csr 1:18 285:22 285:22
cst 7:2 283:5
cult 254:19 255:14
cur 65:12
cura 32:17
curious 58:25
current 101:22 102:7 160:20 168:12 217:3
currently 22:17 40:2,24 42:4 46:8,11 47:20 54:6 108:1 111:2 121:21 122:1,14 150:15 158:20 205:2 211:23 243:7 244:5 249:14
curriculum 4:5 26:23 27:1,7 49:23 63:23,25
cursor 101:17 101:19
cut 129:19 246:16
cutting 126:6
cv 1:6 42:15 44:16 50:3 51:5 53:8 54:23,25 67:3,7,11,22 71:2,9 72:13 75:22 78:25 85:6,9 93:19 97:16 99:10 116:22 123:8

d

d 7:17,17
d.c. 48:3 52:20 213:16
daily 254:25 255:3,6,9
dangers 182:18
data 135:8,11 135:15,23 136:13,15 139:2 140:6,10 148:11 149:6,24 150:3 151:4 152:23 153:2 154:1,12 154:22 155:6,17 156:22 158:10 208:25 209:14 217:20 266:20 267:20 268:6
database 148:23
date 240:18,19 241:20 287:24 288:12
dated 5:19
day 66:5 175:6 177:3,22 178:19 207:22 229:9 236:17 281:5 284:16 285:18 288:15
days 286:17
de 102:11 199:14,19,23 202:17 203:2 266:23
deadly 95:3
deal 162:2
dealing 230:17
dealt 131:5
dean 44:22
dean's 44:20 68:23
death 54:7 69:19 70:8,12 141:10,17 142:13 146:11
decade 136:6 148:15 229:20
decades 198:10 207:24 208:13 229:21
decatur 2:13
decide 96:6
decided 47:17 87:1 171:22
deciding 195:25 200:24
decision 47:1 98:9 110:13 114:15 115:20 115:24 116:3,19 117:3 118:24 120:6 203:3 206:6
decisions 83:15 108:24
declaration 4:3 12:4,11 14:10 14:21 15:4 18:14 120:22 140:20 209:23
declarations 20:1,2,5,7,14,16 20:19
declare 288:4
decreased 268:8
deemed 288:6
deems 244:16
defendant 16:25 49:17 281:13
defendants 1:8 2:16 10:17 16:25 20:7,14 20:15,19 25:17 25:20 120:23 281:3
defense 2:11 10:14 13:7,11 21:4,5 49:11 281:2
defer 242:15
deficiencies 217:2,9 218:25

deficient 230:18 271:1
define 144:11
definitely 276:23
definition 194:17 254:6 272:8,21,22 273:7
definitive 274:23
defy 144:11
degree 28:14
degrees 29:12
dehydration 146:8
dekker 1:4 7:9 120:24 286:4 287:1 288:1
delayed 233:9
delaying 199:5
delineated 208:16 229:18
delivered 216:25
delusion 144:9
demonstrate 140:25 153:10 160:1 204:11 268:17 274:5,16 274:19
demonstrates 232:21
denies 155:6
density 239:2
deny 178:21
department 17:10 65:15,17 65:19
depend 36:13 37:21 109:11
depending 108:18
depends 38:2 73:24 275:14
depiction 27:6
deponent 286:13 288:3
deposed 7:19 23:12,13,15,18 23:22 24:7 49:14
deposes 7:3
deposing 7:10 286:13
deposition 1:12 6:4,16 8:22 9:25 17:4 18:3 21:2,9 22:22 23:1,5,8 121:13 139:9 278:13 283:1,5 284:5 285:11
depositions 121:14
depression 110:23 264:5
depth 20:17
describe 49:8 60:7 63:18 65:11 77:17 226:23 235:8 238:5 248:25
described 72:14 97:12 144:6 156:8 176:14 234:15 235:1,12 257:7 258:3,22 258:24 259:3,8 259:20
description 32:8 57:18 156:14 235:3
design 275:13
designed 271:18
desire 146:7
details 261:6,13
determine 90:18 97:4 104:21 194:20 195:20 196:3 204:19 210:14 218:8 241:25 253:9 272:13 273:16
determined 150:18 167:17 168:1 246:10 275:21
determining 194:23 195:5
develop 28:17 158:6 159:1
development 172:12 236:23 237:8,20 239:2 242:9
devona 276:16
diagnose 147:17 161:6,17
diagnosed 129:24 144:18 252:25 253:4 261:15
diagnoses 147:14 193:17 193:21 222:6 250:1,10 251:8 251:17,17
diagnosing 160:4 249:16 251:22 252:7 253:5,15 254:4
diagnosis 11:10 11:13,20 128:8 131:2 141:9,17 142:20,21,22,25 143:1,2,3,4,6,14 143:18 144:23 145:1,2,3,12,13 158:9 159:14 161:8 162:3,13 163:6,10,22 164:1,3 172:5 172:23 177:24 194:5 219:14 221:8 228:24 248:22 251:2 252:3,15,16 253:21 258:17 261:17 266:9,14

267:3,8,12,21 268:24 269:1,3 269:6,7
diagnostic 143:9,10 160:25 163:18
diapers 52:14
dick 160:19
dictated 54:22
diekema 74:10
dietary 69:16
difference 82:12 87:16 96:19 144:16 163:1 278:2
differences 201:4,5,5,9
different 18:22 31:15 42:21 67:6 69:10,10 69:20 78:13,19 81:11 96:22 112:1 144:1 149:25 151:24 160:4 200:23,25 201:1,14,17 207:15 209:9 213:13 216:9 223:11 232:19 238:19 242:13 242:18 246:4 262:24
differentiate 90:14
differentiating 225:17
difficult 14:23 103:1 177:21 187:23 209:10 222:5 227:22 229:16 233:10 256:23 261:13 266:13,18 267:2 279:19,23
difficulty 227:17,20
digestive 45:18
dignity 35:17
dilemmas 97:18
diocese 53:3,19 53:24 54:10,15 55:2,5
direct 3:5 7:5 33:11 52:15 111:18 238:21 239:14 280:25
direction 266:19
directive 34:25 35:1,8,11 38:22 39:1
directives 4:6 34:2,15 35:2,6 35:15,24 36:2 36:12 43:9 47:2
directly 30:16 48:19 116:2 151:7 169:10 228:16 249:12
255:11 261:12
director 29:25 30:3,20 31:1,6 35:9,18,22 40:2 41:9 42:22 43:14 44:3,9 53:18 112:16 113:8 121:19
directors 52:3
disabled 4:12 76:10
disagree 112:10
disagreeing 252:1
disagreement 19:6
disagreements 120:14
discharging 23:24
discipline 49:2 65:9,10 206:22
disciplines 65:21
disclose 135:7 154:12,21 179:20
disclosed 208:7
disclosure 138:17
discontinue 202:9,15 203:6 203:9
discontinuing 201:13
discrepancy 224:9
discrimination 39:5,8,15 49:18
discuss 239:18 257:5
discussed 29:9 64:3,7 65:5 70:11 73:21 84:11,24 123:7 123:13,14 154:2 154:4 188:25 228:5 245:19 247:5 268:3 279:10
discussing 108:23 123:17 142:1 196:20,22 219:25 220:7 228:23 229:9 275:11
discussion 125:22 196:14 247:14,20
discussions 73:23 125:11 128:14 262:15 270:17
disease 269:13 269:17
diseases 251:13 251:15
disfavor 270:14
disorder 172:9 172:24 219:15

227:10,11,11
249:2 269:9,14
269:17,18
disorders 45:19
displayed 12:9
13:21 26:16
33:21 36:17
38:25 40:1
42:18 44:18
46:20 50:1 56:6
74:18 75:24
86:18 88:8
89:25 93:20
97:15 100:6
113:24 117:17
120:20 134:25
149:2,12 151:19
157:16 159:10
162:10 170:10
173:9 175:18
182:22 183:14
185:20 188:13
191:23 210:2
213:2 215:10
222:9 223:4
240:14 245:12
248:3 257:16
260:5 262:2
276:4 277:1
279:13
dispute 24:2
disqualified
26:4
distinct 55:3
distinction
96:10 97:1
distinguish
39:18
distortions
146:4
district 1:1,1
disturbed
254:12
divided 71:12
division 1:2
45:22 67:7
dnr 98:17
doctor 36:5 42:1
70:3 95:3
147:15 185:11
217:22
doctors 55:25
86:20 262:8
document 12:7
12:9,10,20
13:18,18,21,23
13:25 14:14
26:14,16,18,20
26:22 27:5
33:20,21,22,25
34:8,18,20,24
36:15,17 38:25
39:23 40:1
42:18 44:18
46:19,20 50:1
56:3,6,10 74:18
75:7,24 86:9,18
88:8,23 89:25
93:20 97:15,17
100:6 113:24,25
114:3,5 116:12
117:16,17
120:20 134:25
135:23 136:17
149:2,12 150:4
150:5 151:18,19
157:16,20
159:10 162:10
170:10 173:9
175:18 182:22
182:23 183:14
185:20 188:13
191:23 210:2,3
211:20 213:2
215:10 222:9
223:4 240:14,16
240:20 241:1,19
243:16 244:18
245:12 248:3
257:16 259:19
260:5 262:2
273:11 276:2,4
276:5 277:1
279:13
documentation
86:21
documented
140:23 156:17
208:14 246:10
247:2 273:12
documents 9:2
22:16 113:22
137:13
doing 25:8 40:8
42:7 44:14 57:8
97:23 141:22
153:13 178:1
207:7 217:18
229:15,16,20
246:8
don 97:23
donovan 1:13
4:19 6:5 7:1,7
7:16,18 12:11
13:22 15:7,24
23:13 26:18
33:23 36:18,20
37:3 39:10
72:13 76:23
107:3 109:4
136:10,22 138:7
141:2 160:14
161:24 166:15
171:17 178:7
179:15 181:22
187:7 203:21
207:19 209:18
210:4 218:1,15
218:20 220:9
223:1 230:12
231:6 237:25
240:16 241:13
244:17 245:9
259:14 260:9
270:1 271:12
273:21 276:3
281:5,21 282:16
282:21 284:3,11

285:7 286:1,5 287:2,24 288:2 288:4,12
donovan's 209:17 231:15
double 224:19
doubt 187:13 261:17
doug 74:10 92:22
dozen 18:22 23:20 75:12 124:23 125:1,19
dr 7:7,18 13:22 15:7,24 23:13 26:18 33:23 36:18,20 37:3 39:10 69:3 72:13 76:23 102:9 107:3 109:4 136:10,22 138:7 141:2 160:14 161:24 166:15 171:17 178:7 179:15 181:22 187:7 199:11 200:19 202:2,16 203:12 203:21 207:19 209:17,18 210:4 218:1,20 220:9 223:1 230:12 231:6,15 237:25 240:16 241:13 244:17 245:9 259:14 260:9 270:1 271:12 273:21 276:3 281:5,21 282:16 282:21
draft 5:20 211:8 276:21,24 277:2 277:13,15 278:11
drafted 121:1
dragons 51:3
dress 145:10
drugs 60:10
ds 74:2
dsm 143:11,19 247:6,17 248:5 248:6 280:3,18 280:22
due 70:25
duly 7:2 285:8
dunn 2:4 3:5 7:6 7:8 12:25 13:17 16:2 26:17 27:12 34:7 36:24 38:16 39:16 56:3,7,15 72:7,12 76:22 77:3 88:6,22 89:7,12 93:7 100:13 107:7 109:14,20,24 110:3 112:20 113:1 114:21 115:8 117:21 135:22 137:17 137:25 138:3,7 140:19 141:6 149:21 154:19 154:21 158:2 160:8 162:5 166:22 171:4,21 178:11 179:17 181:11,16 183:6 183:22 186:6 187:10 188:21 204:1 207:23 209:22 210:20 213:10 215:8,11 218:16,20 220:18 223:2 231:2,9,17 232:1,16 238:4 244:21 245:4 257:23 260:14 270:5 271:21 272:17 274:4 276:14 277:8 280:24 282:10 282:15,18,25
duration 275:12
dutch 102:17,19 102:24 103:3 170:13 172:5 242:5
duties 138:21
dysmorphia 145:24
dysphoria 10:3 19:5 25:11,15 46:15 63:10,13 63:15,23 64:5 67:24 68:14 71:18,23 102:17 110:18 118:14 119:13,16 120:11 129:25 131:2,15,18 143:14,16 145:16 146:2 156:13,16 157:3 158:8,19 159:14 161:8,18 163:22 172:7,7 180:6 196:10 199:6,13 205:2 217:4 219:15 220:16 221:9,13,23 226:24 228:9 229:7 230:8 231:13 232:4,18 240:13 247:8 248:5,6,22 249:4 253:5,14 254:3,6 267:3 269:14,19 270:6 280:22 281:15 281:22
dysphoric 101:21

e

e 2:1,1 3:1 7:17 7:17 284:1 285:1,1 287:3,3 287:3

earlier 8:22 21:13 49:14 121:15 147:13 247:5 267:19
early 68:12 151:22 152:2 176:3 177:13 242:6
easier 8:3 54:25 104:25 238:16 261:4 266:12
easily 127:14 239:1
ebola 4:14 86:5 89:1
edit 13:5
edited 13:8
edition 98:10
editor 183:8 184:15,18 280:11
editorial 82:24 86:3,10,11,12 86:20,24 87:1 89:24 92:8 96:10,24,24 97:3,6 100:18
editors 89:15 94:1 96:20 109:12
edits 96:21 277:16,18
edmund 28:24 32:18
education 2:11 27:15,16 29:9 29:11,20 30:7 32:15 50:16 65:24 118:8 122:3
educational 30:7 40:21 44:23 45:1 52:16
effect 6:15 69:5 201:6 236:23 237:10 239:2
effective 228:23 229:6,10,12 230:8 231:12 232:4,18 233:4 274:1,21
effects 183:13 184:9 186:14 187:21 193:2 194:15 237:20 237:20 239:1
efficacy 168:12 241:12 275:1
effort 117:7
eight 30:25 81:25
either 61:23 63:20 66:19 68:14 69:4 107:18 124:13 124:23 128:16 132:21 140:11 171:13 206:6 262:19 264:14 265:4
elaborate 160:20
elderly 98:9
elements 206:3 206:4
eligible 176:2 177:12,14,17
eliminated 39:14
else's 116:22 145:19
elucidated 193:3 194:15 207:22
email 5:19 15:18 89:13,15 97:2 100:21 184:25 276:8,22
embark 146:18
embarked 219:13
embraced 157:9
emedicine 79:11
emergency 48:14
emeritus 48:8
emmaus 262:11
emotional 114:9
empathy 254:12
emphasis 158:5
empirical 77:14 84:10,14,20 97:12
employed 16:20 138:20
employee 35:19 35:23 138:22
employees 35:12
employment 24:2 35:4
empty 256:4
encourages 255:18
encyclopedia 85:22
ended 45:25 53:14 57:23
endo 147:16
endocrine 105:8 180:17 242:14 242:18
endocrinologist 97:23
endocrinology 103:15 165:2,6
endorsed 57:6 145:6
endorsing 37:9 37:19 148:10
endotext 97:18
engage 30:24 112:7
engaged 15:21 208:20
england 168:16 174:17

enhance 87:9
enlarge 257:25
ensure 37:8 106:5
entail 30:4 43:17 48:13 54:12
entailed 78:18
enter 254:1
enthusiasm 174:9 267:11
entire 30:25 41:14 105:24 151:14 196:21 230:18 282:4
entirely 131:7,8 208:10
entirety 130:25 132:12 242:21 284:5
entitled 19:4 23:1 114:1 132:19,24 135:10
entry 98:11
enumerated 216:20
environment 256:20 266:13
epidemics 4:14 86:5 89:2
equate 253:25
equestrian 50:7 50:8
erds 34:3,7 38:21 130:17
errata 286:11 286:13,17
error 249:18 251:23,24 252:4
especially 233:8
esq 286:1
essentially 270:11
establish 102:23 187:20
established 32:4 103:14 129:11 153:16 154:18 193:19,23 281:10
estimate 15:9 128:10,18 250:19,25 251:4
estimated 150:15
et 1:4,7 7:10 286:4,4 287:1,1 288:1,1
ethic 70:20
ethical 4:6 30:19 31:6 32:19 33:1,9,13 34:1,13,15,21 38:20 42:4,7,11 43:9 44:1,13 47:2 81:18 92:17 94:11 97:17 98:8,20 103:20 128:16 128:19,23 129:6 130:10 197:8 215:3 216:12 235:9,16,20 238:5,10 282:6
ethicist 10:24 34:17 38:9 140:22 141:18 281:15,16
ethicist's 21:18 210:10
ethicists 33:3
ethics 4:14 28:16 29:3,22 32:20 41:20,23 42:20,23 43:2 44:20,24 45:1 53:3 54:11 58:2 66:23 89:2 91:22,24 92:5 99:4 122:7,19
european 173:11
evaluate 30:10
evaluated 174:3
evaluation 170:13 180:24 181:5
evaluations 47:10 174:22
event 94:25 285:16
eventual 59:3
eventually 165:4
everybody 69:12
evidence 102:6 103:24 104:4,4 104:13,15,19,22 105:12,13 106:11,17,20,22 106:25 107:5,6 107:11,14,19 108:13 109:1,7 114:7 115:11 116:15 134:16 144:12 152:6 154:1,6,12,22 155:17 156:12 159:16,18 160:20,23 161:9 161:11 164:4 165:10,14,19 167:2,10 172:16 172:19 173:3 174:4,24 176:8 176:11 179:1 182:4,13 191:13 192:1,4,7,10 194:22 195:1 199:15 203:4,10 204:10 206:13 206:21,22 207:14 208:19 209:2,4,5,6,7 217:8,14,20 226:10,15,18

227:1,24,25
228:21,25 229:4
229:9,15,16
230:5,10,13,15
230:16,18,21,22
231:8,10 232:2
232:8,8,10,13
232:15,22,23,25
233:2,3,13,17
234:8,10,17,21
236:3 237:2,16
237:18 239:4
241:10 252:9
253:3,13 254:2
260:18 264:5
265:12,13,15
266:15 267:5,14
267:15,16,25
268:17 270:21
272:14
exactly 66:24
109:6 117:6
128:6 246:1
274:18
exam 178:2
examination 3:5
3:6 7:5 281:8
examinations
180:5
examiner 5:17
257:13
example 8:1
10:8 37:24 61:8
65:13 73:12
242:14
examples 54:4
273:1
exams 177:19
excellent 112:23
except 6:12
70:11 284:8
exception 36:3
exceptional
240:7 241:25
242:24 243:9
244:6,19
exchange 202:2
exclude 214:6
exclusive
270:18
exclusively
212:13 279:18
excuse 43:22
196:13
executive
112:16 113:8
151:13 212:22
exhaustive
132:23 133:11
239:5
exhibit 4:3,4,5,6
4:7,9,11,12,14
4:15,16,17,19
4:20,22,23 5:4,5
5:6,8,9,10,11,12
5:13,14,16,17
5:18,19,20
12:22 13:1,14
14:10,12,13,22
18:14 27:9,13
34:4,9 38:13,17
38:18,20 43:11
46:19 56:12,15
56:16 64:15
76:16,18,19,25
77:4 88:19,25
89:3,4,8,9,13,21
93:4,11 100:10
100:14 114:18
114:22,24 115:5
115:9 116:24,25
117:18,23,23
120:17 130:18
134:22 140:2
149:18,22
157:24 158:3
160:5,12 162:8
171:1,7 181:13
181:18,20 183:3
183:7 186:3,7
188:18,22
210:17,21 213:7
213:11 245:1,7
257:20,24
260:11,15
276:11,15 277:5
277:9
exhibits 3:3 4:1
5:1 139:4 245:5
exist 121:22
142:25 143:2
178:10 204:15
237:11 271:16
existent 174:23
192:7
exp 110:11
expansive
107:17
expect 93:25
expectations
7:23 51:18,24
expected 9:20
56:4 221:7
expedited 283:1
283:4
experience
45:10 51:7
93:17 140:21
141:25 233:16
256:9,13
experienced
281:15
experiences
27:6 256:14
experiencing
22:21 46:14
228:9 249:4
253:14 254:3
experimental
193:5 194:16,18
194:20,24 195:6
195:9,11,21
196:4,9,17
198:6 210:15
245:16 246:21
246:25 273:24
experimentation
210:9 245:24
246:3,5,6

expert 4:3 10:13 10:18,21 12:4 12:10,13 14:9 14:21 15:3,21 16:3 18:13 19:10,11,25 20:2,5,7 21:17 22:3 23:16 25:6 25:10 26:5 27:2 64:13 120:21 121:12 131:22 132:6,16,18,20 134:10 135:7,24 137:2,9 138:9 138:13,20,22 139:8 140:1,2,5 169:2,3 179:18 209:23 216:4 234:4 248:16 279:16
expertise 14:25 28:17
experts 25:18 25:21,23
expired 47:25
expires 284:21
explain 11:12 23:14 32:11 53:7 63:22 217:23 230:14
explanation 268:16,20
explanations 155:21 156:10 156:21 158:23
explication 159:21
explicitly 214:6
exploded 148:15
exposed 114:8
express 138:25 213:18,24
expressed 174:2 214:8,9 279:2
expressing 168:11
extends 129:2
extensive 108:20 160:19
extensively 123:8
extent 51:24 82:14 163:20 204:25 217:18
extremely 279:19

f

f 205:13 285:1
face 130:19 144:13
fact 101:8 104:8 105:13 108:23 141:8 150:22 153:9,13,15,18 158:17 162:12 163:10 176:19 176:20 187:14 199:22,24 203:24 208:16 208:22 214:18 218:4 227:13 229:2,12 235:19 237:19 243:2 267:7 268:3 270:25 271:25 280:18
factor 68:24 148:19 149:7 150:1,9,19
factors 160:21 161:12
facts 135:8,10 135:15,23 136:13,15,18 139:2 140:6,9
factual 201:14
faculty 23:24 29:22 31:4 40:14 43:7
faded 214:16
failed 260:22
fails 109:1 286:19
failure 202:22
fair 8:10 22:7 25:9,12,13 31:18 32:8 51:15 67:12 68:5 131:21,24 144:2,3 200:12 247:10
fairly 31:4 223:24
faith 68:24 84:1 130:13
fall 15:13 16:1 99:2 228:6 252:17
fallat 73:18 75:1
fallen 270:14
false 261:10
familiar 55:8 57:2,5,9 59:8,17 83:18 88:12 104:3,12 115:16 160:13 172:18 242:2 262:4
familiarize 18:11
families 30:18 207:5
family 49:11 118:7 237:14
far 165:13 277:15
fashion 82:7 208:14
fast 189:2 190:18
fat 145:25
fault 126:5 263:6
favor 279:20
favorable 233:11
fda 224:2,3 246:14 247:3

featured 157:11
february 12:4 240:17
federal 135:6 136:12 138:10 138:11 222:14 223:5,12 224:13 224:14
feel 17:5 132:4 135:17 197:6,25 255:15 258:19 268:5 278:10
feeling 256:21
fellowship 27:25 28:4
felt 133:18 258:16 282:8
female 105:22 227:14,23 257:8 258:4,24 259:3 259:18,21 261:3
females 153:14 155:4 156:16 158:20 228:20
fertility 104:8 181:25 184:10
fetal 56:18 58:11
fewer 214:4 267:1 268:4
field 45:17 103:14
figure 79:17 88:3 263:9 273:4
file 19:17 88:7
filed 49:11
files 21:25 154:10 255:22
fill 32:4
final 278:4
finally 277:12
financial 51:23 201:5,19
financially 51:21
find 22:11,18 39:25 56:5 66:17 79:14 80:5 150:11 151:4 154:10 155:7,10 156:4 165:24 166:4 169:8 176:17 182:15 189:7 205:10 222:20 224:10 235:2 249:11 252:2 257:4 259:9 260:17,22 262:14 271:20 273:9,10 275:1
finding 67:2 227:21
findings 162:3
fine 218:18 238:17 244:23 282:24
finish 8:9,14,16 8:19 109:24
finland 168:16 173:17
first 7:2 15:6,11 49:24 59:23 73:5,6 76:9 79:1 98:11 101:15 115:22 124:7 139:20 149:3 150:12,12 163:3 176:3 177:3,13 178:19 182:8 198:13,15 199:1 199:7 207:20 216:3 219:11 225:3,9,23 274:12 278:12 285:8
fit 71:10 81:23 145:22 275:10
five 64:20 72:9 109:22 121:12 121:16 218:13 244:24
fl 2:6,19 286:15
flack 157:7
flaked 33:5
flaw 245:10
flip 248:1
flipping 85:8 238:13
florida 1:1 16:7 16:21,24 17:10 65:16 180:20,25 181:2 200:16 201:24 202:3 210:13
florida's 181:6 194:19 199:25 209:25 210:7
fluid 260:19
focus 32:16 42:25 248:24
focused 45:13
focusing 20:24 191:4 247:8
follow 35:8 113:1 177:21
followed 164:8 164:9 206:2,2
following 118:3 264:5
follows 7:4 196:14 267:16
fond 218:24
footnote 155:19 156:4
footnotes 182:11 192:24
force 6:14
forced 199:23 203:2
foregoing 284:5 285:10 288:5
forget 228:15
forgotten 79:8
form 6:12 37:10 37:20 38:6 39:9 107:2 109:3 127:16 149:16 161:23 162:3

166:14 171:16 173:11 178:6 179:14 187:6 203:20 207:18 209:16 217:25 220:8 230:23 231:5 232:14 237:24 265:7 269:25 271:11 273:20
formal 49:1 128:13 158:8
formally 15:21
format 71:11
formed 142:10 153:3 174:5 256:13
forming 135:9 135:11,16,24 136:2,14,16 140:7,10 141:1 152:24
forms 19:19 38:4
formula 52:14
formulating 152:17 196:1 272:15 279:7
forth 12:3 96:5 189:19 266:24
fortunately 19:2
forum 68:19
found 40:9 143:11 149:14 171:22 179:16 222:17 236:5,10 263:13 264:16 267:1 275:10
foundation 94:13,15,24
foundation's 255:4
founded 50:14
founding 95:12 121:19
four 31:17 77:8 77:10 281:6
framed 167:25
framework 87:8
framing 217:21
france 173:20
francis 29:6 122:11,12,15
frankly 19:13
frantic 254:13
fraught 147:10 249:17 251:23 252:3
free 17:5
frequent 133:4
frequently 16:16 31:5,23 31:24,25 111:12 239:12 251:12
friend 55:23
front 177:10
full 7:16 8:23 9:20 41:5 112:4 119:6,7 256:4 284:6
fully 9:8 12:3 90:17 110:25 121:2 193:3 194:15 207:16 216:23 219:2,5 219:9,23 220:5 221:13,21,22
function 107:9 184:10
functioning 184:11
fund 2:11
fundamental 245:10 269:12
funded 61:17 62:7,19 63:6 173:5
funding 202:24
funds 50:16
further 6:10 76:1 103:21 119:17 159:21 181:23 184:5 189:4,12 269:10 282:9

g

g 1:13 5:13 6:4 7:1,17 16:18 35:19 37:3 284:1,3,11 285:7 286:1,5 287:2,24 288:2 288:4,12
ga 2:13
gainesville 2:6
gap 220:3
gapms 5:13 16:18 17:8,18 18:18 22:4 64:17 175:21 209:25 215:6 277:14 278:5,5 281:11,18
gaps 219:13
garofalo 206:18
gary 13:12 15:18 21:6
gastroenterolo... 45:11 46:9 47:7 85:3 129:11 250:2
gastroenterolo... 24:15,18 28:1 30:25 42:2 45:13,21,22 46:4,12 60:17 61:1 129:14,24 250:12
geez 11:15
gemish 132:15
gender 5:6,15 10:3,4,7,10 11:3 11:5,14 16:8 19:4 25:11,14 46:15 47:14,15 61:4,14 62:8 63:7,10,12,15 63:23 64:5,6 67:24 68:7,14

71:18,23 72:3,6 99:13,19,23 100:25 101:4,21 101:23 102:16 110:18 118:14 119:12,15 120:11 121:6 129:25 131:2,15 131:17 141:15 142:6 143:14,16 143:25 144:8 145:16 146:2,14 146:25 147:7 148:1,10 151:23 156:13,15 157:3 158:8,18 159:14 160:2,9,21 161:8,12,17 163:21 170:21 172:6,7,8,16,19 172:23 173:3 174:9 180:6,23 181:4 195:19 196:8,8,10,19 196:24 197:21 198:13 199:6,13 200:17,22 202:1 203:16 204:18 205:1,23 210:15 211:24 212:8,17 213:15,20 214:2 214:6,11,14,19 216:7 217:4 218:23 219:2,5 219:10,14,14,15 219:24 220:6,15 221:8,11,13,23 225:5,18 226:7 226:9,16,19,20 226:24 227:10 227:23,24 228:9 229:7 230:7,8 231:11,13 232:3 232:4,17,18 235:10,17 240:6 240:13 242:6,7 243:7 245:18,20 247:9 248:4,6 248:22 249:4 253:4,14 254:3 254:6,17 260:19 264:19 267:3,18 269:4,9 270:6,8 270:19,22 271:3 274:5,20 275:1 279:21 280:21 281:14,22

general 38:4 41:22 57:4 112:9 124:22 252:5 256:19 263:14

generalized 196:5

generally 16:11 16:19 22:25

generating 159:6

genes 160:1,22 161:13

genetic 81:18 159:13,20,24 160:23 161:6,7 163:25

genitalia 105:24

genome 87:9

georgetown 26:24 28:24 32:2,3 33:17 34:10 35:23 37:4 42:1 43:4 43:14 46:2,5 53:8,15 54:23 62:16,21 65:6 65:23 67:10 71:5,11,17 73:5 80:9 85:7 87:3 90:3 122:22 128:17

gerard 7:16

geriatrics 85:20

getting 21:11 31:9 185:22 213:1 250:7

girl's 261:14

girls 105:19 258:15

give 9:20 15:9 37:24 45:16 55:21 58:1 66:19 88:1 96:20 140:16 148:11 162:5 175:4 205:9 208:16,18 211:21 217:12 231:23 250:9 251:4

given 47:22 67:4 71:5,21 94:23 128:23 135:12 147:13 164:15 164:19 166:13 166:24 175:10 178:18 187:24 231:19,21 244:19 284:7 288:9

giving 69:25 138:22 209:9 243:17,19 273:7

glass 256:4

glover 73:18 75:2

gnrh 103:23 104:5,8 108:3 240:7 242:1 243:6

go 7:21 12:16 15:13 20:11 39:24,25 58:1 66:17 68:3 81:25 86:16 89:23 96:8 103:12 104:18 148:13 151:18 154:10 155:8 162:24 163:6,12 163:13 165:4 180:2 181:21

