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 VII OF XXI
PART 2 OF 2

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Dated: October 13, 2023

/s/ Mohammad O. Jazil
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embracing progressive political ideologies, he replied that my letter would not be published, in part, because some would find my criticism of this ideology offensive. These personal experiences mirror what I observe globally in the medical and psychiatric literature. The viewpoints in the medical literature do mainly endorse support for gender affirmative care for gender dysphoria. Yet my personal interactions with thoughtful well regarded psychiatrists display a full range of views, and many consider automatic affirmation to be harmful and unsupported by science. Similarly, my assessment is that many Endocrinologists also believe their professional organization is too strongly influenced by gender ideology. Most physicians will not speak frankly in public on these issues for fear of reprisals. Attacking a physician as hateful is easily accomplished and can be instantly amplified online. These personal attacks are hard to defend, affect careers and can be personally devastating.

11. Regarding professional organizations input regarding the treatment of gender dysphoria, it should be put in the context of their political activism. Two recent press releases provide examples. The September 28th 2022 American Academy of Pediatrics (AAP) press release regarding the State of Oklahoma condemns any limits on gender affirming health care. Defending scope of practice is typical for medical associations. Yet the press release frames these limits as discrimination based on gender identity. The AAP thus takes a polarized position by invoking moralized characterization of these limits, rather than calling for a respectful, nuanced science-based dialogue on how to best care for and support transgender and gender diverse youth. This statement sidesteps an opportunity to call for open independent review of the evidence base and a thorough review the logic behind current treatment affirmative approaches. It also creates a serious contradiction. Parents are often skeptical of medicalization of self-reported gender. The AAP statement invokes parental rights, but without clarifying if the AAP supports the many parents who do not want affirmation of their child's self-reported gender.

Similarly, the American Academy of Child and Adolescent Psychiatry's (AACAP) March 18th, 2022 press release reveals their leadership's strident position by remarking on an education bill, typically considered outside psychiatrists' area of expertise. AACAP promotes politicized derogatory phrasing by calling Florida's legislation the "Don't Say Gay or Trans" bill. The press release demonizes supporters of the bill as unconscionable and implies they "target and harm" LGBTQ+ youth". The press release claims that differences in gender identifications are "part of healthy physical, social, and emotional developmental processes." The press release does not explain why if these differences in gender identification are part of healthy development, why would they require puberty blockers, sex hormones or surgery. The American Academy of Child and Adolescent Psychiatry's leadership moralizes the debate, uses polarizing language and does not engage in forthright discussion which must include skepticism, not just affirmation.

These professional organizations admonish those who they claim pathologize, but will not acknowledge that it is an unanswered scientific question to what degree, and in what circumstances, discomfort with biological sex is related to mental illness. As in body dysmorphic disorder or anorexia, there are longstanding examples where non-acceptance of one's body is aptly pathologized. Holding the opinion that logic and the evidence base do not support medical interventions for gender dysphoria is not a moral failure or discrimination as they infer, this conclusion is the result of deliberative analysis.

12. To conclude, I am presenting on the subject of misinformation at the October 2022 American Academy of Child and Adolescent Psychiatry conference Social Media Institute. My research into misinformation research leads me to determine that on the subject of gender dysphoria, academia, including academic medicine, has created conditions where perceived social justice, ideological and political priorities have undermined the creation of trustworthy science. Group-think and coercive tactics have led to the creation of misinformation. These dynamics have contributed to

subsequent misguided attempts of these professional organizations to suppress open inquiry, demand conformity of opinion and exaggerate the evidence base regarding gender dysphoria treatment.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 3rd day of October, 2022.

Respectfully submitted,

Kristopher E. Kaliebe, M.D.