184:2,3,13 186:12,17 187:10 189:3,4 189:6,11,12 190:8,11,17,19 191:2,9,10,22 222:8,20,24 239:18 240:5 245:8 248:18 261:5 262:20 280:5
goal 227:5 270:7
godfrey 50:15
goes 53:17 67:18,21 82:7 165:12 167:4,12 178:16
going 7:21 9:10 13:17,18 17:6 26:13 27:14 29:14 34:11,24 36:15,25 38:19 38:22,24 45:7 49:23 50:7 52:1 55:16 56:16 66:21 67:6 68:17 70:23 71:1 72:12,13 75:21 76:17 78:25 85:5 88:3 88:22 89:13 93:19 97:16 104:17 113:21 113:22 114:21 114:25 115:8 117:15,15 118:6 118:8 120:15,18 122:3 124:19 126:3 128:15 129:10 138:11 138:14 147:20 149:21 151:20 156:6 160:8 162:7 164:22 170:4 171:8,25 175:4 181:9 182:19 186:25 189:2,3,5,6,8,9 189:23,25 190:1 190:4,5,6,7 191:22 203:13 206:5 208:22 210:20 211:18 212:18 219:19 221:25 222:8 223:2 225:21,25 240:12 245:8 249:10 257:3,15 257:23 260:3,14 262:14 263:10 265:2 266:2 269:10 273:23 276:2,14,24 277:10,25 279:11 280:7
gonadal 105:20
gonadectomy 106:4
gonads 105:22 105:23
good 7:7 35:17 50:20 66:19 98:17 110:1 112:21 132:4 183:17 185:16 191:3 194:3,6 223:13 226:15 229:15,17 271:17 273:7
gotten 178:1
govern 133:21
governs 138:13 215:16
graduate 28:13 63:20 64:24,25 65:2,3,8,17,19 65:23 66:15
grand 50:6
grant 61:17 62:3,7,19 63:6,9
grants 61:22 62:10,15
great 28:18 162:2 173:14 174:11 219:18 270:14
greater 155:22 263:13
green 277:17,22
grn 108:3
grnh 106:18
ground 7:21 126:4
group 13:13
grow 105:23
guardians 101:6 203:19 208:9
guess 24:3 51:4 51:15 58:25 65:12 69:8,24 85:9 93:8 96:9 126:15 127:1 128:16 147:16 151:2 162:7 176:1 179:1 183:25 219:8 220:20 224:6 242:22 251:6,11 253:3 267:5 275:19
guessing 125:6
guest 41:6,8,15
guide 224:5
guided 34:15,17 47:1 137:14 194:18
guidelines 5:16 105:9,13,16 173:12 174:6 177:22 180:17 194:23,25 208:5 215:20 223:10 223:13 224:2 240:6,10,13 242:14,17,18 245:6
guidepost 92:17
guides 224:1 243:12

guy 261:12

h

h 16:22 143:13 287:3
half 23:20 75:12 124:23 125:1,19 211:23 212:6,11 212:12,16 214:2 214:5 256:4,4
hand 36:14 116:22 285:18
handbook 99:5
handed 31:3
handy 15:23
hang 71:14
happen 168:5 203:13 208:23 253:20
happened 251:12
happening 178:5 180:20 199:16,17 202:5 203:11 206:14 268:1
happens 36:21 168:3
happy 36:19 151:1 235:5 280:10 282:19
hard 112:10 116:8 132:17 141:3 179:10 183:15 189:16 256:17
harder 232:10 267:7,12,21
harm 114:10
harmful 109:1 109:17 115:13 116:16 186:14 237:7 248:23
harms 189:7 274:18 275:17
hazelbaker 1:18 6:7 285:5,22
head 8:2 17:21 264:1
health 4:7 17:9 28:5 56:20 91:25 93:22 144:19,23 147:14,18 158:9 200:5 241:5 243:5,21 249:22 250:1,9 251:1,8 251:18 264:17 269:23
healthcare 10:1 16:12,21,23 18:17 33:18 34:2 35:1,12 37:8,18 39:18 47:3 53:18,24 91:11,20,21,24 194:19 195:4 199:12 200:7 210:13 276:18
hear 226:21 282:19
heard 112:18 127:22 157:13 172:20 231:2,4
hearing 121:13 127:21
hears 225:23
heavily 32:23
held 159:20
help 9:4 15:19 30:18 36:19 58:19 104:21 146:1 210:25 231:24 249:5 273:6
helped 30:5
helpful 193:10
helping 41:4
helps 212:22
hematological 182:1
hereto 6:3,11 288:7
hereunto 285:17
heritage 94:12 94:15,24 255:4
hesitant 133:9
hhs 58:24
hierarchy 82:24
high 241:8
highlight 101:17 166:3 184:12
highlighting 171:20
highly 105:17 229:1
historic 268:6
historical 185:7
historically 152:4
hli.org 248:6
holtzman 2:16 16:3
holtzmanvoge... 2:20 286:1
holy 50:7,9,17 51:22
homosexual 4:20,22 114:1,8 114:24 115:12 116:15,25
honestly 54:20
honor 50:18,22 50:23 51:8
honorary 55:17
honors 50:3
hope 57:9
hopefully 162:8 207:4
hoping 278:12
hormonal 159:12,19,23 163:25 177:2 183:19,25 235:23 243:7 245:19
hormone 118:13 176:3 177:13 191:6

hormones 10:10 61:11 102:2 105:25 106:3 118:13 119:18 119:19 146:23 160:1,22 161:13 164:9 165:12,18 167:4,11 175:23 178:19 196:24 197:2,16 198:20 198:22,25 222:4 236:22 237:7 238:6,11 274:1
hospital 28:16 29:6,7,23 30:8 30:10 36:6 41:25 43:12,24 54:14 122:11,12 122:15 128:21 206:20
hospitals 29:5 44:5,14 122:10 174:10
hour 181:9
hours 11:16 40:24 278:12
http 90:25
huge 133:22
huh 31:13 76:13 77:21 80:13,16 95:6 102:13 175:9 188:15 190:13 223:15 254:24 257:14
human 35:17 56:18 58:11 60:5 118:14 133:21,21 137:16 215:17 215:21 216:6,10 223:18 224:6 248:13 280:19
humans 161:15
husband 65:13
hydration 98:21
hypotheses 156:9,10 158:6 159:2,4 161:15 270:12
hypothesis 158:14 159:6,6 270:23
hypothesize 268:10
hypothetis 268:10

i

i.e. 227:3
ich 223:10,13 224:2
idea 194:4 200:13 204:23 266:6
identi 224:10
identically 201:18
identification 12:23 13:15 27:10 34:5 38:14 56:13 76:20 77:1 88:20 89:5,10 93:5 100:11 114:19 115:6 117:19 149:19 157:25 160:6 171:2 181:14 183:4 186:4 188:19 210:18 213:8 245:2 257:21 260:12 276:12 277:6
identified 11:23 11:25 99:4 120:21 143:17 150:14,16 193:14 235:7,17 260:18
identify 15:3 123:8 129:15 148:14 166:6 171:12 179:12 179:17 180:3 191:7,12,20 224:10 236:1,13 258:10 262:25 266:12 268:15 279:24
identifying 127:2 170:17 179:9 202:12
identity 5:7 144:1,8 146:14 147:7 148:2 151:23 160:2,9 160:21 161:12 172:8,23 219:15 227:10 236:2 267:18 269:4,9 270:8
ideological 32:22
ii 105:17
image 146:1,5
imagine 119:1 194:21
immaturity 105:21
immediately 145:9
immunizations 74:3
impact 104:8 111:14 247:14
impacted 43:8 120:6
impacts 109:1 109:17 201:13 201:19 271:3 272:6
impair 107:8 110:25
impaired 112:3
impersonation 119:17
implications 197:8
important 51:5 104:12 132:1

137:12 153:11 225:6,14 230:2 236:23 237:9,19
impossible 209:11
improve 207:14
impulse 254:11
inability 217:11
inappropriate 231:23 232:7
inaudible 159:4 185:4 192:24
incidence 263:13
incidents 259:23
include 18:13 37:25 38:5 67:7 108:8,10 132:2 133:22 134:3 137:14 199:13 206:4 278:10
included 39:6 107:14 108:11 133:19,23 183:1 212:8 217:13 236:9
includes 18:16 67:4
including 18:23 20:6 29:24 105:7,10 131:17 132:2 160:22 161:13 165:16 196:23 197:5
income 130:24
inconclusive 241:17
incongruence 242:7,7
inconsistent 180:9,12,16 236:15
incorporated 52:4,23
increase 150:9 150:19
increased 114:9 148:17 168:9
index 3:3 4:1 5:1
indicate 261:10
indicated 151:9
indicates 71:6 184:25
indication 246:15
indications 222:4,7 247:2
individual 17:12 31:20 95:11 129:1 162:3 200:20 226:12 258:10 259:17,19
individuals 10:2 11:21 17:17 31:15 39:17 63:3 64:5 78:6 78:12 94:10 148:14 200:6,10 211:2 228:9 235:7 253:4 254:3 272:19,20 273:12 276:17
infection 17:14
infertile 106:2,9
infertility 103:24 104:5 105:4 106:19 108:4
influence 160:1 160:21 161:12
influenced 136:5
informal 124:8 124:12 125:25
informally 124:1
information 103:17 134:6 135:12 146:17 146:19 148:21 148:22 150:6 151:6,6,11 152:11 166:12 170:18 177:7 186:21 191:19 206:14,16 208:2 208:4,7,18 209:1,14 213:25 214:13,17,23 220:2,3 233:15 239:5,19 258:2 261:13,19 273:3 273:5,17
informed 72:3,5 101:6,9,12 110:25 111:8,14 111:24 112:4 130:12 141:23 187:23 191:4 197:8 202:11 203:18,23,25 204:10,12,14,20 204:22 205:9,16 205:24,25 206:1 206:3,11 207:16 208:17,20 210:9 215:4,14 216:24 217:12,22 218:21,22 219:2 219:6,10,23 220:1,2,5,20,22 221:3,13,21,22 222:21
informing 139:3
initial 7:18 174:21
innercological 104:2
innovative 204:5 217:19 246:7
inordinate 278:17
insistence 254:13
insofar 163:23

instance 133:20 137:15 142:17 206:18 221:25 251:11
instances 126:15 180:19 180:22 181:3
institute 5:4 42:20,23 43:3 43:19 56:20 57:10,13,21 58:9,15,16,23 62:20 149:5,13 212:3
institutes 28:5
institution 29:4 33:18 35:3,13 35:14,20 36:8 37:18 39:18 40:12 55:6
institution's 35:16
institutional 60:10 122:7,19
institutions 37:8 207:5
instructed 139:12,22 140:5
instruction 35:5
insufficient 241:16 271:7
insurance 200:5
intake 146:7
intend 139:14 139:17,23 140:3
intended 23:6
intending 224:15 247:24
interact 33:1
interchangeable 72:21 246:19,22
interest 28:18 269:20
interested 58:20 59:5 65:25 285:15
interesting 156:19 187:22
internal 82:7 279:1
international 168:10,14 169:11 170:19 248:14 280:19
internet 250:6 250:23
interrupt 126:8 126:9,10 248:9
intervention 193:3 238:25
interventions 168:13 196:22 224:25
interviewed 37:14 260:24 261:12
interviewer 206:20
introducing 7:13
introductory 66:13
invalid 162:16
investigation 19:4
investigations 62:17
investigator 61:17,23,24 62:6,12,18 223:25 224:5
invited 88:14
involve 84:21 131:1 138:22 216:6
involved 58:16 59:1 60:9,11 61:21 87:25 124:6 153:4 154:17 170:14 210:22 228:1
involvement 101:3 110:14 121:25 222:11 222:12
involves 60:5 63:10 88:17
involving 59:25 215:17 216:10
ir 223:24
irb 122:7,14 223:25 224:4
irrelevant 278:20
irreversible 182:3 184:8 191:25 192:11 192:18
issue 8:20 24:8 24:13 36:14 44:4 53:25 110:12 114:12 162:11 202:10 202:11 205:5 235:6,20 257:5 260:4,16
issued 4:9 43:9 56:8,23 116:12 157:6,11 158:14
issues 30:19 42:25 43:1 45:2 53:18,24 54:5,6 62:16 69:19 70:8 81:18 98:21 113:20 123:4,10,18,23 124:17,20,21,25 126:17 127:12 127:18,24 128:2 128:3,11 131:5 141:12 142:12 142:16 191:6 235:9,17 238:5 238:10
issuing 137:2
italian 85:22
iterate 197:25

j

j 284:1
jacqueline 75:2
jana 1:18 6:7 285:5,22
jason 1:7 276:16 286:4 287:1 288:1
jehovah's 69:12
jennifer 19:6
jerusalem 50:12
jesuit 32:6,13 43:3
jesuits 32:14
jewish 69:16 130:21
jh 284:24
job 31:4 252:18
jobs 31:23
john 205:13
jorgensen 198:16
josefiak 2:17
journal 18:24 22:5 76:5,8 77:25 78:1,7,10 79:2,2,3,7,13,22 80:4,15,18,24 80:25 81:1,2 83:13,19,22 84:6,6,24 85:11 85:14,16,25 86:2,7 87:11,20 87:21 88:9 89:16,22 92:4,5 92:6,16 93:9,24 94:16 96:7,20 97:2 100:20 117:11 118:25 160:11 187:5 279:15,25
journals 72:15 72:25 74:24 85:13,15 126:20 127:7
judge 134:16
july 186:1
jumbled 80:8 221:15
jump 118:6 126:11
jurat 3:7
jurisdiction 49:3
justice 216:23
justification 11:24

k

k 7:17
kansas 58:2
karasic 20:4 200:19 202:2,16
karasic's 199:11 203:12
keep 57:8 125:5 125:21 189:3,5 189:6,8,9,17,23 189:25 190:1,3 190:5,6,7 273:3
kennedy 42:19 42:23 43:2,19 205:13
kennedy's 204:2
kettenis 102:12
kevin 1:13 6:4 7:1,16 12:11 37:3 284:3,11 285:7 286:1,5 287:2,24 288:2 288:4,12
kiekema 74:2
kind 19:14 33:4 45:16 67:12 103:4 112:9 125:25 189:18 217:6 220:25 226:17 268:2 270:24 272:4 275:14 279:10
knew 198:15
knight 50:6
knighted 51:11
knighthood 50:4,13 51:14 51:19
know 8:15 9:1,4 13:6 17:23 25:17,23 26:1 33:12 36:4 38:3 51:10 54:6 55:20 56:22 57:1 58:18 60:12 65:12 67:8 69:13,13 69:15 70:5,11 70:18 71:13,15 76:1 77:25 78:6 78:9,16 79:11 79:23 80:1,2,20 80:24 81:5,14 82:4 84:17 85:12 87:23 88:15 92:25 93:8,23 95:22 96:6,7,23 97:20 97:21 113:16,17 116:7 117:6 119:5,24 121:25 122:2,4 124:1 125:16,17 126:8 131:25 132:4,20 132:21,24 133:24 134:6 135:10 136:7 137:22 139:16 141:21 144:4,16 147:23 150:8 153:7,9 155:9 156:14 172:21 173:5,14 177:14 179:3,24 180:19 180:22 181:1 183:11 185:1 187:8,24,24 188:23 192:5 193:10 195:3,7 199:20 200:3,15 201:24 202:14 203:22,22

205:18 207:12 209:8 212:15 213:5 216:22 217:5 220:11,13 220:15 222:3,5 224:1 225:16,21 226:8 229:25 230:15 232:9,11 237:6 239:12 240:9 241:24 243:2,4,14,25 247:18 248:16 248:18 250:22 252:15,16 253:19 256:4 258:13 260:22 260:23,24 261:11,15 262:6 262:16 264:8 265:9,10,11 268:3,11 272:6 272:19,22,25 274:13,15,17 275:14,17 277:16 278:24 279:1 281:5
knowing 116:10 116:17 202:8 219:16
knowledge 26:5 26:8 59:7 64:25 95:25 129:15,17 129:18,22,23 130:1 137:18 173:24 203:4 204:19 219:1,12 241:7 242:15
known 59:8 115:23 148:12 193:8 205:8 217:13 234:20 271:6

l

l 6:1
lab 252:10,23
label 38:10 245:15,23 246:2 246:5,13,21,24 247:1
labeled 12:10 90:1 215:12
labeling 245:5
lack 84:1 233:7
lacking 241:8
lagging 206:23
laidlaw 4:19 100:2 102:9 112:13
lambda 2:11
lambdalegal.org 2:14
land 50:17 51:22 95:11 96:3 97:11
language 120:13
laptop 21:12
large 67:3 82:20 82:21 142:7,11 142:15 152:19 273:8,11 275:4
largely 241:7
larger 150:13 155:4 229:20
lasting 236:23 237:10,20
late 20:13
law 9:15 134:12 214:12 216:4
lawsuit 7:9 49:6 49:9,18 120:24 228:1
lawyer 42:15 218:3
lay 176:14
lead 106:3 146:7 146:10
leaders 103:5
leadership 116:14
leading 155:20
leads 106:19 268:22
learned 77:15 77:20 84:10,12 84:15 97:12,14
learning 68:24 93:17
leave 40:5,7,11
lecture 71:21 94:5,19,22
lectured 72:2
lecturer 41:7,8 41:16
lectures 67:16 67:21
led 247:6 254:13
left 42:10 52:11 122:20
legal 2:5,11 7:12 101:6 224:12 286:23
lend 52:6
length 107:16 107:16
letter 183:8 184:15 280:10
letters 184:18
level 60:12
levels 164:9
levine 5:12 169:7 170:7 171:13 182:15 186:22 187:17 188:10 280:2
lgbtq 39:6
license 47:20,23 47:24 48:6,7,8 48:20 147:17,19
licensed 144:14 144:15 147:15 249:22
licenses 48:24
life 70:8,12 83:15 119:16 248:14 280:19 282:4
lifestyle 114:8

light 181:24 207:6
likely 105:23 233:12 267:23
likened 204:17
limit 146:7 188:1
limitation 85:9
limitations 22:21 133:13
limited 26:7 107:15 131:19 160:24
linacre 77:24 78:3 84:2,5 95:14,17 117:10 120:6
line 53:2 94:3 95:2 149:3 174:25 287:4,7 287:10,13,16,19
lines 266:22
link 149:5,14
linked 149:9 151:8
links 150:7 156:12 259:7,12 259:23
lipidology 97:18
list 39:6,17 44:19 49:23 50:6 51:5,11 52:2 57:25,25 58:5 69:20 74:15 76:7 90:13 96:6 98:12 108:15,16 108:17 132:8,22 133:1 139:7 154:25 156:18 156:24 197:1,3 197:18 198:2
listed 15:4 22:16 39:13,16 42:13 45:4 51:9 52:2 53:20 57:16 67:16 68:20 71:2 72:23 73:16 74:13,20 74:21,22 75:1,5 76:7 82:10 85:7 99:10,22 102:9 102:15 106:23 107:20 109:8,8 109:11,15 118:7 133:14 152:20 156:1 157:18 170:6,24 171:9 197:15 223:16 223:23
listing 39:21 90:10 191:24 197:4 213:17
lists 39:3 50:3 72:14 88:10 90:25
literature 12:2 60:4 126:20,23 126:24 131:14 131:15,16,19,21 140:22,25 156:11 161:10 161:11 172:10 174:14 176:15 176:16 199:7 239:25 255:12 280:14
little 9:25 20:9 33:5 44:23 45:9 49:21 67:5 77:10 80:8 84:18 108:1 113:19 121:18 125:16 127:16 127:20 149:23 183:22 184:6 189:11,12 190:22,23,24,25 191:1,9 201:23 213:1 218:3 221:15 223:22 247:4 250:7 280:6
littman 5:5 156:15,24 157:18
live 84:21 256:17
lives 4:13 76:10
living 51:21
lobotomies 203:17,23 205:3
lobotomy 203:16 204:3 205:5
local 60:12 87:2 174:18
locally 123:6,13 124:13 126:18
located 1:14 6:6 285:13
location 239:24
locations 22:24 178:15
long 77:8 84:17 108:7 109:10 184:9 194:7 199:2 204:7,23 207:3 219:17 229:17 233:4 236:17 270:25 272:20 275:5 281:5 282:11
longer 42:9 47:24 48:22 53:21 107:15 199:24 201:2,15 227:11 268:5
look 15:13 20:13,15 21:24 38:22 46:17,19 63:1 66:15 74:14,16 96:6 118:8 132:1,3 133:4 134:5 145:21 149:11 158:4 169:9 183:13 185:15 186:23,25 187:3 209:24 213:5

222:24 228:5 230:11 240:25 253:19 259:10 273:6 282:21
looked 76:16 100:21 131:9 191:17 222:16 245:6 260:16 280:9
looking 21:20 22:1 39:1 56:3 62:25 73:12 107:13 133:10 151:3 155:12 178:24 179:1 181:17 186:11 207:2 224:4 225:8 236:11 238:14,18,19 241:14 259:18 263:3,4,20
looks 12:14,21 13:24 52:13 68:2 71:11 77:10 79:10 80:22 81:22,25 82:3 90:4 93:21 95:6 149:25 182:24 183:2,10 186:1 187:11 259:5 280:1,2 280:23
loss 202:24
lost 200:10 250:3,17
lot 8:3,3 11:15 21:25 54:7,25 109:11 125:16 136:7 157:7 187:17 209:9 220:17 227:17 227:19
love 255:17 256:10 266:7
low 105:13,14 105:15
lower 267:6,19 268:12
lozier 57:10,12 57:20 58:9,15 58:16,22
lunch 112:24
lurie 206:19

m

m 16:18
m.a. 1:13 6:5 7:1 12:11 284:3 284:11 285:7 286:5 287:2,24 288:2,4,12
m.d. 1:13 6:5 7:1 12:11 284:3 284:11 285:7 286:1,5 287:2 287:24 288:2,4 288:12
ma'am 8:11 18:15 64:18 253:12
made 6:14,15 12:23 13:15 27:10 34:5 38:14 40:11 56:13 58:17 69:5 76:20 77:1 88:20 89:5,10 93:5 100:11 106:8 110:7 114:15,19 115:6 115:20 117:19 149:19 155:2 156:1 157:25 160:6 161:2,20 166:18 169:20 171:2 176:21 181:14 183:4 186:4 188:19 191:14 210:18 213:8 219:18 220:25 221:13 245:2 255:15 257:21 260:12 276:12 277:6 281:19 288:5
maf 1:6
mail 255:6,9
maintain 35:15 105:21
major 204:4 205:4,6
make 19:15 21:16 39:7 67:5 78:22 87:1 108:7,13,24 138:12 141:7,9 147:22 149:6 155:17 159:16 164:3 165:20 171:20 192:14 222:10 224:19 226:17 233:5 271:8 282:23
makes 39:5 104:25 233:9 253:11
making 37:11 98:9 103:25 154:7,13,22 155:23 158:17 166:23 168:19 206:6 209:7 214:1 245:25 251:18 267:12 269:12 272:5
male 105:22 158:20 227:13 227:24 228:20 253:8 258:7
maleficence 216:23
males 151:22 152:2,3
malpractice 23:17,21 24:7 24:24 25:1 49:6
malpractices 24:25
man 145:18 227:22 253:19

man's 145:18 253:23
manage 199:21
manageable 67:5
management 102:16
manner 275:6
march 1:16 6:6 285:13,18 286:2
margins 39:4
mark 27:12 34:8 38:17 77:3 88:24 89:1,13 93:10 100:13 114:21 115:8 117:23 149:21 158:2 160:12 171:6 181:18 183:6 186:6 210:20 213:10 257:23 260:14 276:14 277:8
marked 12:22 13:1,14 14:10 14:13,22 18:14 27:9 34:4 38:13 38:20 46:18 56:12,15 76:18 76:19,25 88:19 89:4,9,21 93:4 100:10 110:11 114:18 115:5 116:24 117:18 120:16 134:22 149:18 157:24 160:5 171:1 181:13,19 183:3 186:3 188:18,22 210:17 211:20 213:7 224:23 235:24 242:8 245:1,6 249:14 257:20 260:11 266:3 276:11 277:5
mary 73:18 75:1 79:8 81:13
mary's 69:21
mason 170:7
mastectomy 220:13 221:5,6 225:20,25 226:12 227:3
master's 41:13 65:22
masters 28:10 28:25
match 147:12 148:2
materials 83:5
math 31:21
matter 15:22 16:4 24:21 47:5 64:14 108:9 150:21 153:8 201:14 281:23 282:1
maturation 181:25
maturity 233:8
mbeato 2:20 286:1
mcadams 92:22
mean 11:8,9 17:4 21:24 22:10 24:10 25:25 36:4 40:18 50:13 54:13 57:24 63:2 71:2 72:16 82:17,22 83:4 103:10 104:7 107:17 113:16 113:19 116:10 121:8 124:18 125:5,15 126:22 127:23,25 128:13 133:15 134:8 142:7,8 143:4 151:23 153:20 160:24 162:16 163:11 167:18,19 178:8 186:11 194:1 212:12 216:16 220:19 222:20 225:7,13 227:19 229:19 230:11 235:13,14 238:7 246:2,16,24 247:22 248:9 251:5 254:5 260:25 261:9 265:17 268:9,10 275:15
meaningful 127:12,15
means 10:8 32:11 36:5 40:20 53:12 79:17 96:18 110:19 125:1 177:14 194:3 212:10 224:12 252:14
mechanism 82:15 88:18
mechanisms 82:23
medicaid 5:14 16:7,24 180:25 181:6 199:25 200:5,15 210:7 211:24 212:16
medical 4:10 10:8,23 16:8,11 16:19 18:24 22:5 23:21 24:11,12,25 25:1 27:16 28:20 29:8,11 30:11,15 33:17 34:10 35:4,6,19 35:24 36:7 41:11,20,20,22 42:1 44:20 48:6 48:7,24 49:5,18 52:15,15,24 53:1,3 54:11

55:9,11,15 56:8 56:22 57:3,6 61:5 62:8 63:7 63:20 64:23 68:7,25 69:7 70:20 71:22 78:4,8,15 79:3 79:22 80:4,15 80:17,23,25 84:7 90:2 92:3 94:16 95:19 99:13,23 101:1 108:12,24 117:12,22 118:1 118:5,12,16,18 118:25 119:14 119:22 120:2,7 121:6 126:23,24 129:6,9 130:6 133:25 140:21 143:3,6 145:6 146:20 147:8,15 148:1 162:14 169:16 173:23 180:23 181:4 185:11 193:1,7 193:13,17,21 195:19 196:4,9 196:10 199:7,24 200:22 201:15 201:16 202:22 204:4,7 205:4,6 210:8 211:15 213:20 214:15 214:19 215:3 216:8 217:16 219:24 220:6 225:1 228:14,22 229:6 230:7 231:12 232:3,17 256:19 269:21 273:16 274:8,12 274:20

medication 130:2 246:23,24 246:25

medications 9:6 10:11 46:22 103:18 129:7 130:11 147:4 164:25 199:6 201:7 245:21,24 247:1

medicine 26:25 27:21 28:6 29:21 32:5 47:21,25 48:21 49:2 51:1 69:18 99:4 130:25 170:21 172:16 172:19 173:3 206:19 252:4

medium 207:3

meeting 21:3 124:10

meetings 21:1 26:3 40:21 124:1,9

meixel 69:3

melbourne 184:22 185:9

member 23:24 55:11,14 57:7 59:11,14 75:5 75:20 80:12 81:21 82:2 118:17 172:25

members 32:24 56:24 74:15 75:9 78:8,14 119:14

membership 55:17 76:3

memo 17:8,18 64:17 277:14

memory 9:3,4 15:25 67:1

men 228:19

menarche 105:19

mental 114:9 144:18,23 147:14,18 158:8 249:22 250:1,9 251:1,8,18 264:17 269:23

mention 58:25 184:8 259:8

mentioned 7:8 8:12 18:10 21:13 29:13 39:12 42:3 58:7 118:17 122:6 152:21 170:2 234:13 239:3

mentions 101:15 169:4

mere 163:10

merely 22:3 187:15 232:1,13 232:23 268:7

messages 96:17

met 25:20

method 274:8

michael 2:16 13:13 112:12,22 154:20 231:17 286:1

michelle 112:13 112:15 113:4 114:16 115:21 116:20 117:4

mid 236:2

midway 269:11

mightily 218:7

millennia 91:11

mind 7:13 109:21 154:20 181:9 218:13 267:24

minds 267:13

minimal 174:23

minimize 217:17 242:3

ministries 262:11

minors 100:25 101:2 111:4 123:5 208:8

217:3 234:15 236:1
minute 21:3 72:9 109:22 218:13 244:24
mis 145:12,13 147:8
mission 32:8 35:14,20 36:7 57:2 83:18
mistake 204:16 269:12
mistaken 8:25
mistreatment 145:13,14 146:14 147:9
mistyped 222:19
misunderstood 267:9
mode 222:2
modeled 193:11
moment 38:24 55:21 223:3 262:1
momentarily 248:20
money 62:21
monroe 2:18
months 15:8 136:7
morality 70:14
morbid 110:10
morning 7:7 22:1 278:19
move 39:22 59:21 71:1 103:21 110:3 119:11 164:22 171:6 209:24 235:22 245:9 266:2
moved 52:20 53:15
moving 129:5 167:7 262:20
multi 60:10
multiple 65:21 107:18 226:23
multiplicity 165:21
muslim 69:15 130:20
muted 36:21,22 141:2
myth 170:20

n

n 2:1 3:1,1 6:1 7:17,17,17
n.w. 2:5
name 7:8,11,14 7:16 17:11,23 55:9 66:9,11,14 66:16,19 72:17 73:6,7,16 83:14 83:24 86:20 91:9 107:22,25 108:2 123:20 124:3 127:8,11 152:10,14 226:4 227:2 263:24 275:20,23,24,25 276:7
named 248:4
names 17:16,20 75:12 211:1
narrow 125:16
national 28:5 56:19 67:17,19 124:16 243:4,21
nationally 123:6 123:13,22,23 126:18
natural 8:5 92:17
nature 217:11
nauseam 279:10
nbhw 244:16
near 101:19
nearly 40:9 203:17
necessarily 133:23 134:8 144:13 243:24 246:25 253:25 268:9,13
necessary 193:16 197:6 246:15 288:6
need 12:15 22:18 32:4 37:8 53:24 76:1,15 132:22 138:3 192:4 197:25 198:4 202:18 230:2 234:7 241:9 244:21 273:8 274:24 278:10
needed 17:6 133:18 135:14 135:17 159:21
needs 52:10 71:15 133:23 147:12 154:19 282:5
negative 206:7 232:10 279:22
neither 186:10 207:21
neonatal 28:5 92:18 99:4
neonatology 99:5
nervosa 145:23 146:3
neurobiology 5:6 160:9
neuroendocri... 160:11
neurologist 141:19
neurosurgeon 141:19
never 25:10,13 46:21 50:24 51:15,16 57:24 58:3 63:5,9 71:21 114:13 119:23 129:6