CURRICULUM VITAE

Kristopher Edward Kaliebe, MD

Associate Professor
University of South Florida, Morsani College of Medicine, Tampa Florida

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Citizenship

United States

Education

Graduate/Medical: St. George's University
School of Medicine, Grenada, West Indies
Medical Doctor — January 1995- June 1999

Undergraduate: Columbia College,
Columbia University
New York, NY,
Bachelor of Arts, Biochemistry — September 1988-May 1992

Postgraduate Training

Clinical Fellowships:
Fellow, Forensic Psychiatry (PGY6)
Louisiana State University Medical Center
1542 Tulane Ave., New Orleans, LA 70112 — July 2004 to June 2005

Fellow, Child and Adolescent Psychiatry (PGY 4-5)
Louisiana State University Medical Center
1542 Tulane Ave., New Orleans, LA 70112 — July 2002 to June 2004

Chief Resident in Child and Adolescent Psychiatry

- Acted as liaison between Child Psychiatry Fellows and Administration
- Coordinated with Program Director lecture and rotation schedules

July 2003 to June 2004

Residency:

Resident, Psychiatry (PGY 2-3)
University of Medicine and Dentistry-
New Jersey Medical School
185 S Orange Ave, Newark, NJ 07103 — July 2000- June 2002

Internship: (PGY 1)
University of Medicine and Dentistry-
New Jersey Medical School
185 S Orange Ave, Newark, NJ 07103 — July 1999- June 2000

Diplomate, American Board of Psychiatry and Neurology:

- Board Certification in General Psychiatry, awarded 2004, active
- Specialty Board Certification Child and Adolescent Psychiatry, awarded 2005, active
- Specialty Board Certification Forensic Psychiatry, awarded 2007, active

Awards, Honors, Honorary Society Memberships:

Department of Veterans Affairs Special Contribution Award for Clinical Service in Psychiatry
February 22, 2002

Outstanding Resident Award, Presented at the American Academy of Child and Adolescent Psychiatry, Miami, Florida,
October 17, 2003

Inducted into Berkeley Preparatory School Athletic Hall of Fame, Tampa, Florida,
November 7, 2003

Fellow, Louisiana State University Academy for the Advancement of Educational scholarship
October 2007 – 2016

Best Doctors, Louisiana in the subspecialty of Child and Adolescent Psychiatry
Awarded 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015 and 2016

Best Doctors, in Tampa Florida
2017, 2018, 2019, 2020, 2021, 2022

Awarded status as a Distinguished Fellow of the American Academy of Child and Adolescent Psychiatry
July 6, 2016

Appointments:

Associate Professor, University of South Florida Medical School, Department of Psychiatry. September 2016 to present

- Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF General Psychiatry Residents and Child and Adolescent Psychiatry fellows who performed assessment, consultation, and treatment.

Tampa General Hospital Psychiatrist on Duty September 2016 to present
Manage the night, weekend and holiday clinical responsibilities of Tampa General Hospital including the over 1000 bed hospital and a 24-hour emergency room. Usually done in partnership with a psychiatric resident from the University of South Florida.

Facility Psychiatrist. Tampa Residential Facility September 2016 to present

- Performed psychiatric evaluations and treatment in Florida's juvenile correctional system. Tampa Residential Facility is the most intensive level of mental health and substance abuse treatment, subcontracted to Truecore Solutions.

Facility Psychiatrist. Les Peters Academy Residential Facility
May 2017 to present

- Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted to Truecore Solutions.

Staff Psychiatrist, Orleans Parish Justice System March 2018 to July 2018

- Performed telepsychiatric evaluations and treatment in Orleans Parish Prison correctional system, subcontracted to Correct Care Solutions.

Facility Psychiatrist. Charles Britt Academy Residential Facility
November 2019 to July 2022

•Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted by Sequel.

Facility Psychiatrist. Columbus Youth Academy Residential Facility
June 2020 to present

•Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted by Sequel.

Louisiana State University Health Science Center Assistant Professor of Clinical Psychiatry July 2005 to June 2017

Louisiana State University Health Science Center Associate Professor of Clinical Psychiatry July 2016 - 2017

Mental Health Medical Director, St. Charles Community Health Center, Luling, Louisiana July 2005 to 2016

- Evaluated and treated a primarily Medicaid and underserved population of adult, child and adolescent patients in a Federally Qualified Health Care Center.