142:3 217:22,23 247:2
nevermind 189:16
new 86:9 134:6 168:17 242:17
news 255:4 256:15 258:14 260:21 261:2,20 261:23
newspaper 87:5
nih 224:2
nod 270:16
nodding 8:2
noise 21:12
non 171:23 174:23 192:7 216:23
nonjudgmental 254:12
nope 157:15,23 167:1 193:16
norm 144:4 158:21 165:13
normal 105:8 105:17 119:16 227:14,15 249:2
northern 1:1
notary 284:14 284:19 288:13 288:19
note 53:2 76:15 240:5 286:10
noted 97:2 105:12 278:7 284:8 288:7
notes 19:15 85:10 161:10 213:18
noteworthy 55:25
notice 6:9
noting 161:16
notion 227:1
number 12:22 13:14 27:9 34:4 34:25 35:11 38:13,23 39:1 56:12 64:15 73:7,13 74:1,22 76:19,25 79:5 80:10,14,22 81:7,17 85:18 85:21,24 86:4 86:19 88:19 89:4,9 90:2,12 90:20,23 91:5 91:14 92:9 93:4 94:4 98:6 100:10 110:11 114:18 115:5 117:9,18 148:14 148:18 149:18 152:20 155:4 157:24 160:5 171:1 181:13 183:3 186:3 188:18 210:17 213:7 228:4 229:23 245:1 257:20 260:11 276:11 277:5
numbered 83:10,11 263:5
numbers 222:23 271:19 273:11 275:12
nurses 30:18
nursing 35:6
nutrition 98:21

o

o 3:1 6:1 7:17,17 286:1
oath 9:13,14,18 284:4
obfuscate 231:25
object 39:9 107:2 109:3 161:23 166:14 171:16 178:6 179:14 187:6 203:20 207:18 209:16 217:25 220:8 230:23 231:5 232:14 237:24 269:25 271:11 273:20
objection 166:18 231:18
objections 6:12 278:9,16
obligated 282:8
obligation 86:21 152:23 153:25
obligations 138:8
observant 69:17
observation 156:19
observations 158:6 159:1 278:8
observer 141:7
observers 141:9 141:10
obtain 111:8,23
obtained 56:9 220:1
obtaining 206:1
obviously 22:22 68:18 70:18 71:14
occasionally 17:15 126:5
occasions 57:15 250:8
occurred 94:25 107:20 164:17 202:25
occurring 105:18 124:9 125:8
occurs 143:16
october 262:11
offense 218:3
offer 88:14 101:8 139:14,17 139:23 140:3 195:18 197:20

221:4 242:4
offered 221:5 243:9 244:6
offering 37:9,19 216:16
offers 83:22
office 19:20 65:24 178:9
official 78:3 79:3 84:6 95:18 117:11 118:25 120:8 285:18
oh 12:2 16:1 18:22 21:16,24 24:14 26:21 36:20 41:11 44:22 52:6 54:2 54:13 75:21 79:8 80:23 86:10,16 90:19 91:10 122:20 123:19 124:10 126:19 127:6 129:19 139:21 150:24 152:8 170:12 183:17 183:25 185:18 189:20 190:8 212:25 225:11 239:23 240:24 250:4 251:9 258:12 262:8 263:18,22 265:17 279:4 280:12,20
okay 7:21 12:17 17:7,22 23:9,11 24:17 25:6 29:7 29:7 40:7 43:8 44:7,25 46:3 49:21 51:17 52:21 57:20 59:6,21 60:18 62:6 66:1,9,14 72:19 75:16 77:22 79:9,25 80:6 81:17,24 82:25 84:23 85:21 86:10,12 86:16,23 90:5 90:19 91:1,19 92:9 93:14 94:7 94:18,21 95:2 97:9,25 98:6,16 99:3,9,15 100:20,24 101:25 103:21 104:15 105:5 106:13 113:10 113:14 114:5 115:8 119:11 120:3,15 121:11 122:25 127:20 130:5,9 134:20 137:7 138:5 139:21 140:5,9 140:15,19 143:21 147:20 148:5 149:21 150:8,23 152:2 153:22 155:3 159:9 171:12 175:17 182:21 183:15,18 185:23 186:2 187:19 188:8 189:12,13 190:5 190:17,22 191:1 191:2,11,12,17 192:20 205:23 209:22 211:18 214:20,24 223:16 224:17 224:20 225:11 227:5 234:2 236:14 238:12 241:2,15,23 247:13 250:20 253:23 263:2,4 263:7,22 271:13 276:2 277:8,18 280:9,12,20 281:7,17 282:20
oklahoma 1:14 6:7,9 24:6 27:16 28:1,11,21,22 29:1 43:14 44:10 45:23 47:22 48:6,14 53:11 60:19,22 62:13 67:9 121:20 122:15 284:15 285:2,3 285:6,14,22
old 19:17 142:18
once 49:7 55:18 62:22 66:3,8 71:8 80:7 104:1 104:17 107:13 109:10 117:5 137:12 152:19 156:20 169:24 171:18 179:24 240:2
one's 247:9 266:13,18 267:2 267:7,21
ones 58:10 133:7 253:9,16 265:3 276:1
ongoing 41:20 200:2
online 19:16 56:9 79:13 86:7 87:4 127:7 176:17 177:5 178:12 179:5,9 255:6,9 280:21
onset 157:3 158:8,18 242:6
open 36:16 42:14 65:24 87:17 88:11,13 89:8,16,18,20 93:12 100:3 117:15 155:10
opened 161:21

opening 88:7
operations 225:5
operative 263:12
opine 281:14
opinion 19:11 77:15,20 84:11 84:12,15 97:13 97:14 121:10 125:22 126:1 132:20 134:8 136:16 142:2,10 147:6 153:2,3,7 153:8,19,21 168:2 194:24 195:8,11,13,14 195:18 196:7,16 197:20 209:15 216:4,16 217:1 219:6 220:4 256:3,8,25 266:17 270:5
opinions 10:25 11:2,4 12:3 103:22 104:9 121:5,8 127:17 130:24 134:15 135:9,11,16,24 136:14,18 138:25 139:13 139:16,23 140:3 140:7,10 141:1 141:9,11,15,17 152:24 154:2 196:1 256:12 264:23 272:15 278:15 279:3,7
opportunity 20:13 124:11
opposed 32:20
opposite 119:17 258:20
options 94:11
oral 70:17
order 10:18 17:24 21:2 23:4 28:14 44:25 50:7,8 67:5 141:11 145:20 163:3 174:8 193:8,14 217:19 272:7 282:25
ordered 138:17
orderly 208:14
organization 7:11 50:14 52:5 52:6,9,13,18 54:21 55:8 59:8 113:18 116:13 121:21 255:4
orientation 5:7 160:10 262:17
oriented 32:5
original 72:15 72:24 73:1 74:23 77:12,13 108:19 170:13 172:4
originally 14:14
osteoporosis 182:1
outcomes 194:6 207:3 208:15 218:8 219:17 221:7 229:17 231:8 233:10 246:9 264:17
outweigh 243:8 244:5
overall 31:25
overcome 274:17
overenthusiastic 256:1,2,6,10 266:6
overlap 20:24
overruled 252:16
overview 45:16
own 14:24 22:23 41:5 44:6 127:17 173:18 195:16 200:7 211:9 239:8 252:15

p

p 2:1,1 6:1 16:18 143:13 284:1
p.m. 112:25 138:6,6 181:12 218:19,19 244:25,25 282:14,14 283:5
page 3:2,7 4:2 5:2 7:22 34:24 36:25 38:23 39:2 46:17,21 67:15,21 68:10 72:13 81:23 83:10,11 85:8 93:9 117:21,25 118:1 119:23 150:12 160:18 183:13 184:2 211:19 215:11 224:23 235:23 235:24 249:13 249:14 254:10 260:17 261:25 262:20,21 263:10 266:2 268:21 269:10 287:4,7,10,13 287:16,19
pages 69:20 77:8 263:5,5
paid 139:11
palestine 51:22
palestinians 50:17
palliative 91:10
pandemic 40:6
paper 14:7 39:25 74:14 117:7,8 127:7 180:1 225:16 238:3

papers 19:11 29:24 40:22 43:25 72:15,23 72:24 73:1,4 74:23 179:23 238:14 239:8,11
paperwork 23:1 23:2,4
paragraph 39:12 95:3 101:16 122:6 123:3 129:5 130:10,23 131:13 141:6 142:19 151:21 159:11 164:6 168:8 173:7,10 174:21 181:22 192:25 196:14 199:10,10 203:14,15 211:22 222:10 225:9 236:7 237:1 240:25 245:14 247:4 249:11,13,16 254:10 262:21 262:22 263:19 263:20,21 264:3 267:16 269:11
paragraphs 104:20
parallel 20:24 128:6
parallels 205:11
pardon 54:3 277:11
parent 101:10
parental 74:3 110:14 111:4,18 158:5 159:1
parenthood 5:9 175:3,13 176:2 176:19,20 177:2 177:9,12 178:1 178:3,9,15,17 181:18 186:10
parenthoods 175:11
parenting 4:20 52:17 114:2,24 117:1
parents 101:4,5 101:12 238:24 239:6 255:10,15
part 12:23 13:15 14:24 27:10 30:13 34:5 38:14 40:16,18 44:19 56:13 67:3 76:20 77:1 88:20 89:5,10 93:5 100:11 114:19 115:6 117:7,19 149:19 157:25 160:6 171:2 181:14 183:4 186:4 188:19 189:18 202:23 210:18 213:8 220:2 223:6,17,18,21 224:6,16 227:24 235:3,10 245:2 246:13 257:21 260:12 276:12 277:6
partially 126:5 221:24
participate 40:20 94:21
participated 121:15 142:5
particular 32:18 33:2 39:20 65:3,18 66:6 77:17 95:22 96:11 146:20 153:9 154:23 183:12 252:8 259:25 278:1
particularly 39:5,7 57:24 141:21 162:1 172:20
parties 2:2 6:3 6:11 285:15
parts 104:2
party's 138:22
pas 90:23 91:15 91:15,19
passed 189:23
past 23:22 64:20 121:12 125:9 148:15 153:16 158:20
patience 55:21 56:1
patient 36:6,10 37:16 38:5 43:1 43:21 44:2 48:17 106:1,9 128:24,24 129:1 130:3 145:2,23 146:6 147:12 163:14 164:15 164:20 167:17 167:20 174:22 175:7 177:15 178:1,16 179:4 179:13,18 201:1 219:9,23 220:4 220:20,21 221:5 225:23 227:3 252:2,14 253:22 269:20
patient's 98:17 179:6 199:18,18
patients 4:8 30:10,14,17 33:3,10 46:14 46:23 47:10,15 59:25 67:25 68:15 69:4 111:8,13 123:5 123:11,24

124:17 126:17 127:13,19 128:2 128:4,7,12,20 128:22,22 129:8 129:15,24 131:1 143:11 144:20 145:16 162:4 163:21 164:8 165:3 168:6 176:13,22 177:1 180:6 199:12,23 200:15,20 201:24 202:3,8 202:9,12,14 203:1,5,18 207:5 208:7,8 226:5 233:8 248:25 250:10 250:19,25 251:8 253:14,16 254:13 271:19 275:4
pause 126:10
pay 200:6
pba 105:12,21
pdf 5:9 181:17 263:5
pediatric 24:14 24:18 27:25 28:6 30:25 42:2 45:10,20,22 46:4,8,11 47:7 60:17,25 67:24 68:15 81:14 85:3 97:18 103:15 129:10 129:14,24 147:16 170:21 250:2,12 251:8
pediatrician 165:3
pediatricians 59:9,12,15,19 113:7,19 114:1 115:2 116:19
pediatrics 4:11 27:20 45:13 67:17,19,20,20 73:14 74:9,25 76:5,17 81:8,19 82:8,20 97:19 112:17 113:12 114:6,12,23 115:10
peer 72:17,19 73:3 76:5,8 78:7 78:10,14,17,20 78:22,22 79:2,6 79:10,21 80:4 80:17,24 81:3 82:5,6,11,22 83:16 85:11,13 85:15,25 86:2 86:13,14 87:14 87:17,17,20,21 87:22,25 88:11 88:13,13 89:8 89:16,17,18,19 89:20,22 90:14 90:15,21 91:2 92:4,6,12,20 93:2,12,16,24 95:7,8,9,20,21 95:23 96:1,8,11 96:12,15,17,18 96:21 97:3,5 99:12,19 100:3 100:16,19 184:19 186:8 187:5,9,13 262:13,15,19 279:14,18,19,25 280:3,13,14
peers 96:23
pellegrino 28:24 29:14,17 30:20 31:1,7,15 32:3 32:19 33:3,8 34:14,22 35:9 35:18,22 40:3 40:14,25 41:10 42:22 43:22 63:3 64:21
pellegrino's 98:22
pelvic 105:24
penalty 9:16
penectomy 225:20 226:1,11 227:3
people 8:6 10:3 19:5 20:1 26:3 31:22 39:3,6,7 39:15 48:15 51:21 58:18 65:25 69:10 71:10,20 84:21 123:13,15 124:11 125:10 125:21 131:6 153:13 159:22 165:17 197:4 204:22 206:17 207:15 221:20 227:17,19,21 228:2,4,6 229:23 234:20 237:12 239:7,10 247:16 253:18 254:20 258:18 267:12 268:4 273:13 282:7
perceive 163:3 256:24
perceived 37:9 37:19
percent 150:16 150:17 151:21 152:3 214:5 235:25 236:10
perception 152:4 162:19,23 163:2
perfectly 187:2
perform 101:8
performed 198:14 203:18 203:23
period 68:6,11 125:7 128:17

177:23 275:5
perjury 9:16
perko 13:12 15:18 21:6
permanent 106:4
permission 98:1 111:19
permitted 101:3
perpetrator 258:8
persistence 242:7
person 26:11 32:17 91:12 125:20 143:24 143:25 144:8,16 145:18 167:3,11 249:4,5 258:2 258:11,11,23 259:2 261:3 269:23
person's 270:8
personal 233:16 256:9
personalis 32:17
personally 25:19,25 47:17
personnel 35:7
persons 118:14 119:15 264:4
perspective 70:9 134:7 141:18
perspectives 64:7 77:16 83:23
pertaining 131:15,17
pertinent 133:6 133:6,7,16,17 136:8,11
peruse 19:14
ph.ds 32:25
phenomena 266:4 268:11,14 269:13
phenomenon 155:21 156:21 158:12
philosopher 32:24
philosophical 32:23 33:13 42:25 43:20,23 185:8
philosophy 32:25
phone 37:14 124:13,23 125:14,19 178:20
phonetic 104:2
phrase 194:8
phrased 122:17
phrases 246:4
physical 114:10 227:13 275:17
physician 90:2 91:16 140:21 142:13
physicians 29:10 30:18 83:6 111:23 218:5
physics 65:14 65:15,17
physiological 181:25 189:22
pi 61:19
pickle 276:16
piece 39:24
pieces 85:21
pill 95:12
pituitary 105:20
place 49:25 106:14 111:23 191:7 233:6 244:16 284:7
places 102:21 126:20 176:1
plaintiffs 1:5,15 2:4 4:1 5:1 6:6 7:9 10:19 13:1 14:10,13,18,22 18:14 20:1,3,9 25:23 27:13 34:9 38:18,20 43:11 46:18 56:16 64:14 76:18 93:10 100:14 115:9 117:23 120:16 120:23 130:18 134:22 158:3 160:12 171:7 181:19 183:7 186:7 188:22 210:21 213:10 216:13,17 245:7 257:24 260:15 276:15 277:9 282:16,25
plan 44:25 202:19,21
planned 5:9 175:3,11,13 176:2,19,20 177:1,9,12,25 178:2,9,15,17 181:17 186:10
planning 30:6
plausible 178:20
play 33:7 202:23
played 58:8
plays 33:11 116:13
please 8:13,19 9:1,4 17:5 18:25 71:15 138:4 163:8 189:2 190:7 209:6 221:18 238:21 283:2
pleased 119:2

pllc 2:17
pm 181:12
podcast 206:20 207:8
point 58:2 71:20 113:21 120:15 125:6 154:9 159:24 161:19 165:23 166:10 166:22 171:20 174:25 179:8 192:8,21 196:12 207:24 209:22 217:18 225:15 226:17 238:20 249:12 258:21 280:25
pointed 100:17 158:22 184:1 219:20 229:19
pointing 158:19 162:4 204:15 221:2
policies 119:15 212:13
policy 35:2 83:1 114:5,14,23 115:1,3,9,16,19 116:12,18,25 117:2 213:19,22
poorly 172:11
popular 126:21 199:3
population 150:14,16 263:14
posed 244:20
position 29:15 43:18 45:20 52:3 54:16 58:13 59:18 81:10 114:12,15 116:12,18 121:19 127:9,12 146:13 218:22
positions 54:19 118:4 131:5
positive 206:6 225:23 232:11 264:17,20
possibility 206:11 249:18 251:24 252:3
possible 108:15 188:10 214:25 217:18,23 243:8 244:5
possibly 55:18 190:15
post 90:21 93:8 93:9 263:12
potential 156:21 158:23 239:1 274:18
potentially 37:19
practical 133:13
practically 131:17
practice 30:24 43:12 45:12,17 47:21,25 48:21 49:19 83:7 85:3 165:2,5 194:23 194:25 206:24 223:13 246:8 249:20 250:12 251:5
practiced 43:2 270:20
practicing 48:12 96:22
practitioner's 202:23
precision 195:25
predated 121:16
predominance 158:21
predominant 144:5 270:15
preexisted 240:23
preferable 141:8 193:20,24
pregnant 52:7
prenatal 87:8 99:4 160:21 161:11
preparation 18:21 21:9
prepare 18:2 21:2,14 71:9 132:18
prepared 13:25 16:6,12 26:24 138:18
preparing 14:21 131:22 132:6 210:22 211:5,11 264:23 276:22
prepubertal 164:8,15 189:18
prescribe 30:11 130:11
prescribed 46:22 129:7 130:2 180:9,23
prescribing 181:1
prescription 175:5
present 15:5 62:5 68:6 122:18 131:1 151:22,23 153:1 207:22 253:7
presentation 68:19,22 69:2 70:13,15,19,21 71:22
presentations 59:22 67:4,8,23 68:2,10,13,21 69:21,25 70:4,5 70:24 71:1,4,16 72:8 99:16 123:9 131:4

142:5,12
presented 70:17 72:2 94:5 104:10 106:21 134:16 206:9 253:22
presenting 70:2 143:24 152:2 209:15 248:25
presents 256:21
president 204:2 205:13
press 4:9 56:7 56:23 94:4 126:21
presumption 200:12
presumptive 145:3 147:14 250:9
pretty 22:7 148:12 185:16 192:7 222:22
prevailed 49:12
prevent 219:2
previous 14:7 48:23 54:25 267:9
previously 16:3 25:10,14 84:24 139:18 150:15 150:17 233:8
primarily 40:22 41:18 45:13 65:14 128:17 256:15
primary 31:4 59:24 60:1 61:4 61:7,10,13 73:2 73:20 74:11 93:1,3 124:24
principal 61:16 61:24
principles 33:12 33:13,14 95:12 216:12,19,22
print 150:25 183:16
printoff 117:25 175:13
printout 179:2
printouts 19:17
prior 25:18,21 25:24 43:13
privately 62:19 63:6
privilege 8:20
privileges 35:4
probability 251:23
probably 15:12 15:13,14 19:16 20:20,20 29:19 32:15 51:11 66:8 76:15 90:9 107:4 112:21 113:13 119:1 121:9 124:24 125:18 133:2 147:11 176:21 182:16,16 190:4 201:6,7,10 213:6 226:1 228:15,15 249:7 257:19 278:12
problem 31:21 53:7 55:22 66:10 88:5 140:17,17 145:11 192:3 208:12 222:7 228:13,16,17,18 229:2
problematic 11:6,7 220:16 227:8 228:8 257:1
problems 11:9 11:12,17,19,22 11:25 147:10 172:22 183:19 183:19 204:6 233:11 250:21 265:5 269:5
procedure 49:11 135:6 136:12 138:11 205:8,10 226:4 227:2
procedures 204:20 221:19 221:21,23 222:1 225:2
proceed 162:25
proceeded 204:24
proceeding 94:4
process 18:18 22:4 73:3 78:18 78:20 88:16 96:21 164:22 206:6 208:20 209:25 210:14 278:5
proclaimed 258:16
products 69:14
profession 90:3
professional 16:11,19 19:6 27:6 35:15 47:1 47:13 49:22 51:7,14 86:21 130:24 249:23
professionalism 4:11 73:14 74:25 76:17
professionals 96:22 211:16
professor 41:14 65:13
profound 110:23
program 32:12 41:13 65:22 181:6 219:13
programs 211:24 212:16 271:18

progress 219:18
progression 234:16
prohibited 37:10,20 38:4,6
prohibiting 16:7
project 210:8
prolonged 177:23
promise 282:11
promote 35:16
proof 229:13
proper 105:15 194:4,5,5 243:19
properly 50:8
proposed 193:3 196:17
proposition 154:16 255:19
propounded 7:3
propriety 11:2,5
protection 223:18 224:6
protocol 172:13 193:19,23 205:25 242:5
protocols 111:7 111:15,17,22 112:7 172:6 199:13,21 205:24
prove 232:12,19 233:3 268:13
proven 161:15 232:9
provide 10:22 11:1 17:7 31:6 35:5 36:6 50:16 58:4 96:23,25 101:6,12 108:13 110:25 111:14 111:24 112:4 126:16 133:1 136:12 138:20 140:9 144:22 152:23 153:25 154:6 155:15 164:7 182:13 186:21 196:13 205:16 209:18 211:24 212:6,13 212:16 217:22 218:22 219:9,23 220:5,20,22 221:20,22 239:7 250:1 254:7 259:24 263:24 273:23
provided 9:14 13:19 14:17 25:10 26:10 27:2 44:1 89:21 102:4 106:10,17 107:11 120:22 120:23 131:20 131:24 134:21 135:2 143:2 166:9 169:2 174:18 175:12 175:19,21,23 177:19 178:23 180:5 192:13,16 198:9 204:12 206:15 207:24 209:24 210:12 217:10 219:5 229:11 230:5 231:10 232:2 234:4 239:5 242:24 251:1 254:1 255:24 260:2 264:11 272:2,7,16 273:19
providers 199:12
provides 29:20 29:21,22 103:22 135:7 138:14 143:4 253:21
providing 17:17 27:3 47:6,14,14 48:17 53:6 72:3 72:5 108:6 128:16 145:1 148:1,9 206:2 206:17 207:4 215:2,25 216:7 251:7,9,17 253:25 254:17 273:16
proving 232:10
provision 98:21 121:5 141:15 142:6 208:1 242:1
provisos 137:10
psychiatric 110:10,18 111:13,22 204:6 229:3 247:17 249:17 251:13 251:22 252:19 252:23 254:4 270:13
psychiatrist 144:14,15 249:19
psychiatrists 145:5 148:5,9
psychiatry 252:1,4
psychological 110:16 115:14 174:22 177:19 178:2,10,18 180:5,24 181:5 228:13 229:3 242:8 270:13,16 275:16
psychology 236:24 237:21
psychotherapy 4:22 115:11,13 116:15,17 269:24 270:7

pubertal 105:18 242:9
puberty 10:11 61:8 102:2 103:18 105:4,7 105:8,17 107:8 110:13 119:18 147:4 152:5 164:7,11,12,14 164:16,17,18,20 164:23 165:4,11 165:17 182:2 186:14,19 188:24 189:21 191:5,15 196:15 196:18,23 199:5 222:3 233:9 235:8 238:23 242:8 243:6 244:8 245:21
public 52:2 142:7 284:14,19 288:19
publication 78:4 79:10,12 80:11 81:12 82:5,18 84:2 87:2 88:10 90:4 90:8,9 91:14,25 93:21 94:2,13 95:18 96:12 97:21 98:4,5,12 99:6,6 114:16 115:21,21,25 116:6,20 117:4 120:8 124:2 157:11 186:9 243:20
publications 59:22 72:14 75:18 76:2 82:1 82:25 83:2,22 85:6,10 99:10 99:16,18 108:12 117:10 123:10 142:5,12
publicly 61:17 62:7 239:25 277:14 278:4
publish 118:24 120:6
published 36:25 77:5,23 78:1,23 78:24 79:6,18 80:14 83:13 84:23 90:11 94:7,12 97:24 98:13,15 99:1 99:12 102:12 105:9 112:12 127:6 152:8,9 160:10 168:20 169:14,15,17 176:14,16 187:11 241:4,21 257:12 262:7,10 279:23 280:13
publishing 81:2
pull 12:7 26:13 42:16 75:21 88:2 134:23 149:10 156:6 170:4 175:17 182:19 188:12 210:1 212:18 215:8 218:16 222:25 223:2 240:12 260:3 261:25 276:24 279:11 280:10
pulled 262:24
pulling 75:22
purely 270:13
purpose 4:13 27:3 32:9 76:11 124:18,19
purposes 12:23 13:15 23:7 27:10 34:5 38:14 56:13 76:20 77:1 88:20 89:5,10 93:5 100:11 114:19 115:6 117:19 149:19 157:25 160:6 171:2 181:14 183:4 186:4 188:19 210:18 213:8 221:12 226:24 242:1 245:2 257:21 260:12 276:12 277:6
pursuant 6:9
pursues 29:23
put 23:7 44:22 109:12 224:1 247:17 257:7 265:4 278:21
puts 39:4

q

qualification 139:6
qualifications 141:11,14
quality 105:12 241:8
quantify 31:5
quarterly 77:24 78:3 84:3,5 95:15,17 117:10 120:7
queen 51:10
question 6:13 7:19 8:6,9,14,17 8:19 26:19 34:12 39:10 65:18 78:13 106:8,14 107:3 109:19 126:6,9 161:1,24 179:15 187:4 188:1 192:15 197:14 207:11 212:10 218:12 225:11 230:4,4,20 231:3,19 232:5 232:6 267:10