Coordinator for Child and Adolescent Integrated Mental and Behavioral Health Services, Louisiana Mental and Behavioral Health Capacity Project
September 2012 to July 2017

- Performed assessment, consultation, training, prevention, and education services to Federally Qualified Health Centers and community clinics in Coastal Louisiana.
- Evaluated and treat both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist, Back-up coverage, Louisiana Juvenile Justice System July 2016 to September 2022

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system, subcontracted to Wellpath (formerly Correct Care Solutions).
- Back up on call coverage for on-site psychiatrists
- As needed evaluated and treated remote video conferencing equipment (telehealth).

Staff Psychiatrist, Louisiana Juvenile Justice System July 2010 to July 2016

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system, subcontracted to Correct Care Solutions.
- Evaluated and treated both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist on Duty October 2011 to July 2016
Children Hospital, Calhoun Campus. New Orleans, Louisiana

- Facilitated development of protocols and supervision regarding the training of Medical Students, General Psychiatry Residents and Child and Adolescent Psychiatric Fellows who utilize the Calhoun unit as primary training site for Child Psychiatry.
- Manage night and weekend clinical responsibilities for Children's Hospital emergency room and Inpatient Psychiatric Unit, including individually assessing all inpatients each weekend.

Staff Psychiatrist, Louisiana State University Juvenile Justice Program
July 2005 to August 2010

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system at Bridge City Center for Youth and Jetson Center for Youth.
- Evaluated and treated both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist, Florida Parish Juvenile Detention Center,
July 2007 to August 2010

- Performed psychiatric evaluations and treatment using remote video conferencing equipment (telehealth).

Medical Officer on Duty July 2002 to July 2005
New Orleans Adolescent Hospital. New Orleans, Louisiana

- Managed clinical responsibilities of Crisis Intervention Services, a 24-hour emergency mental health response team serving families, children and adolescents from the Southeast Louisiana region.
- Managed two psychiatric inpatient units including a twenty bed adolescent and ten bed children's unit after hours on call.
- On call physician for Crisis Respite, a short term residential facility for children and adolescents located on hospital grounds.

Psychiatrist on Duty September 2003 to July 2005
New Orleans Veterans Administration Medical Center, New Orleans, Louisiana

- Managed clinical psychiatric responsibilities of a 450 bed hospital
- Managed clinical psychiatric responsibilities of a 27 bed inpatient psychiatric unit
- Managed clinical psychiatric responsibilities of 24-hour emergency room

Psychiatrist on Duty September 2001 to June 2002
New Jersey Medical Center Veterans Administration

- East Orange Medical Center, East Orange, NJ

Managed clinical psychiatric responsibilities of 24 hour emergency room along with a 295 bed hospital, 30 Nursing Home and 30 Domiciliary beds.

- Lyons Hospital, Lyons, NJ

Managed clinical psychiatric responsibilities of 356 bed hospital.

Teaching, Lecture

Undergraduate Medical Student

BMS6920.002, BMS6920.001 University of South Florida: Created five session elective: "Mind Body Medicine" Developed as part of University of South Florida medical school elective curriculum from 2017-current. Offered for up to 12 students as a credited elective including study guide, organizing readings, and experiential class learning.
2017 to present

At Louisiana State University Health Science Center New Orleans:

4 one-hour lectures instructing all Medical Students (MS2) in Child and Adolescent mental health during Psychiatry Basic Science block
February 2004 to February 2016

LSU Physical therapy
Annual 2 two-hour lectures on a range of mental health topics annually
2012 to 2016

LSU Public Health
Annual 2 hour lecture on psychopharmacology to incoming Masters Level students in Public Health
2012 to 2016

Graduate Medical Teaching

MEL 8602 C65 M: Child and Adolescent Psychiatry

Child and Adolescent Psychiatry Resident Teaching:

Arranged and co-instructed Forensics Lecture Series, bi-annually 10 lecture hours and 4 hours of individual lectures.
2016 to present.

Teach various topics within residency training. 1 lecture per year.

2016 to present.

University of South Florida General Psychiatry Residency:

Co-Produced elective track for 2 residents per year within University of South Florida Psychiatry Residency. Supervision of Integrative Psychiatry residents within the University of South Florida's Integrative Psychiatry Track, biweekly sessions utilizing curriculum from the Andrew Weil Center for Integrative Medicine.
July 2020- present

Forensic Psychiatry Resident Teaching:

Teach child and corrections related forensic topics within residency training. 4 lectures per year.
2018 to present.

LSUHSC New Orleans, General Psychiatry Resident Teaching

- Created and taught one hour weekly (44 weeks per year) Cognitive Behavioral Therapy practicum for PGY 3 residents
2007 to 2016

- One hour lecture on evolution and mood disorder each year for PGY3 residents
  2010 to 2016

LSUHSC New Orleans Child and Adolescent Psychiatry Resident Teaching

- One-hour didactic lectures on psychopharmacology for 8 weeks and cognitive behavior therapy for 4 weeks bi-annually
  2008-2016
- Organized and taught majority of the year-long bi-weekly one hour didactic program entitled Special Topics including a wide range of topics including development, forensic psychiatry, evolution, anthropology, nutrition, effects of technology, electronic media, sleep, exercise and physical activity, wellness and systems of care.
  2008 to 2016

LSU- Kenner Family Practice Residency:
Once yearly didactic lectures for 1 to 2 hours for Kenner Family Practice Residents
2009 to 2016

Created one session Mini-Course: "Optimizing Neurocognition through Nutrition." Developed and co-facilitated a module as part of Goldring Center for Culinary Medicine curriculum for medical students and other trainees with Annie Yeh, MD). Offered as a 1 credit elective for Tulane medical students including study guide, organizing readings, online webinar to be viewed prior to class, case studies during class and test.
2014

At Louisiana State University Health Science Center New Orleans: Core Clinical Psychiatry Rotation Lecture, 1 hour lecture presented to MS3 students every six weeks to 3rd year medical students covering Child Psychiatry Basics.
October 2003 to June 2005

At University of Medicine and Dentistry- New Jersey Medical School, Department of Psychiatry
- Lecture: "The Media and Psychiatry" for General Psychiatry Residents, created as part of the Culture and Psychiatry Seminar
  August 2001 and 2002

Teaching, Supervisory

At University of South Florida, Tampa Florida:

Medical Student supervision

University of South Florida - 2017 to present
MEL 8109 L69 M

BCC 7154 002 M Psychiatry / Neurology Clerkship. Medical Students rotation through clinic one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic

Psychiatry Elective, 2 to 4 week Medical Student rotation through Child and Adolescent Psychiatry Silver Center Resident Clinic

Graduate Medical Education Supervision

Child and Adolescent Psychiatry Residency

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF Child and Adolescent Psychiatry residents who performed assessment, consultation, and treatment.
September 2016 to June 2021

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry correctional psychiatry with USF Child and Adolescent Psychiatry residents who observe clinical care in juvenile correctional facilities.
September 2016 to present

General Psychiatry Residency:

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF General Psychiatry Residents who performed assessment, consultation, and treatment.
September 2016 to present

Forensic Psychiatry Resident Teaching

Supervision of forensic psychiatry trainees within the University of South Florida forensic psychiatry training program. This includes review of resident competency evaluations along with co-evaluation of criminal defendants as individual cases arise.
2018 to present

At Louisiana State University Health Science Center New Orleans

LSU- Kenner Family Practice Residency:

- One month, once weekly half day mental health rotation at St Charles Community Health Center for all Kenner Family Practice Residents
2008 to 2016

Clerkship/Residency Directorship:

Child and Adolescent Psychiatry Fellowship Training Director, Louisiana State University Medical Center. Oversaw and supervised resident physician training Managed administrative, evaluation and scheduling issues within the training program Collaborated with Louisiana State University psychiatric faculty to develop policies and procedures at various clinical site.