271:12 275:7,15 281:25
questionable 112:5 258:18
questioning 282:17
questions 7:3 8:1 9:7 27:15 68:20 72:8 90:17 109:23,25 126:11 188:2 218:14 230:2 265:7 280:24 281:1,6 282:9
quick 74:21 162:5 190:18,18 211:21
quickly 12:17 42:14 44:17 56:5 93:8 126:6 148:25 149:10 248:2
quite 19:13 29:11 54:24 70:18 72:5 121:23 123:16 144:3 212:10
quotation 244:10
quote 16:10 160:18 181:23 196:16 200:13 200:13 222:14 243:11,13,14,23 243:25 244:2,4 245:10 247:12 257:7,11 258:3
quoted 37:2
quotes 247:18
quoting 247:16 247:16

r

r 2:1 7:17,17 284:1 285:1 287:3,3
radiological 159:13,19,23 163:25
random 54:9
randomized 105:6
randomly 19:14
rapid 157:1 158:8,18
rate 229:25,25 263:11 267:6,17
rates 268:8,13
rather 43:1,20 53:9 54:9 82:10 145:13 159:6 162:19 261:5 268:24 270:25
ratio 194:6
rationale 247:22
rays 252:10
rcts 241:8
reach 236:2
read 18:4,7,9 20:3 54:25 90:22 103:12 104:6,18 106:15 116:7,11 127:16 128:6 132:12 133:4 134:2,5 136:4,8 138:15 148:20 150:10 150:20 153:9 156:3 157:14 160:15 161:19 161:22 162:1 166:2 169:21,25 173:21 177:4 179:5,13,18 183:15 185:17 185:21 190:18 212:15 238:16 239:20 241:2,9 241:18 242:20 243:15,24 244:18 259:14 274:19 275:20 275:24 282:20 284:4 286:9 288:5
reading 39:11 105:1,5 126:19 126:23,24 142:9 153:3 158:17 233:19 256:13 256:16 263:17 263:23 282:21
reads 35:1 118:11 119:13 132:16 210:7
ready 142:1
real 172:22
reality 256:3 270:17
realize 8:22,24 89:1
realizing 76:14 256:18
really 19:15 38:1 41:19 59:20 66:18 70:11 71:19 116:1 133:2 145:22 153:12 159:21 162:4 167:23 183:15 184:1,3 191:3 194:3 197:7 207:1 211:13 226:17 228:15 229:8,22 230:3 256:23 268:2 272:9 277:24
realm 60:16
reason 48:24 53:9 92:25 110:21 226:3 230:25 242:22 258:15 278:14 286:11 287:6,9 287:12,15,18,21
reasonable 15:1 106:13 119:10
reasons 129:6,9 130:10 139:1

reassignment 119:19
reassuring 207:5
recall 13:6 15:17 17:4,16 17:22 20:21,23 25:5,8 27:3 37:11,13 46:3 54:4 55:19 60:12,18 62:3 66:23 70:15,21 71:19 78:17 80:21 84:9,16 87:20 90:8,13 91:9 92:19 96:14 157:21,22 172:2 211:1 260:10 276:8,16 276:21 277:2
recalling 64:9
receipt 286:18
receive 29:10 31:11 50:22,23 209:11 233:17
received 27:15 27:19 29:8 49:1 50:5 51:13 63:5 63:9 151:6 170:18 177:2 181:4 216:18 233:15
receives 165:11 167:3,11
receiving 51:18 65:4 164:20 200:17,22 201:25 216:14 264:19
recent 125:9 241:1 266:25
recently 41:2 113:9 199:3 269:18
recess 72:10 112:24 138:6 181:12 218:19 244:25 282:14
recognize 13:22 26:17,20 33:22 36:18 76:12 149:15 182:23 210:3 212:20 237:12 240:15 240:20 276:5,6 277:23
recognizing 36:23 244:11
recollection 46:16 55:1 97:8 233:25 236:12 236:16
recommend 78:23 105:16 145:25
recommended 242:10
reconstruction 164:10
record 7:14 12:24 13:16 27:11 34:6 38:15 55:23 56:14 76:21 77:2 88:21 89:6 89:11 93:6 100:12 114:20 115:7 117:20 142:8 149:20 158:1 160:7 171:3 181:15 183:5 186:5 188:20 210:19 213:9 245:3 257:22 260:13 276:13 277:7
red 277:21
redline 277:16
redlines 277:21
redone 80:8
reduced 206:12
refer 10:3,7 16:18,22 22:14 30:11 36:10 38:21 47:10 130:10 141:6 143:24 144:24 259:2
referee 82:23
refereed 72:15 72:16,24 74:23 78:10 82:10 85:11,13,15
reference 14:7 23:6 29:15 108:16 121:20 129:9 131:13 136:24 142:19 150:5 170:16 171:20,22 181:23 182:20 184:14 200:13 212:1 215:2,13 222:10,16 224:1 224:5,15 225:1 225:3 236:6 242:23 245:10 257:4 259:4 264:10,25 266:3
referenced 22:6 43:10 49:14 62:11 64:11 106:15 138:1 169:12 185:13 188:16 196:3 199:7 212:19 213:4 273:4 286:6
references 93:9 106:23 107:17 108:10,17,18 109:7,8,11 241:1
referencing 22:13 37:5 75:14 125:25 131:9 137:20 138:10 140:2

146:21 151:25 156:23,25 175:14,22 185:25 188:14 190:12,14 196:18,19 199:22 201:12 222:12 238:20 245:17,18 249:12 264:7
referral 37:25
referrals 130:7 251:18
referred 34:3 38:8 46:22 129:7 144:21 246:7
referring 16:19 37:16 38:5 47:13,15 54:17 145:2,7,15 147:23 168:15 175:16 200:20 201:20 212:7 226:7 246:13 251:10 254:17 265:16 266:5,8 275:9
refers 187:17 260:23
reflect 195:9,12 240:6
reflected 143:19
reflection 243:22
reflections 94:3
reflects 202:10
refresh 9:2
refusals 74:3
refused 265:9
regard 59:23 105:14 127:9 128:24 157:6 158:14 204:9 219:19 229:5 265:13
regarding 11:10 35:5 53:24 111:3 196:16 215:13 264:14
regional 67:20
regularly 138:22
regulated 224:3
regulation 195:5 216:4
regulations 133:20 195:7 222:15 223:6,8 223:12 224:13 224:15
reinforce 134:7
reiterate 197:6
reject 119:14
rejected 119:20
related 24:17 44:2 60:24,25 67:23 85:2 99:6 99:19,23 110:12 128:3,19,21 175:11 197:21 218:14 235:9 238:5,10 268:12
relates 220:15
relationship 58:3
relative 285:14
relatively 133:4 142:15
release 4:9 56:8 56:23
released 277:14 278:4
relevant 51:6 104:9 105:3 110:6 150:18
reliability 275:11
reliable 83:3,4 170:20 247:23 274:23 275:21 275:23,25
relied 14:9,20 15:3 102:6 103:24 106:11 132:23,25 134:21 135:11 137:1,9 140:20 140:25 152:17 152:19,24 154:6 154:22 175:20 212:23 232:22 247:20 279:7,15
relies 108:14,25
religion 68:25 69:4,7
religious 4:6,7 34:1,15 35:13 35:20 38:21 43:9 47:2 55:6 278:9,16,18 279:3
reluctant 282:7
rely 14:24 34:20 83:6 137:14 155:23 162:14 162:15,17 166:23 169:19 172:1 207:10 209:7 247:13 248:13 270:21 271:16 275:2,18 279:17
relying 154:1,13 165:19 168:18 169:11 188:10 212:21 234:8 271:8 272:15,25 273:17
remain 40:14 105:24 214:21
remained 206:21
remains 241:7
remember 17:11 54:20 60:13 61:19 78:19 84:16 166:20 255:20

263:22
remind 126:7
reminding 107:5
removed 278:24
render 141:11 141:14 142:2
rendering 141:17
repeat 33:4 166:15,17,18 250:5
repeatedly 152:9 165:16
rephrase 196:11
reply 7:3
report 5:4,20 10:16 12:13 13:3,5,20 14:15 14:21 16:6,10 16:12 17:8,18 17:24 18:16 21:17 22:3,4 25:10 27:2 46:17,18 64:13 64:17 81:8 120:17 121:2,4 131:22 132:6,18 132:25 133:16 134:11,15 135:5 135:7,25 136:2 136:9,12 137:2 137:9,19,19,21 138:1,9,14,18 138:24 139:12 139:22 140:1,6 140:11,13,15,23 140:24 149:9,13 149:15,24 150:8 151:7,8,14,20 152:18,25 153:20 154:14 154:24 155:18 155:19 156:24 158:9 159:9 161:3,20 162:7 162:12,13,15,17 162:20 163:2,4 163:6,11 168:1 169:2,3,7,8,20 169:23 172:2 173:8 174:14,15 175:21 177:19 178:10,18 179:18 181:22 182:5,6 186:15 186:18 191:22 192:16,20,24 196:2 197:1,14 197:17 198:2 199:11 207:8 209:24 210:12 210:23 211:6,8 211:12,19,19 212:4,18,20,23 213:3,12 214:1 215:1,2,6,12,13 215:16,24 216:3 216:11,20 217:1 217:7 218:17 222:8 224:23 230:6,11,22 231:14 232:13 232:24 233:5 234:4 235:11,21 235:24 236:3 237:3 238:4,9 238:14 239:24 240:1 245:8 247:11 248:11 248:17 249:14 254:2 258:10 259:15 260:1,17 260:20 261:25 262:24 264:12 264:23 265:1 271:2 276:21,24 277:3,15 278:1 278:2,3,4,11 279:16 281:11 281:11,17,18,19
reported 1:18 162:22 165:16 175:1,4 187:21 218:10 239:23 239:25 252:20 258:13 264:21 265:8,11
reporter 6:8 7:24 9:14 285:6
reporter's 3:8 76:15
reporting 163:14 253:10
reports 19:20 25:7 64:11,13 83:1 107:18 175:8 176:25 178:12,14 179:13,18 186:11 209:9 233:19,20 255:10 258:12 265:18
represent 89:14 120:4 151:2
representation 131:21,23 137:1 137:8
represents 268:23
request 8:15 14:17
requested 95:6
requesting 71:20
require 35:3 111:4 135:6 208:6 237:15
required 53:8 78:7 84:19 96:8 136:11 139:13 180:16 195:5 208:11 288:13
requirements 51:17 69:16,18 137:15 215:3
requires 96:22 242:6

rescue 92:18
research 56:19 58:2 59:22,24 59:24 60:1,4,7,9 60:23,25 61:4,4 61:7,10,13,17 61:21 62:3,7,10 62:19 63:6 77:12,14 84:10 84:15,19,20 86:13 97:12 108:1 122:7,19 133:21 137:16 141:24 142:9 170:20 186:9 197:11 207:2,14 215:3,14,17,20 215:22 216:5,9 217:18 222:12 222:13 237:22 244:15
reserved 6:13
residency 27:20
residents 41:12
resist 278:23
resolution 118:9 118:9,11,15 119:4,7,8,12,12 119:21 120:5,12
resolutions 4:23 57:5 117:22 118:4,6 120:2
resolved 119:9 119:13
resources 152:23 248:6
respect 35:13 87:9
respectfully 259:15
respective 6:3 6:11 22:24
respond 7:25 30:17 91:20
responding 74:3 92:24 101:7 188:2,4 199:11 203:12
response 48:15 89:18 108:20 175:21 207:11 230:9 242:9
rest 81:22 225:16
restart 34:11
restate 163:8
restricted 87:8
restrictions 4:8
restrictive 242:25
result 51:18 105:22 106:1,9 106:19 148:14 182:2 186:19 194:13 219:21 256:1
results 128:9 264:20 271:1
resume 42:13 42:14 54:23
retained 10:13 138:13,20
return 28:13 38:19 72:12 269:22 286:13 286:17
reveal 84:1 272:24
reverse 228:20 236:1
reversible 239:1
revert 152:4
review 12:15 20:18 60:4 73:3 78:12,17,20 81:4 82:22 87:25 88:18 89:17 92:4,10 96:8,10,11,21 97:3,3,7 99:12 99:19 100:16,18 100:19 104:21 131:13 140:22 186:8 241:4 286:7
reviewed 18:20 19:8,21 20:6 72:17,19 76:5,8 79:2,6,10,21 80:4,17,24 82:5 82:6,11,13 83:16 85:11,13 85:15,25 86:2 86:13,14 87:14 87:17,20,21,22 88:13 89:19,22 89:23 90:14,15 90:21 91:2 92:6 92:8,12,20 93:2 93:16,24,25 95:8,9,20,21,23 96:1,12,15,18 97:5 131:14,16 131:19,22 184:19 187:5,9 187:13 213:25 262:13,15,19 274:4 279:6,14 279:18,19,25 280:3,13,14 281:17
reviewers 78:7 78:10,14,22,22 93:2 96:17
reviewing 81:3 278:3
reviews 160:19
revised 105:9
rh 1:6
rid 21:12
right 14:15 16:8 16:15 19:7 21:14,17 22:2 22:14,21 26:13 28:2 29:13 36:8 39:22,25 43:13 45:3,7 46:6 47:7 47:18 49:25

52:24 57:10 60:13 66:25 67:3 68:17 70:23 72:7 74:16,19 75:18 78:25 83:9 84:3 85:1,5,19,23,24 86:24 87:5 88:6 90:1 91:12,13 92:4 94:13,14 95:15 98:8 99:13,24 100:4 100:13,16,23 101:19 102:4,5 102:10 105:2 107:5 109:2,6 111:5,10,25 112:8,13,14,20 113:7 117:12 121:17 122:24 123:11 129:12 129:12,12 131:2 131:6,7,7 138:12 148:19 148:20 151:17 152:15 153:19 153:23 154:5 156:25 163:19 166:1,25 174:19 177:10 180:3 181:21 183:20 185:9 186:11,21 197:2,18 198:6 198:14,21 199:8 199:9 200:24

209:10,13 215:14,18 216:1 216:10 221:17 222:20,23 224:8 224:22 228:1 230:17 233:6 235:11 236:21 236:25,25 237:17 238:2 239:16 240:3,3 245:21 249:20 250:13,20 255:1 263:8 264:13 269:1,6 276:20 277:12,20 280:23

rising 19:5

risk 114:9 149:4 150:1,2 194:6 207:16 208:15 217:24 218:6 242:4 258:19 272:9,21 273:10 273:18

risks 189:20,22 206:8 207:21 208:4 217:15 218:8 219:16 220:14 221:6 243:5 244:4 272:1,10,13,14 272:18,23 273:1 273:3,9,15 274:1

road 262:11

robbins 5:11 182:16 185:13 185:24 186:20

robert 206:18

roberts 70:17

role 30:9 33:7 33:11 41:6,16 43:17 44:9,14 45:4 53:17 54:11 55:2 116:14 128:15 130:3,4,8

roles 55:3 58:8

room 21:7 207:13 254:1

rooted 32:6,12

rose 183:11

rotating 31:16

rotation 31:8,14

rounds 41:25

routine 47:5,10 235:3

routinely 30:9 47:16 83:6 234:15 235:1

rule 16:7 138:10 138:11,15,16

rules 7:22 126:4 135:6 136:12 222:11,21

rupture 233:11

rush 256:5

s

s 2:1,10,18 3:1 6:1,1 16:18 50:10 287:3

sabbatical 28:23

sad 216:11

safe 200:9 274:6 274:7,8,13,20

safely 206:25

safety 105:8 168:11 241:12 274:17,25

saint 29:5 122:11,12,15

salpingectomies 54:8

sand 1:14 6:6 285:13

satisfaction 265:18

saw 18:23 98:7 133:9 189:14 213:6

saying 57:10 75:4 106:22 112:6 129:21 131:10 145:8,11 146:16 151:5 161:7,9 164:5 175:7 182:7 201:13 202:22 203:10 207:13 207:15 214:22 217:9 220:10,21

221:10,19 236:8 239:13 242:3 244:7,9 249:1 253:19 259:22 265:3 268:5 269:4 271:14 273:17
says 7:3 75:2 77:24 79:16 86:10 89:23 90:23 110:11 117:6 119:9 126:12 138:16 150:13 158:4,7 158:25 172:17 176:20 177:11 178:17 185:10 193:9 211:23 214:8,12,20 242:12 244:4,15 258:7 262:11 268:7,16 278:7
scale 229:20,22
schizophrenia 110:22
schizophrenic 253:2
schizophrenics 253:1
scholar 42:19 57:17 94:3
scholarly 29:23
scholars 58:1
scholl 62:20
school 26:24 28:13,20 65:3,8 66:15 185:7
schools 256:19
schrier 262:3
schusterman 68:23
scientific 4:21 114:2 156:12 168:10,12,14 169:11 194:8
scientifically 271:17
scope 26:7
screen 38:24 49:24 113:23 120:18 151:1 157:17 185:19 212:24 215:7 238:15
screenshot 88:9
scroll 12:17 29:15 36:19,25 52:1 75:11 76:1 102:14 105:10 107:9 175:25 184:6 189:1,25 190:22,23 212:21 277:10
scrolling 123:3 189:17 224:22
scrutiny 168:10 245:15
seal 285:18
searching 66:25
second 74:21 88:1 117:15 140:16 162:6 211:21,22,22 245:13 249:13 249:16 262:21 262:22 263:20 263:21 269:11 282:11
secretary 54:23 90:10
section 50:2 54:21 67:18 68:9 74:23 83:11 85:1,10 105:4 107:9 110:4,9,10 189:7 222:17 235:22 238:20 238:21,23 245:9 245:13 257:9
sections 67:6 224:17
see 12:10 20:11 23:2 26:19 29:7 39:20 44:17 50:2 55:1 85:17 86:17 104:19 105:11 109:7 116:23 119:6 128:7 134:2,4,5 150:21,22 178:9 185:6,23 189:6 189:13,17 190:21 195:22 205:20,22 212:1 223:5 238:1,13 240:2,18,19 251:25 252:1 254:20 256:3 257:9 263:16,16 268:4,4 276:25 277:18,21 280:25
seeing 30:14 86:9 87:23 155:4 157:21,22 158:19 177:22 191:11 197:7 204:22 205:1 234:12 260:10 265:25 277:2
seek 204:7
seeking 146:19 226:13 247:7
seem 106:23 116:1 145:22 237:14 278:17
seemed 20:9 144:11
seems 122:17 126:13 178:20 245:23 254:20
seen 26:3 56:10 114:3,13 115:3 115:22 117:24 117:25 119:5,23 153:12 157:20 178:12 179:9

193:4 194:16 229:13 240:15 240:22 245:15 260:8
self 146:1 152:4 162:12,13,15,15 162:17,19,20,23 163:2,2,6,11 168:1,7 249:16 251:22 252:3,7 252:20,25 253:5 253:15 254:4 257:7 258:3,17 258:24 259:3,20
semantic 225:4
semantics 225:14 228:3 247:15,21 248:13,21
semester 40:17 41:1,4
send 78:21 96:13
sending 276:8
senior 42:19
sense 144:12 145:22
sent 13:12 14:14 19:19 21:19 82:13 89:15 96:5,14 286:14
sentence 103:22 126:12 145:8 211:23 225:10 239:21 241:21 245:14 249:15 263:21 264:3 278:5
separate 42:24 44:4 49:16 54:19 233:25 234:7 237:15 255:22
separated 53:12
separately 81:15
sepulchre 50:11 50:12
sequence 167:13 167:15 196:22
sequencing 87:9
series 275:4
serious 219:12
serve 58:19 78:6 159:1 269:20
served 55:1 172:11
serves 158:6
service 39:19 51:14 52:2,18 53:5
services 34:2 35:2 47:3 241:6
serving 282:5
session 71:24
set 12:3 222:14 285:17
setting 137:17 216:6,8
settings 215:25
seven 134:23
several 32:24 134:4 160:18 258:12
severe 120:14
sex 10:9 61:11 105:25 106:3 119:17,19 144:1 146:15,23 147:8 148:2 151:24 164:8 165:12,18 196:24 197:2,16 198:20,25 222:4 225:4,18 236:22 237:7 238:6,11 258:20 270:8
sexual 5:7 107:8 118:7 160:10 184:10 233:7 257:6 258:3,19 259:12,13 260:7
sfh 122:8,9,12 122:19
shaking 8:2
share 33:20 38:24 49:24 88:22 113:22 120:19 150:13 151:1 160:8 173:7
shared 64:8 185:19
sharing 13:17 36:15 45:7 88:3 149:1 151:17 209:23
shed 207:6
sheeran 276:17
sheet 282:23 286:11
shelf 222:22
shift 225:4,14 227:5,6,15,16 227:18,20 228:3 228:8 247:6 248:21 268:23
shifted 248:24
shipping 222:18 223:7
shooting 83:25
short 31:3 70:25 106:15,21 138:3 207:2
shorthand 6:8 285:5,12
show 13:18 37:1 93:8 114:25 117:15 165:25 166:5 237:6 257:15 276:2 277:20 278:21
showing 56:7 89:12 153:14 157:17 244:11 274:25
shown 264:4 272:18
shows 241:6

sic 44:1
side 20:1,3,9 187:20
sides 23:17
sign 286:12
signal 255:1,3
signature 12:18 285:21
signed 12:4,19 138:19 286:20
significance 50:18,25 127:9 153:18,21
significant 103:4 105:18
significantly 242:13,17 267:19
silent 214:12,21 214:21
similar 43:18 68:11 82:14 98:20 204:25
similarities 201:11
similarly 98:22 233:1
simone 2:4 263:4
simone.chriss 2:8
simply 117:7 234:19 282:4
single 55:2 63:24 69:9 109:15,15 175:5 175:23 177:22 203:24 204:9 217:23 254:13 254:15,16 255:14 275:20 275:23
sinus 17:14
sir 241:11
sister 204:2 205:13
site 132:14,14
sitting 19:3 23:5
situation 112:1 230:18,19 269:2 269:7
situations 111:12,16,20 112:8,10,11 205:24
six 24:9 49:13 125:2,2,13
skip 85:5 278:12
skirt 258:8 259:6 261:14
slay 51:3
slide 183:20
slightly 264:2
sloppiness 245:5
sloppy 208:25 262:9 265:25
slow 174:9 189:10
slowly 183:20 280:6
small 62:15,21 150:25 183:16
smaller 60:11 229:21
social 39:3,7 155:22,22 156:12,16 189:20 190:2,3 241:6
society 39:4 105:9 145:6 172:15,18 173:2 180:17 242:14
sole 73:9,11 180:1
solely 211:8
solution 228:14
solutions 286:23
somebody 13:13 252:16 260:24
someone's 146:14 147:7 148:1
somewhat 32:14 282:8
sorry 10:2 14:3 17:13,20 20:8 21:11 22:12 23:12 27:19 32:2 33:4 34:11 38:23 42:14,17 43:22 47:14 50:8 54:2 57:7 61:18 62:5 65:7 66:4,24 67:19 73:10 75:22 76:10 80:23 83:10 88:24,25 89:3 90:23 91:10 95:19 98:25 103:13 105:1 125:20 127:10 128:15 129:19 138:3 139:19 141:4 143:1 147:16 150:10,24 155:16 162:15 163:8 166:21 168:25 169:15 171:5 172:3 173:7 175:12,15 179:6 185:5 186:16 187:1,25 189:13,15 190:17,19 191:9 192:15 196:8 198:25 201:12 203:15 208:3 211:4 212:25 214:16,17 223:22 225:11 234:2 239:21,23 240:25 241:9,19 242:21 243:12 244:2,12,17 246:16 248:9 250:3,4,13,17

254:7,15 257:4 257:11 262:23 263:18 267:9 272:3 280:5,8 281:2
sort 30:19 52:23 61:3 63:6 71:21 77:11 124:9 144:18 163:17 164:4 167:4 173:22 178:24 179:11 180:23 195:24 232:22
sorts 196:19
sought 58:13 111:19 247:3
sound 114:7 119:10 145:17 226:1
sounding 218:3
sounds 177:16 199:9 276:20
source 133:14 149:10 152:13 154:6 155:5,16 165:22 166:7 170:17 171:13 174:13 175:10 200:2 230:21 231:10 232:2 234:3,9,21 236:8,13 237:2 243:13,18,19 244:9 247:20 248:4 254:22 261:20,23 262:13,19 271:2
sources 14:9,20 15:2 103:7 127:3 132:5,8 132:20,23,24 134:20,24 135:14 137:18 137:20 138:1 153:4 155:23 165:21 166:11 166:23 168:18 168:21 169:10 169:19 175:12 175:20 182:12 192:21 209:5 239:14 255:13 256:15 260:21 261:2,7 262:16 279:6
southern 2:5 7:11
southernlegal.... 2:7,8
space 107:15
sparse 233:9
speak 8:8,18 21:8 57:14 209:17 282:7
speaking 22:12 28:20 48:3 123:23,25 146:22,25 147:3 170:19
speaks 231:15 231:16
specialized 142:4
specially 138:20
specialty 30:15 65:7,8 103:15 129:10
specific 54:4 64:9 71:17 90:3 127:11,18 128:11 137:20 137:25 166:11 173:8 202:3 230:5 236:6 238:9 240:3 246:14 247:25 271:2 278:1
specifically 10:22 19:18 20:23 30:4 39:13 50:19,24 64:2 68:21 108:25 118:8 124:20 128:3 142:6 148:11 155:15 158:7 196:18 238:12 282:3
speculative 117:5
spelled 217:6
spelling 7:14
spend 278:17
spermarche 105:19
sphere 32:19
spirituality 68:25 69:5
split 53:9
splits 213:12
spoke 211:2
spread 174:10
springs 1:14 6:7 285:13
square 2:12
ss 285:3
st 69:21
staff 35:7 176:2
stage 105:17,18 164:19,21 275:18
stand 66:20 281:18
standard 16:20 101:22 102:8,20 102:24 103:2,8 141:24 180:9,13 180:16 223:24
standards 16:11 16:20 35:16 111:2 112:7 143:20 194:18 195:4,12,15,16 195:20,22 196:3 196:5 197:11 208:5
stands 16:23 122:12 156:11

start 8:6 60:15 67:15 76:9 123:22 127:10 176:3 177:12
started 68:3 126:4 219:16 225:19
starting 139:19
starts 50:9 68:9
starvation 146:10
state 6:8 47:21 48:3 49:2 80:15 80:23 84:24 105:21 121:11 123:4 145:4 151:21 180:20 211:24 212:16 216:2 231:18 233:7 238:24 241:6 259:19 284:4,14 285:2 285:6,22
stated 113:5 121:1 188:9 234:5 265:23
statement 37:12 37:15 46:24 83:19 112:9 114:6,23 115:1 115:3,10,17,20 116:25 117:3 126:16 138:25 139:10 152:7 154:7 155:1 165:20 168:19 169:20 171:19 178:13 179:4,6 179:11 180:4 182:5,9 209:3,5 209:7 214:1 237:5 251:22 254:22 255:25 266:16 278:1,11
statements 59:18 83:1 106:24 133:25
states 1:1 35:12 101:16,20 103:8 114:7 116:14 118:3 160:18 212:7,12,13 213:12,14,16,17 213:18,19,23 214:2,5,5,6,10 214:14,18 217:1
stating 7:14 56:23 115:11 168:3
statistically 144:5
statistics 268:12
stature 105:23
status 121:23
statute 213:18
stayed 149:1
step 136:23
sterility 106:5
sterilization 106:4
stigma 227:7
stipulated 6:2 6:10 138:17
stipulations 3:4
stop 13:17 36:15 42:7 45:7 88:3 120:18 122:18 151:17 200:17 200:21,24 201:3 201:16,25 209:23
stopped 31:2 42:3 52:11 53:21 148:25
stopping 105:8
story 183:10
strain 242:8
strange 95:11 96:3 97:11
strangers 95:11 96:2 97:11
street 2:18
strict 69:17
strictly 153:7
strike 109:20 127:10 137:6
strive 218:7
strong 256:18 266:9 279:21
stronger 268:4
strongest 205:11
strongly 32:6,12 195:24 266:19 267:22
struggling 60:13 66:11
student 87:4 184:22 185:1 260:18
students 29:21 41:12,19,21 43:24 63:20,21 64:23,24 65:1,2 65:15,16,17,19 65:19 71:25
studied 123:4 126:12,17,22 127:18 128:2,4
studies 60:8,9 60:11,25 105:6 105:15 107:24 127:8,11,15 136:24 137:1,5 137:8 152:14,16 159:25 168:8 170:13 172:5 185:8 222:13,14 237:6,10,23 264:3,7,14,16 264:22,25 265:6 267:19 270:25 271:8,15,16,24 272:23 273:8,14 274:4,16,19,24 274:25 275:8,22 275:24
study 21:24 28:23 54:20 60:4 62:7 63:6

107:22 108:2 127:14 139:11 149:23 152:10 158:5,25 160:13 161:2,4,20,21 161:25 171:25 172:2 181:23 244:15 263:12 263:15,25 264:9 267:1,17 268:7 271:22,23,25 272:9 275:20
studying 126:25 127:3
stunted 105:24
subject 23:21 49:5 64:2 89:17 92:4 97:6 134:5 281:22 282:1
subjects 60:5 133:21 215:17 215:21 216:10 222:13 223:19 224:7
submission 132:19
submit 13:11 78:21
submitted 10:17 13:6,10 18:5,8,8 18:17 22:4 25:6 64:14 133:24 134:11 152:25 154:14,23 277:12 281:10
submitting 17:18 135:5 138:9
subscribed 284:13 288:14
subsection 139:20
subsequent 98:10 157:8 266:22
substance 211:18
substantiate 261:2,8
substantiated 260:21
substantiating 260:18
successfully 202:8
suddenly 202:17
sufficient 136:25 137:7 208:21 229:13 231:7 271:18 274:16 275:12 275:12,13
sufficiently 246:10 275:23
sugg 96:24
suggest 103:23 104:4,5 199:11 203:5 208:19 242:25
suggested 17:25 58:10
suggesting 101:5,11 108:8 110:17 156:9 162:14 163:24 266:25
suggestion 58:17 219:7 245:25 255:14
suggestions 78:22 96:14,25 155:25 161:14 272:17
suggests 107:7 219:4
suicidality 264:5
suicide 90:2 91:17 95:4 142:13 229:24 229:25 263:11
suing 228:6
suit 49:11
suite 2:12,18
summarize 77:11 139:5
summarized 167:6
summarizes 187:16
summarizing 188:7
summary 22:8 108:21 151:13 212:22
summation 15:1
summer 15:15 15:16
supplement 8:24
supply 52:14
support 16:6 17:8 18:18 26:10 101:20 102:6 103:7 104:16,22 106:12,18 107:1 107:12,22 108:2 109:2 118:12 139:5 155:13 162:15 165:10 165:14 166:7,12 167:3,10 168:9 180:4 182:4,9 182:13 191:13 192:10 199:15 204:7 209:2,4 209:25 227:1 228:22 229:12 230:6,13 231:11 232:2,16,19 233:13 234:17 236:4,19 237:23 251:21 266:15 266:20 267:11 267:15,20
supported 69:6 107:25 155:1 186:13,18 204:4

205:4,7
supporting 102:1 232:21 279:22
supportive 265:3 266:24
supports 102:19 109:16 167:22 192:16 271:3,22 271:23,25
suppose 57:4 60:3 116:10 131:20 248:19
supposed 51:20 69:13 78:9 143:7 145:19 164:24 165:4 177:23
suppressing 243:6
suppression 105:20
sure 12:15 13:9 18:1 21:16 24:10 54:24 67:14 80:10,20 81:2,5 82:9 83:4 86:2 98:2 99:15 105:6 113:21 121:23 123:16 124:5,5 127:1 131:23 132:7 137:16 138:12 144:20,25 147:22 149:16 152:12 156:5 165:24 166:24 175:15 187:4 189:10,10 193:13 202:25 212:10 213:6 216:7 222:22 224:9,19,21 228:6 233:6 236:18 238:22 241:3 276:9 281:4
surgeon 81:14 141:20 221:4
surgeons 145:5 233:16,18 234:5 234:13
surgeries 10:10 61:14 147:1 196:24 197:22 198:13 225:3,5 226:16,20,23 229:5 231:12 235:10,18 245:20
surgery 46:22 118:13 119:19 129:7 167:4,12 167:19,21 204:5 220:16 225:9,19 225:22 226:8,9 226:14,20 234:6 235:4 274:1
surgical 119:17 119:19 130:7 164:9 183:19 221:25 228:14
surprise 4:8
surprised 86:25
surrounding 123:5,10,24 126:17 127:13 127:19 128:2
surveillance 150:1
survey 149:4 150:2,2,21
surveys 149:25 265:18
suspect 125:19 144:24 166:8
suspected 251:17
suspecting 251:10
suspended 48:24
swaab 160:19
sweden 168:16 173:19 198:16 239:19 240:5 243:5 263:13
swedes 244:8
swedish 5:16 240:10,12 241:5 242:17 243:13 245:6
switched 225:17
switching 189:19 266:24
sworn 7:2 284:13 285:8 288:14
symptom 253:12
symptoms 162:16,22 252:20 253:10
system 150:1 199:25
systemic 241:4
systems 54:14

t

t 3:1,1 6:1,1 143:13 284:1 285:1,1 287:3,3
table 8:15 248:20
tabloid 255:9
take 4:8 8:13,17 9:15 26:15 31:22 55:22,24 72:9 88:5 108:1 109:22 110:13 127:16 144:13 156:6 162:11 174:11 181:9,11 218:13,17 223:23 227:9 240:24 244:21 244:23
takeaway 69:8,9
taken 1:15 6:5 9:6,13 72:10 112:24 138:6

145:5 181:12 218:19 244:25 282:14 285:11 285:13
talk 8:10 9:24 21:8 45:9 49:21 55:18 58:1,7 124:20 144:4 164:6 183:25 187:22 216:5,21 224:24,24 247:4
talked 71:24 74:20 80:10 99:15,16 113:2 114:22 117:9 121:14,18 130:17 172:5 183:11 252:10
talking 19:24 20:10 37:22 54:18 62:21 64:4,13 69:3 70:7 96:2 100:7 102:21 106:6,7 112:2,3 124:21 126:14 128:18 138:8 139:16 141:20 147:22 147:25 176:22 182:17 190:8 197:7,13 198:24 201:21 202:16 202:18 218:21 225:2 234:23 235:20 244:3
248:12 253:6 274:11,15 275:16,22 278:18
tallahassee 1:2 2:19
tally 125:21
tank 29:20 42:24
tanner 105:17 105:25 164:19 164:21
taught 63:12,16 64:1
tavistock 173:15 174:8
teach 41:5,10,18 66:5
teaches 65:14 65:14
teaching 28:16 29:5 40:25 41:2 43:24 44:10 46:11 64:19 99:17 122:10
team 31:8 89:24
technology 55:23 241:5
tell 19:2,18 81:6 125:23 136:20 155:12 179:25 189:2 208:22 218:5,6 221:5,7 229:22 258:1 277:16 279:17
telling 207:9
tells 260:25
temporarily 45:8
tempt 278:22
ten 40:9 55:20 62:25 109:14 125:11,12 208:24 230:1
tend 42:25
tendency 8:6
tense 122:18
term 10:5 38:2 42:15 60:2 72:19 101:25 162:18 184:9 194:7 204:23 207:3 219:17 226:11,22 229:17 233:4 270:25
termed 219:1,13
terminally 94:11
terminology 10:6 54:22 128:1 227:5,6 227:16 247:6 248:5
terms 11:23 14:25 16:15,16 33:15 54:10 60:23 69:18 128:8 145:16 246:18 247:23
271:17 275:12
terribly 251:25
test 164:1 270:3 271:19
tested 270:18
testified 23:25 24:20 25:4,14 121:12 139:8 250:8
testify 10:23 285:8
testifying 9:16
testimony 8:24 9:1,11 10:18,21 26:8,10 138:21 138:23 139:11 281:5 284:7 286:9,18 288:8
testing 81:18 159:6 271:1
tests 252:11,24
texas 5:9 175:13 181:17
text 73:22 105:3 108:7 119:6,7
thank 7:18 9:23 12:21 17:2 23:11 39:22 66:25 93:18 189:11 212:25 215:8 224:20 261:24 281:4 282:15,18
thanks 183:17 184:5

themself 11:24
theological 33:12
theology 33:1,7
theory 270:3 271:19
thepublicdisc... 187:12
therapies 217:19
therapy 101:23 176:3 177:13 193:4 196:17 270:19 271:1
thin 192:7
thing 50:20 52:10 62:21,24 72:17 113:2 145:25 150:10 160:4 176:20 186:10 191:5 233:24 243:25 261:12 270:3
things 14:24 18:4,7,8 19:13 19:14,23 21:14 21:15,22,25,25 22:2,10,13,18 32:25 51:9 52:14,16,16 53:10 54:8 60:10 80:7 96:7 107:19 126:1 128:5 131:25 132:2,13 133:3 134:1 136:3,4,5 136:7 137:11 142:16 152:20 154:25 177:4 179:5 184:15 195:25 197:5 199:2 206:10 207:6 208:13 217:12 228:5 246:8 262:15 268:19
think 8:5 11:6,9 11:17,19 13:7 13:24 14:25 15:11,23 17:19 21:6 22:20 23:9 29:20 31:9 38:16 42:24 50:20 55:16 58:17,24 70:24 71:6,13 72:1,7,9 73:4 86:6,7 91:4 92:7,7,21,21,22 96:19,20 97:1 98:7 102:21 103:1 107:4,13 109:6,25 112:20 113:9,16 118:2 121:23 125:23 126:3 128:5 130:14,16,19,20 132:3,21 133:23 137:5,7 139:15 139:17 141:16 144:3,10 145:17 145:18 147:10 147:11 148:8,11 153:16 154:15 154:18,19 159:21 161:16 162:1 164:2 168:23 169:5,8 170:1 172:9 175:25 176:21 177:9 178:16 179:8,10,22 181:8 182:15,16 183:18,21,24 184:2 189:23 190:4,15,16,21 191:3,4 193:20 195:2 196:21 198:18 199:5 200:19 201:7,20 201:23 205:5,7 207:1,4,12 209:16,21,22 217:6 218:25 219:11,12,18 220:2 222:19 223:8,17 226:1 226:16 227:17 227:21,24 228:4 228:8,12,12,18 228:25 229:1,8 229:14 231:14 231:15 234:6,11 234:19 235:19 236:5 237:10,12 239:22 240:23 241:14,20 243:20,24 244:21 248:24 249:7,8,10 250:6,17,20 253:1,20 256:2 256:17,22 257:3 258:17,18 259:22 262:18 262:23 266:1,5 266:22 267:11 267:22 268:3 269:3,19 270:2 270:24 271:13 274:10,23 275:3 280:1,15 281:21 282:11
thinking 57:1 136:21 170:23
thinks 206:24
third 20:8 222:10 249:15 254:10 264:2
thought 28:17 82:12 133:5,7 136:4,8 151:9 153:11 156:18 175:1 185:15 187:22 188:4 236:10 247:23 248:10 269:8 278:20 282:7
thoughtfully 203:6,8

thoughts 121:8
three 21:22 22:15 83:9 124:11 173:10 213:13
time 6:13,14,15 8:13,19 15:10 26:15 28:24 30:14 35:9 36:21 40:16,19 53:25,25 55:22 55:24 60:19,21 68:6,11 70:18 81:16 84:17 85:7 88:5 104:18 108:17 110:1 112:19,21 113:5,10 115:22 125:7 128:18 152:5 155:14 156:6 158:9 162:2 166:13,24 172:8,9 177:23 199:3 204:6 205:4 218:18 219:12 236:2 249:25 251:1 263:9 269:22 275:5 278:18 279:12 282:15 284:7 286:19
timeframe 286:8
times 23:18 58:18 66:1,6 95:5 124:23 128:10 134:4 263:13
tired 213:1
tissue 56:19 233:10
title 68:18 70:19 71:6 119:6,8 210:7 223:6,13 223:14,16,21 224:6,13,14,16
titled 73:14 81:18 83:14 87:7 92:16 97:17 160:9
today 7:10,23 8:4 9:6,11,16,21 9:25 18:21 21:15 72:20 103:14 115:22 120:24 121:16 166:6,10 180:7 192:6 196:20 197:13 209:10 219:25 220:7 225:2 228:23 239:16 263:25 279:6 281:18 282:15
today's 18:2 21:2 141:21 256:17 266:12
together 23:7 81:14 113:11 149:11
told 23:13 50:24 51:16 97:24 99:1 161:21 206:20 218:24 238:25
tomes 133:22
took 28:23 121:24,24
top 262:8 264:1 268:21 280:7
topic 9:25 18:6 28:18 66:2,6 68:6 70:13 99:12 116:21 118:7 124:24 141:21 180:1 279:20
topics 142:1
total 31:12
totality 121:4,7
totally 68:19 271:6
touched 179:22
toward 189:4
towards 32:5 52:15 254:12 268:23 270:16 279:22
town 44:5 48:16
track 125:5
tradition 32:7 32:13 43:4 83:15
trainees 29:21
trans 131:5 257:8 258:4,11 258:24 259:3,18 259:21 261:3 262:8
transcribe 8:4
transcribed 285:12
transcript 94:18 282:22 283:1,3 284:6 286:6,20 288:5,8
transcripts 286:15
transgender 10:3 21:18 26:11 46:23 64:5 103:5 110:24 118:9 119:8 123:5,10 123:24 124:17 124:20,24 126:17 127:13 127:19 128:2,3 128:11,20,22,22 128:25 129:8,15 142:23,24 143:11,17 148:15 150:14 150:16 161:18 202:12 210:8,10 236:1 255:18 258:11,17,19 259:9 260:19 261:16 263:12

264:4,18 265:18 266:12 269:13 269:16,22
transgenderism 142:20,21 143:9 143:15,18
transition 108:24 153:14 199:23 202:17 203:2 267:6,17 268:8,13 269:19
transitioned 267:1
transitioning 199:14,19 239:11 247:8 266:23,23
transplant 141:19
transplantation 69:19
transsexuality 160:24
trapped 249:5 268:24,25
treat 10:2,2 30:16 115:13 130:6 193:8 199:6 221:23 230:8 231:13 232:4,18
treated 46:14 193:15 201:18 227:15 269:17 269:23
treating 30:18 41:25 105:14 159:22 199:12 217:3 226:24 229:6
treatment 10:9 11:10,13 21:19 24:12 25:11,14 30:12 47:6,11 63:10 67:24 68:14 71:18,22 71:22 110:20 111:4,24 118:14 120:10 128:9 146:21 147:11 163:15 164:6 167:6,8,16,17 172:6,13,23 173:12,23 174:6 177:2 180:24 181:4 182:2 193:19,23 194:16,17,20,24 195:6,8,21 198:9 199:1 200:3,14,16,18 200:22,23 201:2 201:3,13,22 202:1,7,9,11,15 203:7,9 205:1 205:14,17 210:8 210:10 214:19 216:8 221:12 234:16 235:7,23 240:13 241:10 242:19 243:6,7 243:8 244:6,16 249:4 264:6 266:10 270:6 271:4 274:9,12 281:21
treatment's 193:2 194:11
treatments 11:23 16:8 24:18 61:5 101:1 118:10 119:9 121:6 184:1,9 193:11 194:1,5,14 196:7,9,10 198:5 200:24 207:15,23 213:20 214:15 217:16 219:25 220:6,22 221:10 221:12 225:1 228:22 229:6 230:7 231:12 232:3,17 245:19 274:20 281:14 282:6
trial 6:13 23:23 24:20 25:2,4 121:13 139:8
trials 23:17 218:9 241:8 246:9
trouble 88:2,7 127:20 184:7 228:3 262:23
true 56:2 68:8 124:19 167:9,23 200:8 216:11 221:24,25 248:15 264:15 284:6 288:8
truism 274:14
truly 194:25 206:23 258:18
trust 277:19
truth 9:19 231:25 285:8,9 285:9
truthfully 9:8 9:19
try 8:9 67:12 80:5 88:3 126:7 126:9,9 214:16 221:16 250:23 272:4
trying 15:11 21:16 23:3 61:18 71:10 79:17 88:2 97:4 164:2 169:5 185:18,22 204:18 224:9 225:15 226:17 230:14 239:20 255:20 257:4 261:10 262:25 263:9 273:2,4 273:16 275:15

tulsa 52:4,12 53:4,11,21,22 54:15 55:2,5 69:21 122:15,20
turn 34:24 40:10 120:15 148:25 155:11 266:13,18 267:2 267:7,21 280:25
turned 209:8
turning 35:11 130:9 140:15 159:9
turns 172:10
twice 66:8
two 17:19 18:10 54:19 55:3 73:15 91:11 104:20 116:1 155:20 179:23 191:17,21 201:17 246:4 254:23 264:14 266:3 268:11 278:12
twofer 36:23
type 24:12,16 36:11 37:16 48:6 65:14 81:11 82:4 83:5 88:7 102:3 107:14 108:18 110:20 111:3 195:6 199:1 200:10 201:15 207:2 216:13 226:13 273:18
types 24:8,10 30:21 82:25 83:2 112:8 146:20 167:7 198:8 251:15
typically 38:11 47:9 75:13 77:13 166:3

u

u 6:1 284:1
u.s. 43:9 95:13 150:17 222:17 242:19
uh 31:13 76:13 77:21 80:13,16 95:6 102:13 175:9 188:15 223:15 254:24 257:14
umbrella 122:4
unable 90:17 154:5 162:2 200:11,17 261:8
unbiased 141:7 141:9,10
uncertain 193:2 194:2,11,14
unchanged 241:7
uncontrollable 90:24
under 9:16 48:20 53:23 72:23 122:4 136:11 153:25 168:9 223:21 224:5 225:9 284:4
undergo 100:15
underlying 228:16,17,18 229:2 247:7
undersigned 284:14
understand 9:15,20 10:8,16 17:1 23:3 78:11 93:7 127:22 132:22 134:13 134:18 153:6 154:3 168:25 206:5,8 216:3 249:5 253:6 263:8 271:14 273:2,6
understanding 72:20 116:11 137:15 174:20 244:13
understood 131:12 153:1 165:5 197:4
underwent 73:3 99:12,18 100:18
undo 95:12
undoubtedly 201:11
unethical 130:15,16,19
unexplained 155:21 156:20
unfavorably 202:10
unhappy 227:12
unique 32:4,14
united 1:1 103:8
university 24:1 24:4,6 26:24 27:16 28:1,11 28:19,20,22 29:1 32:2,3 33:17 34:10 35:23 37:4 43:4 45:23 53:11 60:19,22 62:13 65:16 70:17 71:17 122:3 184:22 185:8
unknown 193:1 193:6,18,22 194:14 205:9 217:15,23 218:5 218:6 261:16 271:4,6 272:1,9 272:10,14,21,23 273:3,9,10,15
unknowns 219:22
unnecessary 90:24
unreliable 275:9

unscientific 194:12
unsubstantiated 261:9
untested 270:11 270:22
untreated 163:7 163:12,13
unwanted 4:22 115:12,14 116:15
unwise 90:24
update 98:11
updated 53:13
updating 52:11
uphold 35:13,19
urge 256:18 279:21
urgency 254:11
usa 91:22,25
use 10:5,6 16:16 23:4 48:8,11 72:19 105:7 115:13 116:16 118:12 119:18 162:3 182:10 195:5,24 198:23 199:5 221:23 224:25 226:22 226:22 265:24
used 10:2 16:16 19:10 21:14 32:19 111:7 120:13 139:4 161:17 162:19 196:3 199:1,2 226:12,20 240:7 241:24 242:4,19 246:24 247:1 248:10,16 269:8 270:17 286:20
useful 246:14
uses 194:19 195:20
using 8:1 38:2 42:15 60:2,3 79:14 101:25 149:6 159:8 165:17 188:5,5 194:9 196:5 222:3 226:4,15 226:19 227:2 248:7
usual 82:7 158:21
usually 73:25
utero 4:15 87:8 89:7

v

v 7:17,17 286:4 287:1 288:1
validate 158:11
validating 159:7
value 144:13
values 37:22
variability 108:21
variety 65:25
various 19:10 33:16 44:5,14 48:15 54:13 57:15 59:17 82:24 123:19 133:25 137:17 164:9 169:16 224:25 278:18
vary 75:13
vatican 50:6
venue 273:24
verbal 8:1
verify 286:9
veritext 286:14 286:23
veritext.com 286:15
version 211:20 262:24
versus 7:10 84:10 120:24 141:24 197:11 201:2
vicinity 42:9
videoconferen... 1:12 2:2 6:4 285:11
videotaped 284:5
view 21:18 210:10
viewed 278:15
views 34:17 70:2,3
virginia 257:6 260:7
virtual 22:22
virtue 32:20
visit 175:5,24 176:4 177:13
visited 178:8
visual 144:12
vitae 4:5 26:23 27:1,7 49:23
vogel 2:16 16:3
voluntarily 200:24
volunteer 48:11 48:13
vries 102:11
vs 1:6
vulnerable 39:5 39:8,15 222:13

w

w 143:13
wade 281:25
wait 185:18 244:20
waiting 101:20 101:24 102:3,7
walking 253:18
want 9:24 10:6 33:20 39:24 99:17 124:5,6 126:7 147:22 154:9 168:2 186:24 190:19 201:22 209:18 222:24 233:5 240:24 259:1,10 266:1 273:4

278:22 282:23
wanted 21:12 92:22 113:1 130:5 177:16 190:21 200:18 238:17
warn 202:9
washington 5:17 47:22,25 48:2,3,4 52:20 95:5 257:12
wasting 263:8
watchful 101:20 101:24 102:3,7
way 51:6 57:4 65:11 67:12 71:11 82:9 102:23 113:12 121:9 122:17 127:2 134:1 136:20 141:3 154:12 156:2 162:12,19 172:1 177:8 178:23 183:23,24 189:16 190:8,20 200:25 207:4 213:5 216:2 217:21 219:4 228:25 252:8 268:5
ways 52:14
we've 19:23 45:11 54:18 60:9,11 63:19 95:17 103:14 105:11 121:18 124:22 129:11 140:1 154:2,4 154:18 181:8 189:23 196:22 219:18 220:6 225:2,18 229:8 229:19 252:10 253:6 270:24 274:10 279:6,10
wearing 258:8 259:6 261:14
web 79:18 117:25 118:1
webmd 79:16 79:19,21
website 4:16 5:9 57:16,17 58:5 79:15 118:3 120:1 178:13 179:3 181:17 187:12
websites 239:12
week 134:4
weida 1:7 7:10 120:25 276:17 286:4 287:1 288:1
welcome 8:12 8:23 164:3 231:18
welfare 51:21 243:5,21
went 25:1 28:23 71:5 177:15
west 2:12
whatnot 274:2
whatsoever 140:18
whereof 285:17
whistle 262:9
whoa 189:10
wide 65:24 228:4
widely 148:12 152:8 196:6 199:4 218:10 223:24 234:20
widespread 172:12 204:7
wife 21:10
williams 5:4 149:5,9,13 212:3,18 213:3
willing 15:19 58:19 187:2 209:11 210:25
wills 167:20
wilson 97:23
wishful 57:1
wit 7:4
withdrawal 201:6
witness 10:13 15:22 16:1,3 19:10,25 23:16 26:5 36:22 39:11 55:25 69:12 107:4 109:5 135:8 137:3,10 138:19 138:19,25 139:3 139:8 140:7 141:3 154:19 161:25 166:16 166:20 171:18 178:8 179:16 187:8 203:22 207:20 209:20 218:2 220:10 230:24 231:7,21 232:15 238:1 270:2 271:13 273:22 281:7 282:18,24 284:15 285:17 286:8,10,12,19
witness's 139:6
woman 145:9 227:23 253:8,20 253:23
women 52:7
wondering 51:4 96:9 127:1 263:7
word 50:9 72:16 225:1 226:11
words 38:11
work 7:11 30:9 33:15 34:21 43:13 46:1,5 48:11,13 134:10 173:2 211:3

233:10 265:25
worked 17:17
48:14 276:18
working 24:5
40:16,18 43:24
46:8 67:9
132:17
workings 82:8
workshops
67:16,21
world 103:4
218:10 256:18
worldwide
101:23 102:20
102:24 103:2
worse 146:9
worth 161:16
162:2
worthwhile
156:19
wound 233:11
wpath 132:14
143:11,19
167:14 180:10
write 40:22
76:22 103:17
156:2,3
writing 7:24
13:3 29:24
43:25 44:11
90:8 104:1
108:19 123:12
132:25 137:19
137:21 138:1
247:11 278:20
writings 131:4
written 25:6
64:11 120:22
135:7 138:14,18
239:8,11
wrong 71:3
75:22 91:16
132:3 146:19
187:15 192:6
216:15 235:4
249:1,6 253:17
256:22 268:24
268:25 269:3
wrongly 255:17
wrote 92:10
95:10 113:10
134:11 184:22
259:25

x

x 252:10

y

yeah 13:24
20:22 22:7 33:6
50:20 58:6
61:21 75:15
78:11 80:1
81:22 86:25
87:6 98:13
109:5 111:20
123:2 125:3
141:25 142:15
151:16 152:13
153:24 157:8
160:24 172:18
176:1,5,6
183:10,21,24
184:12 185:15
187:2,2,18
198:25 204:5
215:8 221:15
223:18 236:10
241:18 250:15
250:22 263:22
265:21
year 15:10
41:21 55:18
136:6 142:18
206:21 240:17
years 27:17
30:25 40:9 45:5
55:20 62:25
64:20 84:17
101:22 121:12
121:16 122:8
123:1 124:11
125:11,12
140:21 141:25
142:16 198:10
199:8 208:24,24
208:25 219:20
229:24 230:1
251:6
yep 177:6
224:19
yesterday 18:24
young 19:5
151:21 152:2,3
156:16 158:10
164:8 208:23
264:18
younger 128:7
233:8
youth 4:22
110:17 149:4
150:1,13 165:11
267:1

z

zealand 168:17
zoom 34:25
40:21 56:16
104:24,24
124:13,15,23
125:13,18
149:23 185:18
185:21 223:8

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.

Doc. 246

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

AUGUST DEKKER et al.,

Plaintiffs,

v. CASE NO. 4:22cv325-RH-MAF

JASON WEIDA et al.,

Defendants.

_____/

FINDINGS OF FACT AND CONCLUSIONS OF LAW

For many years, Florida's Medicaid system paid for medically necessary treatments for gender dysphoria. Recently, for political reasons, Florida adopted a rule and then a statute prohibiting payment for some of the treatments: puberty blockers, cross-sex hormones, and surgeries. This case presents a challenge to the rule and statute. The controversy is live only for puberty blockers and cross-sex hormones; no plaintiff currently seeks surgery. This order sets out the court's findings of fact and conclusions of law following a bench trial.

I. Background: the parties and claims

The plaintiffs are two transgender adults, August Dekker and Brit Rothstein, and two transgender minors who are proceeding under pseudonyms, Susan Doe and K.F. The minors are suing through their parents, Jane and John Doe for Susan Doe and Jade Ladue for K.F. "Susan Doe" is the same pseudonym, but the plaintiff here is not the same person, as the plaintiff identified by that pseudonym in *Doe v. Ladapo*, No. 4:23cv114-RH-MAF (N.D. Fla. June 6, 2023).

The defendants are Jason Weida, in his official capacity as Secretary of the Florida Agency for Health Care Administration ("AHCA"), and AHCA itself.

In count I of the first amended complaint, all the plaintiffs assert a claim against Mr. Weida under 42 U.S.C. § 1983 and the Fourteenth Amendment's Equal Protection Clause. In count II, all the plaintiffs assert a claim against AHCA under the Affordable Care Act's prohibition of discrimination based on sex, 42 U.S.C. § 18116. In count III, the minor plaintiffs and Mr. Rothstein, who is over age 18 and thus an adult but under age 21, assert a claim against Mr. Weida under § 1983 and the Medicaid Act's requirement for early and periodic screening, diagnostic, and treatment services for beneficiaries under age 21, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5). In count IV, all plaintiffs assert a claim against Mr. Weida under § 1983 and the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B)(i), under which

assistance to an eligible individual cannot be less in "amount, duration, or scope" than assistance available to other Medicaid beneficiaries.

The order granting a preliminary injunction in *Doe* was based in large part on the record compiled in this case. The *Doe* parties had stipulated that this record would be considered there. Many of this order's findings and conclusions have been cut and pasted from the *Doe* order, with any appropriate modifications. Same record, same findings and conclusions.

II. 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.[1] 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.[2]

For less than 1%, the natal sex and gender identity are opposites: a natal male's gender identity is female, or vice versa.[3] This order refers to such a person who identifies as female as a transgender female and to such a person who

[1] Trial Tr., ECF No. 226 at 23–24; Trial Tr., ECF No. 238 at 72–73.
[2] Trial Tr., ECF No. 227 at 222.
[3] *Id.*; *see also* Trial Tr., ECF No. 226 at 23–24; Trial Tr., ECF No. 228 at 29–31.

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 defendants, speaking through their attorney, have admitted it. At least one defense expert also has admitted it.[4] 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.[5] In this litigation, the defendants have explicitly acknowledged that this view is wrong and that pushing individuals away from their transgender identity is not a legitimate state interest.[6]

Still, an unspoken suggestion running just below the surface in some of the proceedings that led to adoption of the rule and statute at issue—and just below the

[4] *See* Trial Tr., ECF No. 239 at 10–11, 31–32, 80–81.
[5] *See id.* at 129–31.
[6] Trial Tr., ECF No. 242 at 97–98.

surface in the testimony of some of the defense experts and AHCA consultants—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] An AHCA consultant, 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]

Any proponent of the challenged rule and statute 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.

---

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

[8] Trial Tr., 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., ECF No. 239 at 129–31.

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

III. Medicaid

Medicaid is a jointly funded federal-state program that provides medical care for patients of limited economic means. *See Garrido v. Dudek*, 731 F.3d 1152, 1153–54 (11th Cir. 2013); *see also Harris v. James*, 127 F.3d 993, 996 (11th Cir. 1997) (quoting *Silver v. Baggiano*, 804 F.2d 1211, 1215 (11th Cir. 1986)). Federal law makes some services mandatory but allows states to "place appropriate limits" based on "such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d); *see also Garrido*, 731 F.3d at 1154; *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1232–33 (11th Cir. 2011); *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980). States may "set reasonable standards" for "medical necessity." *Garrido*, 731 F.3d at 1154.

Exercising this authority, Florida has long limited Medicaid coverage to services that are "medically necessary." *See* Fla. Stat. § 409.905. Florida provides coverage for, among other things, "services and procedures" rendered "by, or under the personal supervision of," a licensed physician, when "medically necessary for the treatment of an injury, illness, or disease." Fla. Stat. § 409.905(9). This does not, however, extend to services that are "clinically unproven, experimental, or for purely cosmetic purposes." *Id.*

For Medicaid beneficiaries under age 21, Florida also covers "all services determined by [AHCA] to be medically necessary for the treatment, correction, or

amelioration of" any "physical and mental problems and conditions." *Id*. § 409.905(2). This provision does not explicitly exclude clinically unproven, experimental, or purely cosmetic services, but as both sides apparently agree, they are excluded here, just as in § 409.905(9). *See Moore*, 637 F.3d at 1234. This coverage tracks with 42 U.S.C. § 1396d(a)(4)(B) and (r), which require states to cover "early and periodic screening, diagnostic, and treatment services" for Medicaid beneficiaries under age 21. *See Moore*, 637 F.3d at 1233–35.

By rule, AHCA has said that to be "medically necessary," a treatment must be, among other things, "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational."[11] The rule says a drug is "experimental" or "investigational" in four circumstances.[12] The first is when any required approval has not been given by the Food and Drug Administration. The second is when the drug is undergoing phase I, II, or III clinical trials or is under study to determine safety or efficacy "as compared to the standard means of treatment or diagnosis." The third is when the consensus among experts is that further studies are needed to determine the drug's safety or efficacy. The fourth is when the drug is used for a purpose not approved

[11] Fla. Admin. Code r. 59G-1.01(2.83); Pls.' Ex. 22, ECF No. 175-22 at 8.
[12] Fla. Admin. Code r. 59G-1.01(2.46); Pls.' Ex. 22, ECF No. 175-22 at 5.

by the FDA, meaning the use is not listed in one of three compendia of off-label uses or supported by peer-reviewed literature. *Id.* r. 59G-1.01(2.46).[13]

IV. The challenged rule and statute

When AHCA considers Medicaid coverage for a type of medical treatment for the first time, it sometimes prepares a report on whether the treatment is consistent with generally accepted professional medical standards—a "GAPMS report."[14]

In 2016, AHCA prepared a GAPMS report on puberty blockers for transgender adolescents. The report concluded Medicaid payment should be available when appropriate based on an individualized assessment of medical necessity for the specific patient. The report noted that "the risks of not treating" an adolescent with puberty blockers "may be worse than" treatment.[15]

In 2017, AHCA staff prepared a GAPMS report, never formally adopted, on treatment of transgender individuals with cross-sex hormones. The report concluded the treatment was "consistent with generally accepted professional medical standards" and met the requirements for Medicaid coverage.[16]

---

[13] *Id.* at 5; *see also* AHCA 30(b)(6) Dep., ECF No. 235-1 at 53–55.
[14] *See* Pls.' Ex. 238, ECF No. 181-2; *see also* Trial Tr., ECF No. 227 at 165.
[15] Pls.' Ex. 240, ECF No. 181-4 at 9.
[16] Pls.' Ex. 243, ECF No. 181-7 at 1, 11.

Consistent with the 2016 and 2017 GAPMS reports, AHCA approved Medicaid payment for puberty blockers, including for Susan Doe and K.F., and cross-sex hormones, including for Mr. Dekker and Mr. Rothstein.[17]

In 2022, however, the Executive Office of the Governor directed AHCA to conduct a new analysis of Medicaid coverage of gender-affirming care.[18] AHCA's practice is to prepare a GAPMS report only when first considering a treatment, but here, apparently for the first time ever, AHCA elected to prepare another report for these already-approved treatments.[19] AHCA ordinarily prepares reports internally, without retaining consultants, but here, AHCA retained consultants.[20] AHCA retained only consultants known in advance for their staunch opposition to gender-affirming care.

The new GAPMS process was, from the outset, a biased effort to justify a predetermined outcome, not a fair analysis of the evidence.[21] The report concluded that gender-affirming medical care—puberty blockers, cross-sex hormones, and surgery—were not supported by generally accepted medical standards and were

[17] Trial Tr., ECF No. 228 at 106–08, 129, 161, 196–97.
[18] AHCA 30(b)(6) Dep., ECF No. 235-1 at 87.
[19] Trial Tr., ECF No. 227 at 171–74, 185–86; *see also* Pls.' Ex. 30, ECF No. 175-30.
[20] Trial Tr., ECF No. 227 at 178–79.
[21] The AHCA employee who drafted the report testified he did not know the preferred outcome. I do not credit the testimony.

instead experimental. The conclusion was not supported by the evidence and was contrary to generally accepted medical standards.

Based in part on the flawed GAPMS report, AHCA proposed a rule barring Medicaid payment for these procedures. AHCA conducted a well-choreographed public hearing that was an effort not to gather facts but to support the predetermined outcome. Afterward, AHCA adopted Florida Administrative Code rule 59G-1.050(7), barring Medicaid payment for gender-affirming puberty blockers, hormones, and surgery.

That was where things stood when the plaintiffs filed this action. Later, though, the Florida Legislature adopted Florida Statutes § 286.31(2). The statute prohibits expenditure of state funds—this includes Medicaid payments—for "sex reassignment prescriptions or procedures" as defined in Florida Statutes § 456.001(9). This includes "puberty blockers" to "stop or delay normal puberty," "hormones or hormone antagonists," and any "medical procedure, including a surgical procedure," "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)1–3. There are narrow exceptions, but they do not apply here.

The plaintiffs amended their complaint to challenge the statute as well as the rule. The plaintiffs in *Doe* challenged another part of the same legislation—a part that made providing these services to minors a crime and grounds for terminating a

healthcare practitioner's license. *See id.* § 456.52(1) & (5). This followed the adoption of rules by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine that prohibited 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. Standing

In *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992), the Supreme Court said the "irreducible constitutional minimum of standing contains three elements." First, the plaintiff "must have suffered an injury in fact—an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Id*. (internal quotation marks and citations omitted). Second, "there must be a causal connection between the injury and the conduct complained of—the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court." *Id*. (internal quotation marks, ellipses, and brackets omitted). Third, "it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Id*. (internal quotation marks omitted). A court must address standing even when not contested by the parties.

A. Puberty blockers and cross-sex hormones

The minor plaintiffs are currently treated with puberty blockers. They were on track to start cross-sex hormones soon. The adult plaintiffs are currently treated with cross-sex hormones.

The loss of Medicaid payment for the needed treatments is an injury in fact; it is concrete and particularized; and it is actual or imminent, not conjectural or hypothetical. The injury is traceable to the challenged rule and statute, either of which, standing alone, would require the plaintiffs to forgo or pay out-of-pocket for the needed treatment, or move out of Florida. The injury will be redressed by a favorable decision.

The plaintiffs thus have standing. This is so despite the statute and rules prohibiting physicians from providing these services to minors. First, the statute and rules do not apply to adults and thus do not affect the adult plaintiffs' standing. Second, at least as of now, Florida law allows minors to continue with treatments they are already receiving, so the statute and rules do not affect the minor plaintiffs' standing to challenge the ban on payment for puberty blockers.[22] Third, as *Doe* held, the statute and rules prohibiting the provision of these services to

[22] *See* Fla. Stat. § 456.52(1)(a); Fla. Admin. Code r. 64B8-9.019(2); Fla. Admin. Code r. 64B15-14.014(2).

minors are unconstitutional—the minor plaintiffs can receive the treatments, if only they can find a way to pay for them.

In sum, the minor plaintiffs have standing to challenge Florida's denial of Medicaid payment for puberty blockers, and all the plaintiffs have standing to challenge the denial of Medicaid payment for cross-sex hormones.

B. Surgery

The result is different for gender-affirming surgery. None of the plaintiffs are currently seeking surgery. The minor plaintiffs have never sought such surgery and are too young even to consider it. Each adult plaintiff has had a mastectomy, and neither seeks further surgery, at least at this time. No plaintiff faces an actual or imminent injury from the denial of Medicaid coverage for gender-affirming surgery.

This is so even though, when this action was filed, Mr. Rothstein was seeking a mastectomy. He had standing at that time to pursue the surgery claim. But he has since had the surgery, paid for through GoFundMe. Past exposure to illegal conduct, without more, does not give a plaintiff standing to pursue prospective relief against a repeat of the illegal conduct, absent a sufficient likelihood that the plaintiff will again be a victim of the illegal conduct. *See, e.g.*, *City of Los Angeles v. Lyons*, 461 U.S. 95, 102, 111 (1983) (holding that a person who had been subjected to a chokehold in the past had no standing to seek

injunctive relief against the city's practice of using chokeholds because there was not a "sufficient likelihood that he will again be wronged in a similar way"); *Malowney v. Fed. Collection Deposit Grp.*, 193 F.3d 1342, 1346 (11th Cir. 1999).

To be sure, Mr. Rothstein asserts a claim for nominal damages based in part on the denial of Medicaid coverage for the surgery he now has had. A nominal-damages claim can be sufficient to establish standing. *See Uzuegbunam v. Preczewski*, 141 S. Ct. 792 (2021). But the Eleventh Amendment bars retrospective relief under § 1983 that would be payable from the state treasury. *See, e.g.*, *Edelman v. Jordan*, 415 U.S. 651 (1974). This principle applies to nominal as well as actual damages. *See Simmons v. Conger*, 86 F.3d 1080, 1086 (11th Cir. 1996). The nominal-damages claim thus does not present a live controversy over Medicaid coverage of gender-affirming surgery.

The surgery claim cannot go forward on the merits.

VI. The Law of the Circuit: *Rush v. Parham*

In *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980), a Medicaid beneficiary challenged Georgia's refusal to pay for gender-affirming surgery. The state said the surgery was experimental and thus not medically necessary. The district court ruled that the surgery was necessary because the plaintiff's physician said so—that the state was bound by the physician's opinion. Not surprisingly, the Fifth Circuit disagreed.

The Fifth Circuit remanded the case to the district court to determine two things: first, whether Georgia had a policy prohibiting payment for experimental services when it first rejected the plaintiff's application; and second, if it did, "whether its determination that transsexual surgery is experimental is reasonable." *Id*. at 1157. The court said this second question—whether the state's determination "is" reasonable, would be controlled on remand by "current medical opinion, regardless of the prevailing knowledge at the time of plaintiff's application." *Id*. at 1157 n.13; *see also Moore*, 637 F.3d at 1259 (stating that Congress could have but did not give the state the role of "final arbiter" over medical necessity).

Rush is binding authority in the Eleventh Circuit. *See Bonner v. City of Prichard*, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc). The remand instructions were the Fifth Circuit's square holding. The case dealt only with surgery, not puberty blockers or cross-sex hormones, but the same principles apply. The decision thus sets out a roadmap for deciding the issue now before this court—the same roadmap the district court was required to follow in *Rush*.

The first issue *Rush* directed the district court to address on remand is easily answered here. The State of Florida prohibited Medicaid payment for experimental services when the plaintiffs submitted their applications. The second question thus is controlling: whether, based on current medical knowledge, the State's determination that these treatments are experimental is reasonable. It is not.

VII. The standards of care

Transgender individuals suffer higher rates of anxiety, depression, suicidal ideation, and suicide than the population at large.[23] 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.[24]

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.[25] I credit the abundant testimony in this record that these standards are widely followed by well-trained clinicians.[26] The standards are used

[23] Trial Tr., ECF No. 226 at 108.
[24] Pls.' Ex. 33, ECF No. 175-33 at 2–3; *see also* Trial Tr., ECF No. 226 at 25–26; Trial Tr., ECF No. 238 at 71.
[25] Defs.' Exs. 16 & 24, ECF Nos. 193-16 & 193-24.
[26] Trial Tr., ECF No. 226 at 31 (psychiatrist); *id.* at 198 (pediatric endocrinologist); Trial Tr., ECF No. 227 at 50–52 (surgeon); *id.* at 106, 112–14 (pediatrician, bioethicist, medical researcher); Trial Tr., ECF No. 228 at 15 (physician specializing in pediatrics and adolescent medicine).

by insurers[27] and have been endorsed by the United States Department of Health and Human Services.[28]

Under the standards, gender-dysphoria treatment begins with a comprehensive biopsychosocial assessment.[29] 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.[30]

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.[31] GnRH agonists are colloquially known as puberty blockers.

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

[27] Trial Tr., ECF No. 227 at 243–44.
[28] *See* Defs.' Ex. 2, ECF No. 193-2.
[29] *See* Trial Tr., ECF No. 226 at 42–43.
[30] Trial Tr., ECF No. 238 at 72 & 74–75; *see also* Trial Tr., ECF No. 228 at 14; Trial Tr., ECF No. 226 at 36 & 176.
[31] *See* Trial Tr., ECF No. 226 at 194–97; Trial Tr., ECF No. 228 at 27–28.

sex.[32] For patients treated with GnRH agonists, use of cross-sex hormones typically begins when use of GnRH agonists ends.[33] 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.[34] The most common example: mastectomy can remove a transgender male's breasts. Perhaps 98% of all such surgeries are performed on adults, not minors.[35]

VIII. 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 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

[32] Trial Tr., ECF No. 226 at 217–26, 228.
[33] *See* Trial Tr., ECF No. 228 at 87–90.
[34] *See* Trial Tr., ECF No. 227 at 42.
[35] *See id.* at 43.

more.[36] The record also includes statements from hundreds of professionals supporting this care.[37] 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.[38]

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.[39] 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.[40] So, too, gender dysphoria presents substantial health risks and ordinarily should be treated.[41] For some patients, GnRH agonists are an appropriate treatment, even

---

[36] *See* Pls.' Exs. 36–43, 45–48, ECF Nos. 175-36 through 176-8 (omitting ECF No. 176-4); *see also* Amicus Brief of American Academies and Health Organizations, ECF No. 192-1.
[37] *See* Amicus Brief of American Academies and Health Organizations, ECF No. 192-1; Bruggeman et al., *We 300 Florida health care professionals say the state gets transgender guidance wrong* (Apr. 27, 2022), ECF No. 11-1 at 11–32.
[38] *See* Trial Tr., ECF No. 226 at 183; *see also* Trial Tr., ECF No. 239 at 54–56.
[39] Trial Tr., ECF No. 226 at 183–84, 200–02.
[40] *Id.*
[41] *Id.*

though, just as with their use to treat central precocious puberty and other conditions, GnRH agonists have attendant risks.[42]

The 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.[43] The medications are an effective treatment for conditions that should be treated, even though the medications have attendant risks.[44] 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.[45] He would demand appropriate safeguards, as discussed below, but he would not ban the treatments.[46] These plaintiffs qualify for treatment under Dr. Levine's proposed safeguards.

---

[42] *Id.* at 201–16.
[43] *Id.* at 216.
[44] *Id.* at 218–29.
[45] Trial Tr., ECF No. 239 at 81–83.
[46] *Id.* at 91–94.

IX. 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 or to exclude them from the state's Medicaid coverage.

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

X. The plaintiffs' history and medical care

A. August Dekker

August Dekker is a Medicaid-eligible, 28-year-old transgender man.[47] He identified as male from a young age but suffered without disclosing the situation to his family or others. He repeatedly attempted suicide in high school.[48] He began cutting his hair short at age 18, began using a male name and pronouns at age 20, and came out to his family at age 22. He still experienced gender dysphoria. After eight months of therapy and evaluation by a multidisciplinary team, he began treatment with a cross-sex hormone, testosterone.[49] His mental health markedly improved.[50]

A romantic partner convinced him to discontinue testosterone. His mental health deteriorated. He resumed the treatment, and his mental health again improved.[51]

In 2022, with approval from his long-term treating psychiatrist, Mr. Dekker had a mastectomy at the University of Florida.[52] His mental health improved again.

---

[47] Trial Tr., ECF No. 228 at 142 & 145–46.
[48] *Id.* at 150.
[49] *Id.* at 154–55.
[50] *Id.* at 156–57.
[51] *Id.* at 159.
[52] *Id.* at 162. The defendants note that, after a single meeting, a mental-health intern wrote a letter supporting the surgery. Neither a single meeting nor an intern's opinion, standing alone, would support a decision to proceed with surgery.

Mr. Dekker believes that had he not received these treatments—cross-sex hormones and surgery—he would by now have died from suicide, substance abuse, or other self-destructive behavior.[53] Instead, he is thriving.

Medicaid paid for all his treatment, including the cross-sex hormones and surgery. But now, the challenged rule and statute, unless enjoined, will make it impossible for him to continue the hormone treatment, which is still medically necessary.

B. Brit Rothstein

Brit Rothstein is a Medicaid-eligible, 20-year-old transgender man. He is a full-time student at a major research university.[54] He began experiencing gender dysphoria as early as age 8 but did not begin to "put words to feelings" until about age 12.[55] He came out to his peers and family at age 13.

After extensive therapy and then evaluation by a pediatric endocrinologist at a major children's hospital, a recommendation was made for treatment with GnRH agonists and cross-sex hormones. Mr. Rothstein's mother objected. Mr. Rothstein's father obtained a court order giving him medical decisionmaking authority, and the

---

Here, though, the long-term treating psychiatrist recommended surgery, and the surgeon performed it. They were not interns. The surgery has been performed and is no longer at issue.

[53] *Id.* at 167.

[54] *Id.* at 113–15.

[55] *Id.* at 115.

treatments went forward.[56] Medicaid paid for the treatments. Mr. Rothstein's mental health improved.

Mr. Rothstein still bound his chest every day. He eventually consulted a surgeon at the University of Miami and decided to go forward with a mastectomy. The surgery was precleared for Medicaid payment, and a date was set.[57] But the challenged rule was adopted, Medicaid approval was withdrawn, and the surgery was canceled. While this lawsuit was pending, Mr. Rothstein obtained crowd funding through GoFundMe, and he had the surgery. He is very pleased with the results. He remains on cross-sex hormones, which are medically necessary.

C. Susan Doe

Susan Doe is a Medicaid-eligible 13-year-old transgender girl.[58] Her parents, John and Jane Doe, adopted her from medical foster care at age 2. Susan told her mother she was a girl at age 3, and she has consistently behaved that way. Her mother, who was previously unaware of transgender issues, attempted to react neutrally and sought professional advice on how best to care for Susan. Susan began seeing a therapist at age 6.[59] She has identified as a girl at school since second grade.[60]

---

[56] *Id.* at 122–23.
[57] *Id.* at 133–34.
[58] *Id.* at 94–96.
[59] *Id.* at 98.
[60] *Id.* at 100.

Susan began GnRH agonists three years ago at age 10.[61] She has had excellent results and is ready to begin hormone therapy. Her treatment has been paid for to this point by Medicaid, but that will stop unless the challenged rule and statute are enjoined.

D. K.F.

K.F. is a Medicaid-eligible 13-year-old transgender boy.[62] At age 7, he told his grandparents, and soon after his parents, that he was a boy.[63] This was consistent with how he had behaved.

K.F. received an extensive psychiatric evaluation followed by five years of therapy at Boston Children's Hospital.[64] He started on puberty blockers. He moved with his family to Florida and continued his treatment here. He had an appointment with a pediatric endocrinologist at the Johns Hopkins gender clinic in St. Petersburg to consider transition to cross-sex hormones, but the appointment was canceled when the State prohibited the treatment.[65]

He has achieved excellent results with his treatment to date. Medicaid paid for it, first in Massachusetts, then in Florida.

---

[61] *Id.* at 102.
[62] *Id.* at 174,176.
[63] *Id.* at 177.
[64] *See id.* at 184–91.
[65] *Id.* at 195–98.

E. Findings on appropriate treatment

I find, based on the record now before the court, that the plaintiffs have obtained appropriate medical care to this point, that qualified professionals have properly evaluated their medical conditions and needs in accordance with the well-established standards of care, and that the plaintiffs, in consultation with their treating professionals and, for the minors, their parents, have determined that the benefits of the treatment they seek—GnRH agonists or cross-sex hormones—will outweigh the risks. I find that the ability of the adult plaintiffs to evaluate the benefits and risks of the treatment far exceeds the ability of the State of Florida to do so. I find that the ability of the minor plaintiffs and their parents to evaluate the benefits and risks of the treatment far exceeds the ability of the State of Florida to do so. I find that the adult plaintiffs' motivation is their desire to achieve the best possible medical treatment for their gender dysphoria. I find that the minor plaintiffs' parents' motivation is love for their children. I find that the motivation of the minor plaintiffs and their parents is the desire to achieve the best possible medical treatment for the minor plaintiffs' gender dysphoria. This is not the State's motivation.

XI. Equal Protection

The ban on treating minors with puberty blockers 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 Florida statute banning these treatments. The decision is on point, well-reasoned, and should be followed. But as an Eighth Circuit decision, it is not binding.

District court opinions also are not binding. But they have consistently reached the same result. *See Brandt v. Rutledge*, No. 4:21-cv-450, 2023 WL 4073727 (E.D. Ark. June 20, 2023) (holding after an eight-day bench trial that a state law banning gender-affirming care was unconstitutional); *K.C. v. Individual Members of Med. Licensing Bd. of Ind.*, No. 1:23-cv-595, 2023 WL 4054086 (S.D. Ind. June 16, 2023) (granting preliminary injunction against Indiana statute banning puberty blockers and cross-sex hormones for minors); *Doe v. Ladapo*, No. 4:23-cv-114-RH-MAF, 2023 WL 3833848 (N.D. Fla. June 6, 2023) (granting preliminary injunction against Florida statute and rules banning puberty blockers and cross-sex hormones for minors); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131 (M.D. Ala. 2022) (granting preliminary injunction against Alabama statute banning puberty blockers and cross-sex hormones for minors).

Florida's denial of Medicaid coverage for GnRH agonists and cross-sex hormones also violates the Equal Protection Clause. Other district courts have reached this same result. *See Fain v. Crouch*, 618 F. Supp. 3d 313 (S.D. W. Va.

2022) (holding state Medicaid plan's exclusion of gender-affirming care violated the Medicaid Act, Affordable Care Act, and Equal Protection Clause); *Flack v. Wis. Dep't of Health Servs.*, 395 F. Supp. 3d 1001 (W.D. Wis. 2019) (holding state Medicaid plan's exclusion of gender-affirming care violated the Medicaid Act, Affordable Care Act, and Equal Protection Clause); *see also Kadel v. Folwell*, 620 F. Supp. 3d 339 (M.D.N.C. 2022) (holding state employee insurance plan's categorical exclusion of gender-affirming care violated the Equal Protection Clause, Affordable Care Act, and Title VII); *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018) (holding state employee insurance plan's exclusion of gender-affirming care violated Title VII, the Affordable Care Act, and the Equal Protection Clause).

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 rule and statute 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 Medicaid patient, perhaps age 16, that a physician wishes to treat with testosterone. Under the challenged rule and statute, is the treatment covered by Medicaid? To know the answer, one must know the adolescent's sex. If the adolescent is a natal male, the treatment is covered. If the

adolescent is a natal female, the treatment is not covered. 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 rule and statute 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 Medicaid-eligible child that a physician wishes to treat with GnRH agonists to delay the onset of puberty. Is the treatment covered? To know the answer, one must know whether the child is cisgender or transgender. The treatment is covered if the child is cisgender but not if the child is transgender, because the rule and statute exclude coverage of 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 (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 rule and statute 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).

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, and the treatments are covered by Medicaid. Not so for transgender individuals—the challenged rule and statute prohibit it. To know whether treatment with any of these medications is covered, one must know whether the patient is transgender. And to know whether treatment with testosterone or estrogen is covered, one must know the patient's natal sex.

The defendants also invoke *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022). There the Court rejected a due-process challenge to an abortion statute, but the Court also said that the statute did not deny equal protection: "The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretex[t] designed to effect an invidious discrimination against members of

one sex or the other.'" *Id*. at 2245–46 (quoting *Geduldig*, 417 U.S. at 496 n.20). The Court said abortion laws thus "are governed by the same standard of review as other health and safety measures." *Dobbs*, 142 S. Ct. at 2246.

The case at bar, in contrast, does not involve a medical treatment that only one sex can undergo, or that only cisgender or transgender patients can undergo. Instead, the case involves treatments that all individuals can undergo; the state has simply chosen to make the treatment legal for some and illegal for others, depending on sex or transgender status. The *Dobbs* statement about procedures only one sex can undergo is simply inapplicable—and would not help the defendants anyway, because this case involves invidious discrimination against transgenders.

In short, the challenged rule and statute impose differential treatment based on sex and transgender status. *Geduldig* and *Dobbs* are 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 rule and statute survive neither level of scrutiny.

The record establishes that for some minors, including Susan Doe and K.F., a treatment regimen of mental-health therapy followed by GnRH agonists and eventually by cross-sex hormones is the best available treatment. They and their parents, in consultation with their doctors and multidisciplinary teams, have rationally chosen this treatment. The State of Florida's decision to ban payment for GnRH agonists and cross-sex hormones for transgender individuals 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 defendants apparently acknowledge this.[66] But the State's disapproval of transgender status—of a person's gender identity when it does not match the person's natal sex—was a substantial motivating factor in enactment of the challenged rule and statute.

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.[67] Nothing could have motivated this remarkable intrusion into parental prerogatives other than opposition to transgender status itself.

---

[66] Trial Tr., ECF No. 242 at 97–98.
[67] Defs.' Ex. 5, ECF No. 193-5 at 1; *see also* Pls.' Ex. 19, ECF No. 175-19 at 2.

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 rule and statute 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.

XII. The pretextual justifications for the rule and statute

In support of their position, the defendants have proffered a laundry list of purported justifications for the rule and statute. 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.[68] A decision for the 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.

It is commonplace for medical treatments to be provided even when supported only by research producing evidence classified as "low" or "very low"

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

on this scale.[69] 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.[70] 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 or Medicaid payment is unavailable, many patients will suffer needlessly.[71] The extensive clinical evidence is important and indeed persuasive 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

---

[69] *See* Trial Tr., ECF No. 227 at 98–101.
[70] Trial Tr., ECF No. 226 at 68–69.
[71] Trial Tr., ECF No. 226 at 64; Trial Tr., ECF No. 238 at 97–98.

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 the effect on bone density; this calls for appropriate monitoring. 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 rule and statute ignore 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. Mr. Dekker attempted suicide four times before beginning successful treatment with cross-sex hormones; he is now thriving.[72]

If the plaintiffs do not continue appropriate treatments, the likelihood is very high that they will suffer attendant adverse mental-health consequences. If, on the other hand, they *do* continue appropriate treatments, they will avoid some of the adverse consequences. They also will face attendant risks.

[72] Trial Tr., ECF No. 228 at 150 & 166–67.

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. Florida's Medicaid program routinely covers treatments with greater risks than those involved here. What is remarkable about the challenged rule and statute 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 rule and statute make the same decision for everybody, without considering any patient's individual circumstances. The rule and statute 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 and to have Medicaid cover the cost.

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 rule 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."[73] 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 opposing viewpoints are slow to speak up, lest they be accused of bigotry. These dynamics could affect a medical association's consideration of transgender

---

[73] *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."

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. 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 or refuses to pay for them. *See also Brandt v. Rutledge*, No. 4:21-cv-450, 2023 WL 4073727, at *30 (E.D. Ark. June 20, 2023) (rejecting the apparently identical assertion that a ban on gender-affirming care for minors was consistent with "nations around the world" and finding the evidence showed no other identified nation took that position).

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.[74] 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 approved facilities—these plaintiffs would qualify, and this lawsuit would not be necessary.

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

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. AHCA is entitled to review any individual Medicaid claim and to pay only for medically necessary treatment. 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 Medicaid-covered 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 cover widely accepted medical treatment.[75] It does not call for the State to make a binary decision not to cover 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

[75] *See* Trial Tr., 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 or refuse to cover 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.[76] Florida Medicaid routinely covers such use.[77] The defendants' contrary implication is divorced from reality.

Obtaining FDA approval of a drug is a burdensome, expensive process.[78] 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.[79] 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.

---

[76] Trial Tr., ECF No. 227 at 121–23.
[77] *See* AHCA 30(b)(6) Dep., ECF No. 235-1 at 35, 53–56.
[78] Trial Tr., ECF No. 226 at 182–84; Trial Tr., ECF No. 227 at 120–23; Trial Tr., ECF No. 239 at 54–55.
[79] Trial Tr., ECF No. 226 at 182–84; Trial Tr., ECF No. 227 at 120–23.

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

XIII. Ruling on the claims

What remains is to match the findings of fact and conclusions of law as set out above to the specific claims asserted in the first amended complaint.

Count I asserts a claim against Mr. Weida under 42 U.S.C. § 1983 and the Fourteenth Amendment's Equal Protection Clause. The plaintiffs are entitled to prevail because the denial of Medicaid coverage for transgender patients for the same drugs covered for others survives neither intermediate nor rational-basis scrutiny.

Count II asserts a claim against AHCA under the Affordable Care Act's prohibition of discrimination based on sex, 42 U.S.C. § 18116. The plaintiffs are entitled to prevail on this claim, just as on the Equal Protection claim.

Count III asserts a § 1983 claim for Mr. Rothstein, Susan Doe, and K.F. against Mr. Weida based on the Medicaid Act's requirement for early and periodic screening, diagnostic, and treatment services for beneficiaries under age 21, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C),1396d(a)(4)(B), and 1396d(r)(5). The plaintiffs are entitled to prevail because the treatments at issue comport with the

standards of care for their medical conditions and there are no alternative, equally effective treatments.

Count IV asserts a § 1983 claim against Mr. Weida based on the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B)(i), under which assistance to an eligible individual cannot be less in "amount, duration, or scope" than assistance available to other Medicaid beneficiaries. The plaintiffs are entitled to prevail because cisgender Medicaid beneficiaries are covered for the same puberty blockers and hormones at issue. That cisgender patients receive the drugs for a different diagnosis does not make the different treatment permissible. Quite the contrary: federal law prohibits a state from denying or reducing a Medicaid-eligible patient's required services "solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c); *see also Rush*, 625 F.2d at 1156 n.12. Indeed, denying coverage for an illness suffered only or primarily by a disfavored group is the very paradigm of prohibited discrimination based on diagnosis.

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 rule and statute that prohibit

Medicaid payment for these treatments even when medically appropriate. The rule and statute violate the federal Medicaid statute, the Equal Protection Clause, and the Affordable Care Act's prohibition of sex discrimination.

These plaintiffs are Medicaid beneficiaries who are entitled to payment, as a matter of medical necessity, for puberty blockers or cross-sex hormones as appropriately determined by their multidisciplinary teams of providers.

IT IS ORDERED:

1. It is declared that Florida Statutes § 286.31(2) and Florida Administrative Code rule 59G-1.050(7) are invalid to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria.

2. The defendants Jason Weida, in his official capacity, and the Florida Agency for Health Care Administration (a) must approve Medicaid payment for services rendered from this date forward for the evaluation, diagnosis, and treatment of the plaintiffs August Dekker, Brit Rothstein, Susan Doe, and K.F. for gender dysphoria, including with puberty blockers and cross-sex hormones, as recommended by their multidisciplinary teams, and (b) must not take any steps to prevent the administration of cross-sex hormones to August Dekker or Brit Rothstein or to prevent the administration of puberty blockers or cross-sex hormones to Susan Doe or K.F. But this injunction does not preclude the

defendants from applying the professional standards that would apply to use of the same substances to treat patients with other medical conditions.

3. This 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.

4. The clerk must enter judgment and close the file.

5. Jurisdiction is retained to award costs and attorney's fees.

SO ORDERED on June 21, 2023.

s/Robert L. Hinkle
United States District Judge

Doc. 247

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

AUGUST DEKKER, legally known as KORI DEKKER; BRIT ROTHSTEIN; SUSAN DOE, a minor by and through her parents and next friends, JANE DOE and JOHN DOE, and K.F., a minor, by and through his parent and next friend, JADE LADUE,

Plaintiffs,

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

JASON WEIDA, in his official capacity as Secretary of the Florida Agency for Health Care Administration, and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

_____/

JUDGMENT

This matter was tried to the court. It is adjudged:

1. It is declared that Florida Statutes § 286.31(2) and Florida Administrative Code rule 59G-1.050(7) are invalid to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria.

2. The defendants Jason Weida, in his official capacity, and the Florida Agency for Health Care Administration (a) must approve Medicaid payment for services rendered from this date forward for the evaluation, diagnosis, and treatment of the plaintiffs August Dekker, Brit Rothstein, Susan Doe, and K.F. for gender dysphoria, including with puberty blockers and cross-sex hormones, as recommended by their multidisciplinary teams, and (b) must not take any steps to prevent the administration of cross-sex hormones to August Dekker or Brit Rothstein or to prevent the administration of puberty blockers or cross-sex hormones to Susan Doe or K.F. But this injunction does not preclude the defendants from applying the professional standards that would apply to use of the same substances to treat patients with other medical conditions.

3. This 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.

4. Jurisdiction is reserved to award costs and attorney's fees.

JESSICA J LYUBLANOVITS,
CLERK OF COURT

June 22, 2023
DATE

s/ *Ronnie Barker*
DEPUTY CLERK

Doc. 248

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

AUGUST DEKKER, legally known as KORI DEKKER; BRIT ROTHSTEIN; SUSAN DOE, a minor by and through her parents and next friends, JANE DOE and JOHN DOE, and K.F., a minor, by and through his parent and next friend, JADE LADUE,

Plaintiffs,

v.

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

JASON WEIDA, in his official capacity as Secretary of the Florida Agency for Health Care Administration, and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

_____/

DEFENDANTS' NOTICE OF APPEAL

Defendants, Secretary Weida and the Agency for Health Care Administration, appeal the final order and judgment following the bench trial, Docs. [246] and [247], entered on June 21, 2023, and June 22, 2023, respectively, to the U.S. Court of Appeals for the Eleventh Circuit.

Dated: June 26, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil (FBN 72556)
Gary V. Perko (FBN 855898)
Michael Beato (FBN 1017715)
mjazil@holtzmanvogel.com

gperko@holtzmanvogel.com
mbeato@holtzmanvogel.com
HOLTZMAN VOGEL BARAN
TORCHINSKY & JOSEFIAK PLLC
119 S. Monroe St., Suite 500
Tallahassee, FL 32301
(850) 270-5938

Counsel for Defendants

CERTIFICATE OF SERVICE

I certify that on June 26, 2023, I electronically filed the foregoing with the Clerk of Court by using CM/ECF, which automatically serves all counsel of record for the parties who have appeared.

/s/ Mohammad O. Jazil
Mohammad O. Jazil

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

AUGUST DEKKER et al.,

Plaintiffs,

v. CASE NO. 4:22cv325-RH-MAF

JASON WEIDA et al.,

Defendants.

_____/

FINDINGS OF FACT AND CONCLUSIONS OF LAW

For many years, Florida's Medicaid system paid for medically necessary treatments for gender dysphoria. Recently, for political reasons, Florida adopted a rule and then a statute prohibiting payment for some of the treatments: puberty blockers, cross-sex hormones, and surgeries. This case presents a challenge to the rule and statute. The controversy is live only for puberty blockers and cross-sex hormones; no plaintiff currently seeks surgery. This order sets out the court's findings of fact and conclusions of law following a bench trial.

I. Background: the parties and claims

The plaintiffs are two transgender adults, August Dekker and Brit Rothstein, and two transgender minors who are proceeding under pseudonyms, Susan Doe and K.F. The minors are suing through their parents, Jane and John Doe for Susan Doe and Jade Ladue for K.F. "Susan Doe" is the same pseudonym, but the plaintiff here is not the same person, as the plaintiff identified by that pseudonym in *Doe v. Ladapo*, No. 4:23cv114-RH-MAF (N.D. Fla. June 6, 2023).

The defendants are Jason Weida, in his official capacity as Secretary of the Florida Agency for Health Care Administration ("AHCA"), and AHCA itself.

In count I of the first amended complaint, all the plaintiffs assert a claim against Mr. Weida under 42 U.S.C. § 1983 and the Fourteenth Amendment's Equal Protection Clause. In count II, all the plaintiffs assert a claim against AHCA under the Affordable Care Act's prohibition of discrimination based on sex, 42 U.S.C. § 18116. In count III, the minor plaintiffs and Mr. Rothstein, who is over age 18 and thus an adult but under age 21, assert a claim against Mr. Weida under § 1983 and the Medicaid Act's requirement for early and periodic screening, diagnostic, and treatment services for beneficiaries under age 21, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5). In count IV, all plaintiffs assert a claim against Mr. Weida under § 1983 and the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B)(i), under which

assistance to an eligible individual cannot be less in "amount, duration, or scope" than assistance available to other Medicaid beneficiaries.

The order granting a preliminary injunction in *Doe* was based in large part on the record compiled in this case. The *Doe* parties had stipulated that this record would be considered there. Many of this order's findings and conclusions have been cut and pasted from the *Doe* order, with any appropriate modifications. Same record, same findings and conclusions.

II. 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.[1] 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.[2]

For less than 1%, the natal sex and gender identity are opposites: a natal male's gender identity is female, or vice versa.[3] This order refers to such a person who identifies as female as a transgender female and to such a person who

[1] Trial Tr., ECF No. 226 at 23–24; Trial Tr., ECF No. 238 at 72–73.
[2] Trial Tr., ECF No. 227 at 222.
[3] *Id.*; *see also* Trial Tr., ECF No. 226 at 23–24; Trial Tr., ECF No. 228 at 29–31.

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 defendants, speaking through their attorney, have admitted it. At least one defense expert also has admitted it.[4] 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.[5] In this litigation, the defendants have explicitly acknowledged that this view is wrong and that pushing individuals away from their transgender identity is not a legitimate state interest.[6]

Still, an unspoken suggestion running just below the surface in some of the proceedings that led to adoption of the rule and statute at issue—and just below the

[4] *See* Trial Tr., ECF No. 239 at 10–11, 31–32, 80–81.
[5] *See id.* at 129–31.
[6] Trial Tr., ECF No. 242 at 97–98.

surface in the testimony of some of the defense experts and AHCA consultants—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] An AHCA consultant, 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]

Any proponent of the challenged rule and statute 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.

---

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

[8] Trial Tr., 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., ECF No. 239 at 129–31.

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

III. Medicaid

Medicaid is a jointly funded federal-state program that provides medical care for patients of limited economic means. *See Garrido v. Dudek*, 731 F.3d 1152, 1153–54 (11th Cir. 2013); *see also Harris v. James*, 127 F.3d 993, 996 (11th Cir. 1997) (quoting *Silver v. Baggiano*, 804 F.2d 1211, 1215 (11th Cir. 1986)). Federal law makes some services mandatory but allows states to "place appropriate limits" based on "such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d); *see also Garrido*, 731 F.3d at 1154; *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1232–33 (11th Cir. 2011); *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980). States may "set reasonable standards" for "medical necessity." *Garrido*, 731 F.3d at 1154.

Exercising this authority, Florida has long limited Medicaid coverage to services that are "medically necessary." *See* Fla. Stat. § 409.905. Florida provides coverage for, among other things, "services and procedures" rendered "by, or under the personal supervision of," a licensed physician, when "medically necessary for the treatment of an injury, illness, or disease." Fla. Stat. § 409.905(9). This does not, however, extend to services that are "clinically unproven, experimental, or for purely cosmetic purposes." *Id.*

For Medicaid beneficiaries under age 21, Florida also covers "all services determined by [AHCA] to be medically necessary for the treatment, correction, or

amelioration of" any "physical and mental problems and conditions." *Id*. § 409.905(2). This provision does not explicitly exclude clinically unproven, experimental, or purely cosmetic services, but as both sides apparently agree, they are excluded here, just as in § 409.905(9). *See Moore*, 637 F.3d at 1234. This coverage tracks with 42 U.S.C. § 1396d(a)(4)(B) and (r), which require states to cover "early and periodic screening, diagnostic, and treatment services" for Medicaid beneficiaries under age 21. *See Moore*, 637 F.3d at 1233–35.

By rule, AHCA has said that to be "medically necessary," a treatment must be, among other things, "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational."[11] The rule says a drug is "experimental" or "investigational" in four circumstances.[12] The first is when any required approval has not been given by the Food and Drug Administration. The second is when the drug is undergoing phase I, II, or III clinical trials or is under study to determine safety or efficacy "as compared to the standard means of treatment or diagnosis." The third is when the consensus among experts is that further studies are needed to determine the drug's safety or efficacy. The fourth is when the drug is used for a purpose not approved

[11] Fla. Admin. Code r. 59G-1.01(2.83); Pls.' Ex. 22, ECF No. 175-22 at 8.
[12] Fla. Admin. Code r. 59G-1.01(2.46); Pls.' Ex. 22, ECF No. 175-22 at 5.

by the FDA, meaning the use is not listed in one of three compendia of off-label uses or supported by peer-reviewed literature. *Id.* r. 59G-1.01(2.46).[13]

IV. The challenged rule and statute

When AHCA considers Medicaid coverage for a type of medical treatment for the first time, it sometimes prepares a report on whether the treatment is consistent with generally accepted professional medical standards—a "GAPMS report."[14]

In 2016, AHCA prepared a GAPMS report on puberty blockers for transgender adolescents. The report concluded Medicaid payment should be available when appropriate based on an individualized assessment of medical necessity for the specific patient. The report noted that "the risks of not treating" an adolescent with puberty blockers "may be worse than" treatment.[15]

In 2017, AHCA staff prepared a GAPMS report, never formally adopted, on treatment of transgender individuals with cross-sex hormones. The report concluded the treatment was "consistent with generally accepted professional medical standards" and met the requirements for Medicaid coverage.[16]

---

[13] *Id.* at 5; *see also* AHCA 30(b)(6) Dep., ECF No. 235-1 at 53–55.
[14] *See* Pls.' Ex. 238, ECF No. 181-2; *see also* Trial Tr., ECF No. 227 at 165.
[15] Pls.' Ex. 240, ECF No. 181-4 at 9.
[16] Pls.' Ex. 243, ECF No. 181-7 at 1, 11.

Consistent with the 2016 and 2017 GAPMS reports, AHCA approved Medicaid payment for puberty blockers, including for Susan Doe and K.F., and cross-sex hormones, including for Mr. Dekker and Mr. Rothstein.[17]

In 2022, however, the Executive Office of the Governor directed AHCA to conduct a new analysis of Medicaid coverage of gender-affirming care.[18] AHCA's practice is to prepare a GAPMS report only when first considering a treatment, but here, apparently for the first time ever, AHCA elected to prepare another report for these already-approved treatments.[19] AHCA ordinarily prepares reports internally, without retaining consultants, but here, AHCA retained consultants.[20] AHCA retained only consultants known in advance for their staunch opposition to gender-affirming care.

The new GAPMS process was, from the outset, a biased effort to justify a predetermined outcome, not a fair analysis of the evidence.[21] The report concluded that gender-affirming medical care—puberty blockers, cross-sex hormones, and surgery—were not supported by generally accepted medical standards and were

[17] Trial Tr., ECF No. 228 at 106–08, 129, 161, 196–97.
[18] AHCA 30(b)(6) Dep., ECF No. 235-1 at 87.
[19] Trial Tr., ECF No. 227 at 171–74, 185–86; *see also* Pls.' Ex. 30, ECF No. 175-30.
[20] Trial Tr., ECF No. 227 at 178–79.
[21] The AHCA employee who drafted the report testified he did not know the preferred outcome. I do not credit the testimony.

instead experimental. The conclusion was not supported by the evidence and was contrary to generally accepted medical standards.

Based in part on the flawed GAPMS report, AHCA proposed a rule barring Medicaid payment for these procedures. AHCA conducted a well-choreographed public hearing that was an effort not to gather facts but to support the predetermined outcome. Afterward, AHCA adopted Florida Administrative Code rule 59G-1.050(7), barring Medicaid payment for gender-affirming puberty blockers, hormones, and surgery.

That was where things stood when the plaintiffs filed this action. Later, though, the Florida Legislature adopted Florida Statutes § 286.31(2). The statute prohibits expenditure of state funds—this includes Medicaid payments—for "sex reassignment prescriptions or procedures" as defined in Florida Statutes § 456.001(9). This includes "puberty blockers" to "stop or delay normal puberty," "hormones or hormone antagonists," and any "medical procedure, including a surgical procedure," "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)1–3. There are narrow exceptions, but they do not apply here.

The plaintiffs amended their complaint to challenge the statute as well as the rule. The plaintiffs in *Doe* challenged another part of the same legislation—a part that made providing these services to minors a crime and grounds for terminating a

healthcare practitioner's license. *See id.* § 456.52(1) & (5). This followed the adoption of rules by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine that prohibited 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. Standing

In *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992), the Supreme Court said the "irreducible constitutional minimum of standing contains three elements." First, the plaintiff "must have suffered an injury in fact—an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Id*. (internal quotation marks and citations omitted). Second, "there must be a causal connection between the injury and the conduct complained of—the injury has to be fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court." *Id*. (internal quotation marks, ellipses, and brackets omitted). Third, "it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Id*. (internal quotation marks omitted). A court must address standing even when not contested by the parties.

A. Puberty blockers and cross-sex hormones

The minor plaintiffs are currently treated with puberty blockers. They were on track to start cross-sex hormones soon. The adult plaintiffs are currently treated with cross-sex hormones.

The loss of Medicaid payment for the needed treatments is an injury in fact; it is concrete and particularized; and it is actual or imminent, not conjectural or hypothetical. The injury is traceable to the challenged rule and statute, either of which, standing alone, would require the plaintiffs to forgo or pay out-of-pocket for the needed treatment, or move out of Florida. The injury will be redressed by a favorable decision.

The plaintiffs thus have standing. This is so despite the statute and rules prohibiting physicians from providing these services to minors. First, the statute and rules do not apply to adults and thus do not affect the adult plaintiffs' standing. Second, at least as of now, Florida law allows minors to continue with treatments they are already receiving, so the statute and rules do not affect the minor plaintiffs' standing to challenge the ban on payment for puberty blockers.[22] Third, as *Doe* held, the statute and rules prohibiting the provision of these services to

[22] *See* Fla. Stat. § 456.52(1)(a); Fla. Admin. Code r. 64B8-9.019(2); Fla. Admin. Code r. 64B15-14.014(2).

minors are unconstitutional—the minor plaintiffs can receive the treatments, if only they can find a way to pay for them.

In sum, the minor plaintiffs have standing to challenge Florida's denial of Medicaid payment for puberty blockers, and all the plaintiffs have standing to challenge the denial of Medicaid payment for cross-sex hormones.

B. Surgery

The result is different for gender-affirming surgery. None of the plaintiffs are currently seeking surgery. The minor plaintiffs have never sought such surgery and are too young even to consider it. Each adult plaintiff has had a mastectomy, and neither seeks further surgery, at least at this time. No plaintiff faces an actual or imminent injury from the denial of Medicaid coverage for gender-affirming surgery.

This is so even though, when this action was filed, Mr. Rothstein was seeking a mastectomy. He had standing at that time to pursue the surgery claim. But he has since had the surgery, paid for through GoFundMe. Past exposure to illegal conduct, without more, does not give a plaintiff standing to pursue prospective relief against a repeat of the illegal conduct, absent a sufficient likelihood that the plaintiff will again be a victim of the illegal conduct. *See, e.g.*, *City of Los Angeles v. Lyons*, 461 U.S. 95, 102, 111 (1983) (holding that a person who had been subjected to a chokehold in the past had no standing to seek

injunctive relief against the city's practice of using chokeholds because there was not a "sufficient likelihood that he will again be wronged in a similar way"); *Malowney v. Fed. Collection Deposit Grp.*, 193 F.3d 1342, 1346 (11th Cir. 1999).

To be sure, Mr. Rothstein asserts a claim for nominal damages based in part on the denial of Medicaid coverage for the surgery he now has had. A nominal-damages claim can be sufficient to establish standing. *See Uzuegbunam v. Preczewski*, 141 S. Ct. 792 (2021). But the Eleventh Amendment bars retrospective relief under § 1983 that would be payable from the state treasury. *See, e.g.*, *Edelman v. Jordan*, 415 U.S. 651 (1974). This principle applies to nominal as well as actual damages. *See Simmons v. Conger*, 86 F.3d 1080, 1086 (11th Cir. 1996). The nominal-damages claim thus does not present a live controversy over Medicaid coverage of gender-affirming surgery.

The surgery claim cannot go forward on the merits.

VI. The Law of the Circuit: *Rush v. Parham*

In *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980), a Medicaid beneficiary challenged Georgia's refusal to pay for gender-affirming surgery. The state said the surgery was experimental and thus not medically necessary. The district court ruled that the surgery was necessary because the plaintiff's physician said so—that the state was bound by the physician's opinion. Not surprisingly, the Fifth Circuit disagreed.

The Fifth Circuit remanded the case to the district court to determine two things: first, whether Georgia had a policy prohibiting payment for experimental services when it first rejected the plaintiff's application; and second, if it did, "whether its determination that transsexual surgery is experimental is reasonable." *Id*. at 1157. The court said this second question—whether the state's determination "is" reasonable, would be controlled on remand by "current medical opinion, regardless of the prevailing knowledge at the time of plaintiff's application." *Id*. at 1157 n.13; *see also Moore*, 637 F.3d at 1259 (stating that Congress could have but did not give the state the role of "final arbiter" over medical necessity).

Rush is binding authority in the Eleventh Circuit. *See Bonner v. City of Prichard*, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc). The remand instructions were the Fifth Circuit's square holding. The case dealt only with surgery, not puberty blockers or cross-sex hormones, but the same principles apply. The decision thus sets out a roadmap for deciding the issue now before this court—the same roadmap the district court was required to follow in *Rush*.

The first issue *Rush* directed the district court to address on remand is easily answered here. The State of Florida prohibited Medicaid payment for experimental services when the plaintiffs submitted their applications. The second question thus is controlling: whether, based on current medical knowledge, the State's determination that these treatments are experimental is reasonable. It is not.

VII. The standards of care

Transgender individuals suffer higher rates of anxiety, depression, suicidal ideation, and suicide than the population at large.[23] 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.[24]

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.[25] I credit the abundant testimony in this record that these standards are widely followed by well-trained clinicians.[26] The standards are used

[23] Trial Tr., ECF No. 226 at 108.
[24] Pls.' Ex. 33, ECF No. 175-33 at 2–3; *see also* Trial Tr., ECF No. 226 at 25–26; Trial Tr., ECF No. 238 at 71.
[25] Defs.' Exs. 16 & 24, ECF Nos. 193-16 & 193-24.
[26] Trial Tr., ECF No. 226 at 31 (psychiatrist); *id.* at 198 (pediatric endocrinologist); Trial Tr., ECF No. 227 at 50–52 (surgeon); *id.* at 106, 112–14 (pediatrician, bioethicist, medical researcher); Trial Tr., ECF No. 228 at 15 (physician specializing in pediatrics and adolescent medicine).

by insurers[27] and have been endorsed by the United States Department of Health and Human Services.[28]

Under the standards, gender-dysphoria treatment begins with a comprehensive biopsychosocial assessment.[29] 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.[30]

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.[31] GnRH agonists are colloquially known as puberty blockers.

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

[27] Trial Tr., ECF No. 227 at 243–44.
[28] *See* Defs.' Ex. 2, ECF No. 193-2.
[29] *See* Trial Tr., ECF No. 226 at 42–43.
[30] Trial Tr., ECF No. 238 at 72 & 74–75; *see also* Trial Tr., ECF No. 228 at 14; Trial Tr., ECF No. 226 at 36 & 176.
[31] *See* Trial Tr., ECF No. 226 at 194–97; Trial Tr., ECF No. 228 at 27–28.

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil

No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME XIII OF XXI

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

Counsel for Defendants-Appellants

INDEX TO APPENDIX

Volume	Tab	Title
1	Dkt	Docket Sheet
1	Doc.1	Complaint
1-3	Doc.11	Motion for Preliminary Injunction
3-4	Doc.49	Redacted Defendants' Response in Opposition to Motion for Preliminary Injunction
4-7	Doc 49-1	Redacted Appendix to Defendants' Response in Opposition to Motion for Preliminary Injunction
7-8	Doc.58	Reply to Defendants' Response in Opposition to Motion for Preliminary Injunction
8	Doc.60	Notice of Scrivener's Error and Filing of Supplemental Declaration to Correct Error re: Motion for Preliminary Injunction
8	Doc.64	Order Denying Preliminary Injunction
8	Doc.65	Answer to Complaint
8	Doc.108	Preliminary Injunction Motion Hearing Transcript
8	Doc.118	Order Allowing Mr. Weida's Deposition
8-9	Doc.120	Motion for Summary Judgment
9	Doc.120-27	Attachment to Motion for Summary Judgment: Dr. Edmiston Expert Report
9	Doc.120-36	Attachment to Motion for Summary Judgment: Dr. Edmiston Deposition
9	Doc.233	Amended Complaint
9-12	Doc.235	Plaintiffs' Deposition Designations
12	Doc.246	Final Order
12	Doc.247	Clerk's Judgment
12-13	Doc.248	Notice of Appeal
13-14	Doc.221	Trial Transcript, Day One
14-15	Doc.224	Trial Transcript, Day Two
15-16	Doc.225	Trial Transcript, Day Three
16-17	Doc.229	Trial Transcript, Day Four
17	Doc.232	Trial Transcript, Day Five
17-18	Doc.234	Trial Transcript, Day Six
18	Doc.241	Trial Transcript, Day Seven
18	Doc.193-1, DX1	U.S. Health and Human Services Notice and Guidance on Care

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Gary Perko
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 Appellants-Defendants

sex.[32] For patients treated with GnRH agonists, use of cross-sex hormones typically begins when use of GnRH agonists ends.[33] 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.[34] The most common example: mastectomy can remove a transgender male's breasts. Perhaps 98% of all such surgeries are performed on adults, not minors.[35]

VIII. 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 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

[32] Trial Tr., ECF No. 226 at 217–26, 228.
[33] *See* Trial Tr., ECF No. 228 at 87–90.
[34] *See* Trial Tr., ECF No. 227 at 42.
[35] *See id.* at 43.

more.[36] The record also includes statements from hundreds of professionals supporting this care.[37] 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.[38]

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.[39] 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.[40] So, too, gender dysphoria presents substantial health risks and ordinarily should be treated.[41] For some patients, GnRH agonists are an appropriate treatment, even

---

[36] *See* Pls.' Exs. 36–43, 45–48, ECF Nos. 175-36 through 176-8 (omitting ECF No. 176-4); *see also* Amicus Brief of American Academies and Health Organizations, ECF No. 192-1.
[37] *See* Amicus Brief of American Academies and Health Organizations, ECF No. 192-1; Bruggeman et al., *We 300 Florida health care professionals say the state gets transgender guidance wrong* (Apr. 27, 2022), ECF No. 11-1 at 11–32.
[38] *See* Trial Tr., ECF No. 226 at 183; *see also* Trial Tr., ECF No. 239 at 54–56.
[39] Trial Tr., ECF No. 226 at 183–84, 200–02.
[40] *Id.*
[41] *Id.*

though, just as with their use to treat central precocious puberty and other conditions, GnRH agonists have attendant risks.[42]

The 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.[43] The medications are an effective treatment for conditions that should be treated, even though the medications have attendant risks.[44] 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.[45] He would demand appropriate safeguards, as discussed below, but he would not ban the treatments.[46] These plaintiffs qualify for treatment under Dr. Levine's proposed safeguards.

---

[42] *Id.* at 201–16.
[43] *Id.* at 216.
[44] *Id.* at 218–29.
[45] Trial Tr., ECF No. 239 at 81–83.
[46] *Id.* at 91–94.

IX. 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 or to exclude them from the state's Medicaid coverage.

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

X. The plaintiffs' history and medical care

A. August Dekker

August Dekker is a Medicaid-eligible, 28-year-old transgender man.[47] He identified as male from a young age but suffered without disclosing the situation to his family or others. He repeatedly attempted suicide in high school.[48] He began cutting his hair short at age 18, began using a male name and pronouns at age 20, and came out to his family at age 22. He still experienced gender dysphoria. After eight months of therapy and evaluation by a multidisciplinary team, he began treatment with a cross-sex hormone, testosterone.[49] His mental health markedly improved.[50]

A romantic partner convinced him to discontinue testosterone. His mental health deteriorated. He resumed the treatment, and his mental health again improved.[51]

In 2022, with approval from his long-term treating psychiatrist, Mr. Dekker had a mastectomy at the University of Florida.[52] His mental health improved again.

---

[47] Trial Tr., ECF No. 228 at 142 & 145–46.
[48] *Id.* at 150.
[49] *Id.* at 154–55.
[50] *Id.* at 156–57.
[51] *Id.* at 159.
[52] *Id.* at 162. The defendants note that, after a single meeting, a mental-health intern wrote a letter supporting the surgery. Neither a single meeting nor an intern's opinion, standing alone, would support a decision to proceed with surgery.

Mr. Dekker believes that had he not received these treatments—cross-sex hormones and surgery—he would by now have died from suicide, substance abuse, or other self-destructive behavior.[53] Instead, he is thriving.

Medicaid paid for all his treatment, including the cross-sex hormones and surgery. But now, the challenged rule and statute, unless enjoined, will make it impossible for him to continue the hormone treatment, which is still medically necessary.

B. Brit Rothstein

Brit Rothstein is a Medicaid-eligible, 20-year-old transgender man. He is a full-time student at a major research university.[54] He began experiencing gender dysphoria as early as age 8 but did not begin to "put words to feelings" until about age 12.[55] He came out to his peers and family at age 13.

After extensive therapy and then evaluation by a pediatric endocrinologist at a major children's hospital, a recommendation was made for treatment with GnRH agonists and cross-sex hormones. Mr. Rothstein's mother objected. Mr. Rothstein's father obtained a court order giving him medical decisionmaking authority, and the

---

Here, though, the long-term treating psychiatrist recommended surgery, and the surgeon performed it. They were not interns. The surgery has been performed and is no longer at issue.

[53] *Id.* at 167.

[54] *Id.* at 113–15.

[55] *Id.* at 115.

treatments went forward.[56] Medicaid paid for the treatments. Mr. Rothstein's mental health improved.

Mr. Rothstein still bound his chest every day. He eventually consulted a surgeon at the University of Miami and decided to go forward with a mastectomy. The surgery was precleared for Medicaid payment, and a date was set.[57] But the challenged rule was adopted, Medicaid approval was withdrawn, and the surgery was canceled. While this lawsuit was pending, Mr. Rothstein obtained crowd funding through GoFundMe, and he had the surgery. He is very pleased with the results. He remains on cross-sex hormones, which are medically necessary.

C. Susan Doe

Susan Doe is a Medicaid-eligible 13-year-old transgender girl.[58] Her parents, John and Jane Doe, adopted her from medical foster care at age 2. Susan told her mother she was a girl at age 3, and she has consistently behaved that way. Her mother, who was previously unaware of transgender issues, attempted to react neutrally and sought professional advice on how best to care for Susan. Susan began seeing a therapist at age 6.[59] She has identified as a girl at school since second grade.[60]

---

[56] *Id.* at 122–23.
[57] *Id.* at 133–34.
[58] *Id.* at 94–96.
[59] *Id.* at 98.
[60] *Id.* at 100.

Susan began GnRH agonists three years ago at age 10.[61] She has had excellent results and is ready to begin hormone therapy. Her treatment has been paid for to this point by Medicaid, but that will stop unless the challenged rule and statute are enjoined.

D. K.F.

K.F. is a Medicaid-eligible 13-year-old transgender boy.[62] At age 7, he told his grandparents, and soon after his parents, that he was a boy.[63] This was consistent with how he had behaved.

K.F. received an extensive psychiatric evaluation followed by five years of therapy at Boston Children's Hospital.[64] He started on puberty blockers. He moved with his family to Florida and continued his treatment here. He had an appointment with a pediatric endocrinologist at the Johns Hopkins gender clinic in St. Petersburg to consider transition to cross-sex hormones, but the appointment was canceled when the State prohibited the treatment.[65]

He has achieved excellent results with his treatment to date. Medicaid paid for it, first in Massachusetts, then in Florida.

---

[61] *Id.* at 102.
[62] *Id.* at 174,176.
[63] *Id.* at 177.
[64] *See id.* at 184–91.
[65] *Id.* at 195–98.

E. Findings on appropriate treatment

I find, based on the record now before the court, that the plaintiffs have obtained appropriate medical care to this point, that qualified professionals have properly evaluated their medical conditions and needs in accordance with the well-established standards of care, and that the plaintiffs, in consultation with their treating professionals and, for the minors, their parents, have determined that the benefits of the treatment they seek—GnRH agonists or cross-sex hormones—will outweigh the risks. I find that the ability of the adult plaintiffs to evaluate the benefits and risks of the treatment far exceeds the ability of the State of Florida to do so. I find that the ability of the minor plaintiffs and their parents to evaluate the benefits and risks of the treatment far exceeds the ability of the State of Florida to do so. I find that the adult plaintiffs' motivation is their desire to achieve the best possible medical treatment for their gender dysphoria. I find that the minor plaintiffs' parents' motivation is love for their children. I find that the motivation of the minor plaintiffs and their parents is the desire to achieve the best possible medical treatment for the minor plaintiffs' gender dysphoria. This is not the State's motivation.

XI. Equal Protection

The ban on treating minors with puberty blockers 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 Florida statute banning these treatments. The decision is on point, well-reasoned, and should be followed. But as an Eighth Circuit decision, it is not binding.

District court opinions also are not binding. But they have consistently reached the same result. *See Brandt v. Rutledge*, No. 4:21-cv-450, 2023 WL 4073727 (E.D. Ark. June 20, 2023) (holding after an eight-day bench trial that a state law banning gender-affirming care was unconstitutional); *K.C. v. Individual Members of Med. Licensing Bd. of Ind.*, No. 1:23-cv-595, 2023 WL 4054086 (S.D. Ind. June 16, 2023) (granting preliminary injunction against Indiana statute banning puberty blockers and cross-sex hormones for minors); *Doe v. Ladapo*, No. 4:23-cv-114-RH-MAF, 2023 WL 3833848 (N.D. Fla. June 6, 2023) (granting preliminary injunction against Florida statute and rules banning puberty blockers and cross-sex hormones for minors); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131 (M.D. Ala. 2022) (granting preliminary injunction against Alabama statute banning puberty blockers and cross-sex hormones for minors).

Florida's denial of Medicaid coverage for GnRH agonists and cross-sex hormones also violates the Equal Protection Clause. Other district courts have reached this same result. *See Fain v. Crouch*, 618 F. Supp. 3d 313 (S.D. W. Va.

2022) (holding state Medicaid plan's exclusion of gender-affirming care violated the Medicaid Act, Affordable Care Act, and Equal Protection Clause); *Flack v. Wis. Dep't of Health Servs.*, 395 F. Supp. 3d 1001 (W.D. Wis. 2019) (holding state Medicaid plan's exclusion of gender-affirming care violated the Medicaid Act, Affordable Care Act, and Equal Protection Clause); *see also Kadel v. Folwell*, 620 F. Supp. 3d 339 (M.D.N.C. 2022) (holding state employee insurance plan's categorical exclusion of gender-affirming care violated the Equal Protection Clause, Affordable Care Act, and Title VII); *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018) (holding state employee insurance plan's exclusion of gender-affirming care violated Title VII, the Affordable Care Act, and the Equal Protection Clause).

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 rule and statute 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 Medicaid patient, perhaps age 16, that a physician wishes to treat with testosterone. Under the challenged rule and statute, is the treatment covered by Medicaid? To know the answer, one must know the adolescent's sex. If the adolescent is a natal male, the treatment is covered. If the

adolescent is a natal female, the treatment is not covered. 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 rule and statute 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 Medicaid-eligible child that a physician wishes to treat with GnRH agonists to delay the onset of puberty. Is the treatment covered? To know the answer, one must know whether the child is cisgender or transgender. The treatment is covered if the child is cisgender but not if the child is transgender, because the rule and statute exclude coverage of 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 (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 rule and statute 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).

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, and the treatments are covered by Medicaid. Not so for transgender individuals—the challenged rule and statute prohibit it. To know whether treatment with any of these medications is covered, one must know whether the patient is transgender. And to know whether treatment with testosterone or estrogen is covered, one must know the patient's natal sex.

The defendants also invoke *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022). There the Court rejected a due-process challenge to an abortion statute, but the Court also said that the statute did not deny equal protection: "The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretex[t] designed to effect an invidious discrimination against members of

one sex or the other.'" *Id*. at 2245–46 (quoting *Geduldig*, 417 U.S. at 496 n.20). The Court said abortion laws thus "are governed by the same standard of review as other health and safety measures." *Dobbs*, 142 S. Ct. at 2246.

The case at bar, in contrast, does not involve a medical treatment that only one sex can undergo, or that only cisgender or transgender patients can undergo. Instead, the case involves treatments that all individuals can undergo; the state has simply chosen to make the treatment legal for some and illegal for others, depending on sex or transgender status. The *Dobbs* statement about procedures only one sex can undergo is simply inapplicable—and would not help the defendants anyway, because this case involves invidious discrimination against transgenders.

In short, the challenged rule and statute impose differential treatment based on sex and transgender status. *Geduldig* and *Dobbs* are 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 rule and statute survive neither level of scrutiny.

The record establishes that for some minors, including Susan Doe and K.F., a treatment regimen of mental-health therapy followed by GnRH agonists and eventually by cross-sex hormones is the best available treatment. They and their parents, in consultation with their doctors and multidisciplinary teams, have rationally chosen this treatment. The State of Florida's decision to ban payment for GnRH agonists and cross-sex hormones for transgender individuals 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 defendants apparently acknowledge this.[66] But the State's disapproval of transgender status—of a person's gender identity when it does not match the person's natal sex—was a substantial motivating factor in enactment of the challenged rule and statute.

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.[67] Nothing could have motivated this remarkable intrusion into parental prerogatives other than opposition to transgender status itself.

---

[66] Trial Tr., ECF No. 242 at 97–98.

[67] Defs.' Ex. 5, ECF No. 193-5 at 1; *see also* Pls.' Ex. 19, ECF No. 175-19 at 2.

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 rule and statute 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.

XII. The pretextual justifications for the rule and statute

In support of their position, the defendants have proffered a laundry list of purported justifications for the rule and statute. 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.[68] A decision for the 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.

It is commonplace for medical treatments to be provided even when supported only by research producing evidence classified as "low" or "very low"

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

on this scale.[69] 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.[70] 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 or Medicaid payment is unavailable, many patients will suffer needlessly.[71] The extensive clinical evidence is important and indeed persuasive 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

---

[69] *See* Trial Tr., ECF No. 227 at 98–101.
[70] Trial Tr., ECF No. 226 at 68–69.
[71] Trial Tr., ECF No. 226 at 64; Trial Tr., ECF No. 238 at 97–98.

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 the effect on bone density; this calls for appropriate monitoring. 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 rule and statute ignore 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. Mr. Dekker attempted suicide four times before beginning successful treatment with cross-sex hormones; he is now thriving.[72]

If the plaintiffs do not continue appropriate treatments, the likelihood is very high that they will suffer attendant adverse mental-health consequences. If, on the other hand, they *do* continue appropriate treatments, they will avoid some of the adverse consequences. They also will face attendant risks.

[72] Trial Tr., ECF No. 228 at 150 & 166–67.

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. Florida's Medicaid program routinely covers treatments with greater risks than those involved here. What is remarkable about the challenged rule and statute 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 rule and statute make the same decision for everybody, without considering any patient's individual circumstances. The rule and statute 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 and to have Medicaid cover the cost.

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 rule 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."[73] 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 opposing viewpoints are slow to speak up, lest they be accused of bigotry. These dynamics could affect a medical association's consideration of transgender

---

[73] *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."

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. 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 or refuses to pay for them. *See also Brandt v. Rutledge*, No. 4:21-cv-450, 2023 WL 4073727, at *30 (E.D. Ark. June 20, 2023) (rejecting the apparently identical assertion that a ban on gender-affirming care for minors was consistent with "nations around the world" and finding the evidence showed no other identified nation took that position).

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.[74] 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 approved facilities—these plaintiffs would qualify, and this lawsuit would not be necessary.

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

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. AHCA is entitled to review any individual Medicaid claim and to pay only for medically necessary treatment. 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 Medicaid-covered 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 cover widely accepted medical treatment.[75] It does not call for the State to make a binary decision not to cover 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

[75] *See* Trial Tr., 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 or refuse to cover 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.[76] Florida Medicaid routinely covers such use.[77] The defendants' contrary implication is divorced from reality.

Obtaining FDA approval of a drug is a burdensome, expensive process.[78] 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.[79] 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.

---

[76] Trial Tr., ECF No. 227 at 121–23.
[77] *See* AHCA 30(b)(6) Dep., ECF No. 235-1 at 35, 53–56.
[78] Trial Tr., ECF No. 226 at 182–84; Trial Tr., ECF No. 227 at 120–23; Trial Tr., ECF No. 239 at 54–55.
[79] Trial Tr., ECF No. 226 at 182–84; Trial Tr., ECF No. 227 at 120–23.

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

XIII. Ruling on the claims

What remains is to match the findings of fact and conclusions of law as set out above to the specific claims asserted in the first amended complaint.

Count I asserts a claim against Mr. Weida under 42 U.S.C. § 1983 and the Fourteenth Amendment's Equal Protection Clause. The plaintiffs are entitled to prevail because the denial of Medicaid coverage for transgender patients for the same drugs covered for others survives neither intermediate nor rational-basis scrutiny.

Count II asserts a claim against AHCA under the Affordable Care Act's prohibition of discrimination based on sex, 42 U.S.C. § 18116. The plaintiffs are entitled to prevail on this claim, just as on the Equal Protection claim.

Count III asserts a § 1983 claim for Mr. Rothstein, Susan Doe, and K.F. against Mr. Weida based on the Medicaid Act's requirement for early and periodic screening, diagnostic, and treatment services for beneficiaries under age 21, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C),1396d(a)(4)(B), and 1396d(r)(5). The plaintiffs are entitled to prevail because the treatments at issue comport with the

standards of care for their medical conditions and there are no alternative, equally effective treatments.

Count IV asserts a § 1983 claim against Mr. Weida based on the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B)(i), under which assistance to an eligible individual cannot be less in "amount, duration, or scope" than assistance available to other Medicaid beneficiaries. The plaintiffs are entitled to prevail because cisgender Medicaid beneficiaries are covered for the same puberty blockers and hormones at issue. That cisgender patients receive the drugs for a different diagnosis does not make the different treatment permissible. Quite the contrary: federal law prohibits a state from denying or reducing a Medicaid-eligible patient's required services "solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c); *see also Rush*, 625 F.2d at 1156 n.12. Indeed, denying coverage for an illness suffered only or primarily by a disfavored group is the very paradigm of prohibited discrimination based on diagnosis.

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 rule and statute that prohibit

Medicaid payment for these treatments even when medically appropriate. The rule and statute violate the federal Medicaid statute, the Equal Protection Clause, and the Affordable Care Act's prohibition of sex discrimination.

These plaintiffs are Medicaid beneficiaries who are entitled to payment, as a matter of medical necessity, for puberty blockers or cross-sex hormones as appropriately determined by their multidisciplinary teams of providers.

IT IS ORDERED:

1. It is declared that Florida Statutes § 286.31(2) and Florida Administrative Code rule 59G-1.050(7) are invalid to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria.

2. The defendants Jason Weida, in his official capacity, and the Florida Agency for Health Care Administration (a) must approve Medicaid payment for services rendered from this date forward for the evaluation, diagnosis, and treatment of the plaintiffs August Dekker, Brit Rothstein, Susan Doe, and K.F. for gender dysphoria, including with puberty blockers and cross-sex hormones, as recommended by their multidisciplinary teams, and (b) must not take any steps to prevent the administration of cross-sex hormones to August Dekker or Brit Rothstein or to prevent the administration of puberty blockers or cross-sex hormones to Susan Doe or K.F. But this injunction does not preclude the

defendants from applying the professional standards that would apply to use of the same substances to treat patients with other medical conditions.

3. This 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.

4. The clerk must enter judgment and close the file.

5. Jurisdiction is retained to award costs and attorney's fees.

SO ORDERED on June 21, 2023.

s/Robert L. Hinkle
United States District Judge

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

AUGUST DEKKER, legally known as KORI DEKKER; BRIT ROTHSTEIN; SUSAN DOE, a minor by and through her parents and next friends, JANE DOE and JOHN DOE, and K.F., a minor, by and through his parent and next friend, JADE LADUE,

Plaintiffs,

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

JASON WEIDA, in his official capacity as Secretary of the Florida Agency for Health Care Administration, and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

_____/

JUDGMENT

This matter was tried to the court. It is adjudged:

1. It is declared that Florida Statutes § 286.31(2) and Florida Administrative Code rule 59G-1.050(7) are invalid to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria.

2. The defendants Jason Weida, in his official capacity, and the Florida Agency for Health Care Administration (a) must approve Medicaid payment for services rendered from this date forward for the evaluation, diagnosis, and treatment of the plaintiffs August Dekker, Brit Rothstein, Susan Doe, and K.F. for gender dysphoria, including with puberty blockers and cross-sex hormones, as recommended by their multidisciplinary teams, and (b) must not take any steps to prevent the administration of cross-sex hormones to August Dekker or Brit Rothstein or to prevent the administration of puberty blockers or cross-sex hormones to Susan Doe or K.F. But this injunction does not preclude the defendants from applying the professional standards that would apply to use of the same substances to treat patients with other medical conditions.

3. This 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.

4. Jurisdiction is reserved to award costs and attorney's fees.

JESSICA J LYUBLANOVITS,
CLERK OF COURT

June 22, 2023
DATE

s/ *Ronnie Barker*
DEPUTY CLERK

Doc. 221

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?

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

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil

No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME XIV OF XXI

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

Counsel for Defendants-Appellants

INDEX TO APPENDIX

Volume	Tab	Title
1	Dkt	Docket Sheet
1	Doc.1	Complaint
1-3	Doc.11	Motion for Preliminary Injunction
3-4	Doc.49	Redacted Defendants' Response in Opposition to Motion for Preliminary Injunction
4-7	Doc 49-1	Redacted Appendix to Defendants' Response in Opposition to Motion for Preliminary Injunction
7-8	Doc.58	Reply to Defendants' Response in Opposition to Motion for Preliminary Injunction
8	Doc.60	Notice of Scrivener's Error and Filing of Supplemental Declaration to Correct Error re: Motion for Preliminary Injunction
8	Doc.64	Order Denying Preliminary Injunction
8	Doc.65	Answer to Complaint
8	Doc.108	Preliminary Injunction Motion Hearing Transcript
8	Doc.118	Order Allowing Mr. Weida's Deposition
8-9	Doc.120	Motion for Summary Judgment
9	Doc.120-27	Attachment to Motion for Summary Judgment: Dr. Edmiston Expert Report
9	Doc.120-36	Attachment to Motion for Summary Judgment: Dr. Edmiston Deposition
9	Doc.233	Amended Complaint
9-12	Doc.235	Plaintiffs' Deposition Designations
12	Doc.246	Final Order
12	Doc.247	Clerk's Judgment
12-13	Doc.248	Notice of Appeal
13-14	Doc.221	Trial Transcript, Day One
14-15	Doc.224	Trial Transcript, Day Two
15-16	Doc.225	Trial Transcript, Day Three
16-17	Doc.229	Trial Transcript, Day Four
17	Doc.232	Trial Transcript, Day Five
17-18	Doc.234	Trial Transcript, Day Six
18	Doc.241	Trial Transcript, Day Seven
18	Doc.193-1, DX1	U.S. Health and Human Services Notice and Guidance on Care

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Gary Perko
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 Appellants-Defendants

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

OTHER RECORD MADE	PAGE
Opening Statements By Mr. Gonzalez-Pagan	4
Opening Statements By Mr. Jazil	14

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

DR. DAN HALABAN KARASIC
Direct Examination By Ms. DeBriere 18
Cross-Examination By Mr. Jazil 95
Redirect Examination By Ms. DeBriere 152

Dr. DANIEL SHUMER
Direct Examination By Ms. Coursolle 174

Doc. 224

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.

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

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil

No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME XV OF XXI

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

Counsel for Defendants-Appellants

INDEX TO APPENDIX

Volume	Tab	Title
1	Dkt	Docket Sheet
1	Doc.1	Complaint
1-3	Doc.11	Motion for Preliminary Injunction
3-4	Doc.49	Redacted Defendants' Response in Opposition to Motion for Preliminary Injunction
4-7	Doc 49-1	Redacted Appendix to Defendants' Response in Opposition to Motion for Preliminary Injunction
7-8	Doc.58	Reply to Defendants' Response in Opposition to Motion for Preliminary Injunction
8	Doc.60	Notice of Scrivener's Error and Filing of Supplemental Declaration to Correct Error re: Motion for Preliminary Injunction
8	Doc.64	Order Denying Preliminary Injunction
8	Doc.65	Answer to Complaint
8	Doc.108	Preliminary Injunction Motion Hearing Transcript
8	Doc.118	Order Allowing Mr. Weida's Deposition
8-9	Doc.120	Motion for Summary Judgment
9	Doc.120-27	Attachment to Motion for Summary Judgment: Dr. Edmiston Expert Report
9	Doc.120-36	Attachment to Motion for Summary Judgment: Dr. Edmiston Deposition
9	Doc.233	Amended Complaint
9-12	Doc.235	Plaintiffs' Deposition Designations
12	Doc.246	Final Order
12	Doc.247	Clerk's Judgment
12-13	Doc.248	Notice of Appeal
13-14	Doc.221	Trial Transcript, Day One
14-15	Doc.224	Trial Transcript, Day Two
15-16	Doc.225	Trial Transcript, Day Three
16-17	Doc.229	Trial Transcript, Day Four
17	Doc.232	Trial Transcript, Day Five
17-18	Doc.234	Trial Transcript, Day Six
18	Doc.241	Trial Transcript, Day Seven
18	Doc.193-1, DX1	U.S. Health and Human Services Notice and Guidance on Care

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Gary Perko
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 Appellants-Defendants

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

PLAINTIFFS' WITNESSES	PAGE
DR. DANIEL SHUMER	
Cross-Examination By Mr. Jazil	256
Redirect Examination By Ms. Coursolle	278
Further Examination By Mr. Jazil	290
DR. LOREN SCHECHTER	
Direct Examination By Ms. McKee	291
Cross-Examination By Mr. Perko	315
Redirect Examination By Ms. McKee	322
DR. ARMAND ANTOMMARIA	
Direct Examination By Mr. Charles	325
Cross-Examination By Mr. Perko	395
JEFFREY ENGLISH	
Direct Examination By Ms. Altman	410
Cross-Examination By Mr. Perko	451
Redirect Examination By Ms. Altman	457
DR KELLAN BAKER	
Direct Examination By Ms. Dunn	461

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

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.

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

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil

No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME XVI OF XXI

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

Counsel for Defendants-Appellants

INDEX TO APPENDIX

Volume	Tab	Title
1	Dkt	Docket Sheet
1	Doc.1	Complaint
1-3	Doc.11	Motion for Preliminary Injunction
3-4	Doc.49	Redacted Defendants' Response in Opposition to Motion for Preliminary Injunction
4-7	Doc 49-1	Redacted Appendix to Defendants' Response in Opposition to Motion for Preliminary Injunction
7-8	Doc.58	Reply to Defendants' Response in Opposition to Motion for Preliminary Injunction
8	Doc.60	Notice of Scrivener's Error and Filing of Supplemental Declaration to Correct Error re: Motion for Preliminary Injunction
8	Doc.64	Order Denying Preliminary Injunction
8	Doc.65	Answer to Complaint
8	Doc.108	Preliminary Injunction Motion Hearing Transcript
8	Doc.118	Order Allowing Mr. Weida's Deposition
8-9	Doc.120	Motion for Summary Judgment
9	Doc.120-27	Attachment to Motion for Summary Judgment: Dr. Edmiston Expert Report
9	Doc.120-36	Attachment to Motion for Summary Judgment: Dr. Edmiston Deposition
9	Doc.233	Amended Complaint
9-12	Doc.235	Plaintiffs' Deposition Designations
12	Doc.246	Final Order
12	Doc.247	Clerk's Judgment
12-13	Doc.248	Notice of Appeal
13-14	Doc.221	Trial Transcript, Day One
14-15	Doc.224	Trial Transcript, Day Two
15-16	Doc.225	Trial Transcript, Day Three
16-17	Doc.229	Trial Transcript, Day Four
17	Doc.232	Trial Transcript, Day Five
17-18	Doc.234	Trial Transcript, Day Six
18	Doc.241	Trial Transcript, Day Seven
18	Doc.193-1, DX1	U.S. Health and Human Services Notice and Guidance on Care

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Gary Perko
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 Appellants-Defendants

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

PLAINTIFFS' WITNESSES	PAGE
DR. KELLAN BAKER	
Cross-Examination By Mr. Beato	511
Redirect Examination By Ms. Dunn	516
DR. JOHANNA OLSON-KENNEDY	
Direct Examination By Mr. Gonzalez-Pagan	520
Cross-Examination By Mr. Jazil	574
Redirect Examination By Mr. Gonzalez-Pagan	591
Further Examination By Mr. Gonzalez-Pagan	598
JANE DOE	
Direct Examination By Ms. Coursolle	601
Cross-Examination By Mr. Jazil	616

PLAINTIFFS' WITNESSES (cont'd.) PAGE

BRIT ROTHSTEIN
Direct Examination By Ms. Chriss 620
Cross-Examination By Mr. Jazil 645

AUGUST DEKKER
Direct Examination By Mr. Charles 649
Cross-Examination By Mr. Jazil 675
Redirect Examination By Mr. Charles 677

JADE LADUE
Direct Examination By Ms. DeBriere 679

E X H I B I T S

PLAINTIFFS' EXHIBITS OFFERED RECEIVED

361 528 528

Doc. 229

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

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?

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil

No. 23-12155

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

August Dekker et al.,
Plaintiffs-Appellees,

v.

Secretary, Florida Agency for Health Care Administration et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME XVII OF XXI

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

Counsel for Defendants-Appellants

INDEX TO APPENDIX

Volume	Tab	Title
1	Dkt	Docket Sheet
1	Doc.1	Complaint
1-3	Doc.11	Motion for Preliminary Injunction
3-4	Doc.49	Redacted Defendants' Response in Opposition to Motion for Preliminary Injunction
4-7	Doc 49-1	Redacted Appendix to Defendants' Response in Opposition to Motion for Preliminary Injunction
7-8	Doc.58	Reply to Defendants' Response in Opposition to Motion for Preliminary Injunction
8	Doc.60	Notice of Scrivener's Error and Filing of Supplemental Declaration to Correct Error re: Motion for Preliminary Injunction
8	Doc.64	Order Denying Preliminary Injunction
8	Doc.65	Answer to Complaint
8	Doc.108	Preliminary Injunction Motion Hearing Transcript
8	Doc.118	Order Allowing Mr. Weida's Deposition
8-9	Doc.120	Motion for Summary Judgment
9	Doc.120-27	Attachment to Motion for Summary Judgment: Dr. Edmiston Expert Report
9	Doc.120-36	Attachment to Motion for Summary Judgment: Dr. Edmiston Deposition
9	Doc.233	Amended Complaint
9-12	Doc.235	Plaintiffs' Deposition Designations
12	Doc.246	Final Order
12	Doc.247	Clerk's Judgment
12-13	Doc.248	Notice of Appeal
13-14	Doc.221	Trial Transcript, Day One
14-15	Doc.224	Trial Transcript, Day Two
15-16	Doc.225	Trial Transcript, Day Three
16-17	Doc.229	Trial Transcript, Day Four
17	Doc.232	Trial Transcript, Day Five
17-18	Doc.234	Trial Transcript, Day Six
18	Doc.241	Trial Transcript, Day Seven
18	Doc.193-1, DX1	U.S. Health and Human Services Notice and Guidance on Care

18	Doc.193-2, DX2	U.S. Health and Human Services Fact Sheet on Gender-Affirming Care
18	Doc.193-3, DX3	U.S. Department of Justice Letter to State Attorneys General
18	Doc.193-8, DX8	Sweden's Care of Children and Adolescents with Gender Dysphoria, Summary of National Guidelines
18-19	Doc.193-9, DX9	Finland's Recommendation of the Council for Choices in Health Care in Finland
19	Doc.193-10, DX10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People
19-20	Doc.193-11, DX11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
20	Doc.193-12, DX12	National Institute for Health and Care Excellence, Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria
20	Doc.193-13, DX13	France's Academie Nationale de Medecine Press Release
20	Doc.193-14, DX14	The Royal Australian and New Zealand College of Psychiatrists' Position Statement on Gender-Affirming Care
20-21	Doc.193-16, DX16	WPATH Standards of Care, Version 8
21	Doc.193-17, DX17	WPATH Standards-of-Care-Revision Team Criteria
21	Doc.193-24, DX24	Endocrine Society Guidelines on Treatments for Gender Dysphoria

Dated: October 13, 2023

/s/ Mohammad O. Jazil
Mohammad O. Jazil
Gary Perko
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 Appellants-Defendants

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

INDEX

WITNESSES FOR THE PLAINTIFFS: PAGE

ELLIOT KALE EDMISTON
DIRECT EXAMINATION BY MS. RIVAUX..... 4
CROSS-EXAMINATION BY MR. BEATO..... 26
RECROSS-EXAMINATION BY MR. BEATO..... 44

KIM HUTTON
DIRECT EXAMINATION BY MR. LITTLE..... 46
CROSS-EXAMINATION BY MR. PERKO..... 63
REDIRECT EXAMINATION BY MR. LITTLE..... 64

ARON CHRISTOPHER JANSSEN
DIRECT EXAMINATION BY MR. GONZALEZ-PAGAN..... 66
CROSS-EXAMINATION BY MR. PERKO..... 99
REDIRECT EXAMINATION BY MR. GONZALEZ-PAGAN..... 102

* * * * * * * *

WITNESS FOR THE DEFENSE: PAGE

PAUL WILLIAM HRUZ
DIRECT EXAMINATION BY MR. PERKO..... 137
CROSS-EXAMINATION BY MS. RIVAUX..... 182
REDIRECT EXAMINATION BY MR. PERKO..... 226

PAGE

PLAINTIFFS REST 132

PLAINTIFFS' EXHIBITS

NO.:	DESCRIPTION	PAGE
21	Florida Administrative Code Rule 59G-1.010	109
22	Florida Medicaid Definitions Policy	110
24	AHCA's automated prior authorizations and bypass lists	109
27	Prior Authorization Criteria	115
28	Agency responses to plaintiffs' questions	116
36	Position statement from the American Academy of Child and Adolescent Psychiatry	203
37	A document from the American Academy of Family Physicians	200
38	Policy statement from the American Academy of Pediatrics	201
39	Opinion document from the American College of Obstetricians and Gynecologists	204
40	Statement from at American College of Physicians	205
41	Position paper from the American College of Physicians	206
42	Letter to the National Governor's Association	207
43	Statement by the American Medical Association	212
45	Guidelines for psychological practice with transgender and gender nonconforming people from the American Psychological Association	208
46	Document entitled, American Psychological Association resolution on gender identity change efforts	190

47	Position statement from the American Psychiatric Association	209
48	Position statement from the American Psychiatric Association	209
49	Position statement by the Pediatric Endocrine Society	210
62	Centers for Medicare & Medicaid Services, EPSDT	118
63	Centers for Medicare & Medicaid Services, CMCS	118
67	FDA Understanding Unapproved Use of Approved Drugs Off Label	117
74	SAMHSA, Moving Beyond Change Efforts	113
254	Arlene Elliott email re GNRH coverage	127
255	Rebecca Borgert email	128
263	Draft GAPMS routing and tracking	128
276	Email from Susan Williams to Shantrice Green	128
291	Email	124
292	Invoices from Romina Brignardello-Petersen to AHCA	125
292a	Attachment to Exhibit 292	125
295	Gender Dysphoria/Transgender healthcare Nonlegislative Pathway - June 2022	120
296	Gender Dysphoria/Transgender healthcare Policy Pathway - June 2022	121
302	Email communication between Dr. Cogle and Jeffrey English	129
313	Email	125
313a	Attachment of Exhibit 313	126
314	Communication between AHCA and EOG	126

315	SMMC Policy Transmittal	126
316	AHCA Medicaid healthcare Alert	126
331	GAPMS - Scleral contact lenses	122
332	GAPMS - Fractional Exhaled Nitric Oxide	122
333	GAPMS - Breast Pump	123
346	Email communication between Sheeran and Brignardello-Petersen	128
357	CV of Dr. Elliot Kale Edmiston	7
364	CV of Dr. Aron Janssen	70

* * * * * * * *

DEFENSE EXHIBITS

NO.:	DESCRIPTION	PAGE
8	Sweden's Summary of National Guidelines	163
9	Finland's Recommendation of the Council for Choices in healthcare in Finland	165
10	The Cass Review, Independent Review of Gender Identity Services for Children and Young People	167
11	National Institute for Health and Care Excellence, Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria	167
12	National Institute for Health and Care Excellence, Evidence Review: Gender Affirming Hormones for Children and Adolescents with Gender Dysphoria	168

13	France's Academie Nationale de Medecine Press Release	170
14	Statement by the Royal Australian and New Zealand College of Psychiatrists	171
29	Curriculum Vitae of Paul Hruz	142

* * * * * * * * *

Doc. 232

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.

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

INDEX

WITNESSES FOR THE DEFENSE: PAGE

***STEPHEN B. LEVINE*, DEFENSE WITNESS, DULY SWORN**
DIRECT EXAMINATION BY MR. PERKO..... 966
CROSS-EXAMINATION BY MR. CHARLES..... 992
REDIRECT EXAMINATION BY MR. PERKO..... 1023

PATRICK LAPPERT
DIRECT EXAMINATION BY MR. JAZIL..... 1058
VOIR DIRE EXAMINATION BY MR. MILLER..... 1070
CROSS-EXAMINATION BY MR. MILLER..... 1087

KRISTOPHER EDWARD KALIEBE
DIRECT EXAMINATION BY MR. PERKO..... 1095
VOIR DIRE EXAMINATION BY MR. GONZALEZ-PAGAN..... 1101
CROSS-EXAMINATION BY MR. GONZALEZ-PAGAN..... 1119

* * * * * * * *

DEFENSE EXHIBITS

NO.:	DESCRIPTION	PAGE
30	Kristopher Kaliebe's Curriculum Vitae	1101
32	Stephen B. Levine's Curriculum Vitae	970

* * * * * * * *

Doc. 234

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.

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: October 13, 2023 /s/ Mohammad O. Jazil