July 2010 to September 2012

Teaching Awards:

Association for Academic Psychiatry Honorary Fellow

October 2001- October 2002

Louisiana State University Child and Adolescent Psychiatry Department Outstanding Teacher Award for the 2006-2007 academic year

Louisiana State University Child and Adolescent Psychiatry Department Outstanding Teacher Award for the 2015-2016 academic year

Peer to Peer: Institutional Grand Rounds

"The Minds, They are a Changin' – An Overview and Update on MDMA and Psilocybin Grand Rounds University of South Florida Psychiatry Department, Tampa Florida

January 28 2022

"3 Simple Rules for Overcoming Obesity" University of South Florida Endocrinology Department, Tampa Florida

November 9, 2021

"A hard pill to swallow: psychotropic medications in foster care", University of South Florida, Department of Public Health, Tampa Florida

November 3, 2017

"Rules of Thumb: The importance of heuristic and cognitive biases in pediatric physical and mental health" Grand Rounds Children's Hospital, New Orleans

July 30, 2014,

Grand Rounds, Louisiana State University Department of Psychiatry, "Rules of Thumb, lifestyle interventions for mental health professionals." New Orleans, Louisiana

January 23, 2014

"Just say No, the Case against Stimulant Medication" Grand Rounds Children's Hospital, New Orleans, Louisiana

May 19th, 2010

"Violence: Neurobiology, Risk Assessment and Beyond", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

August 9, 2012

"Is ADHD a Nutritional Disorder", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

July 28, 2011

"Just say No, the Case Against Stimulant Medication", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

July 29th, 2010

Grand Rounds Department of Psychiatry, Louisiana State University School of Medicine, New Orleans, Louisiana "The Application of Darwinian Principles to Child Custody Evaluations", New Orleans, Louisiana

May 26th, 2005

"Attention Deficit Hyperactivity Disorder" Grand Rounds Department of Pediatrics, Louisiana State University School of Medicine, New Orleans, Louisiana

May 25th, 2005

"The Media, Our New Social World, How Should Pediatricians Respond?" Grand Rounds, Louisiana State University School of Medicine, Children's Hospital, New Orleans, Louisiana

June 2nd, 2004

"Attention Deficit Disorder" for Louisiana State University Health Science Center Juvenile Corrections Program Continuing Medical Education Presentation via telemedicine New Orleans, Louisiana

March 16th, 2004

"The Media, Relationships to Children and Psychiatry", Grand Rounds, Department of Psychiatry, Louisiana State University School of Medicine, New Orleans, Louisiana

June 4th, 2003

"The Media, Relationships to Children and Psychiatry", Grand Rounds, New Orleans Adolescent Hospital, New Orleans, Louisiana

March 28th 2003

Lectures by Invitation

"The Media, Relationships to Children and Psychiatry" Grand Rounds, University of West Virginia, Charleston, West Virginia, Department of Psychiatry and Behavioral Science

April 10th 2003

"The Media and Child and Adolescent Psychiatry –An Evolving Relationship" Chair and Presenter, Media Theatre, Annual Conference of the American Academy of Child and Adolescent Psychiatry
October 21st, 2004

"The Media, Our New Social World, How Should Health Care Professionals Respond?" Continuing Medical Education Presentation Snowshoe Mountain Retreat, Snowshoe Mountain, West Virginia
September 19th, 2004

"The Application of Darwinian Principles to Child Custody Evaluations" Grand Rounds Department of Psychiatry, University of South Florida, Tampa, Florida
October 31st, 2005

"The Evaluation and Treatment of Traumatized Children and Adolescents with ADHD" Web Cast Presentation and Grand Rounds sponsored by the National Center for Child Traumatic Stress Network's Rural Consortium, New Orleans, Louisiana
January 25th, 2007

"Behavioral Disorder or Traumatized Child?" Louisiana Federation of Families for Children's Mental Health, Children's Mental Health Conference, Houma Louisiana
May 9th, 2008

"Behavioral Disorder or Traumatized Child?" Grand Rounds Tulane University Department of Child Psychiatry, New Orleans, Louisiana
March 13th, 2009

"Brother's Little Helper: The Simpsons Satirizes Stimulant Medication as a Response to Childhood Behavior Problems" Media Theatre, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York Kristopher Kaliebe MD, K. Dalope, MD
October 30, 2010

"Violence Risk Assessment" Louisiana Psychiatric Medical Association Annual Meeting, New Orleans, LA
March 2, 2013,

"Telepsychiatry in Juvenile Justice Settings" part of "Telepsychiatry: Challenges and Successes Across Settings." Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Orlando FL
October 22, 2013

"What are they Missing, When Electronic Media Displaces Sleep, Academics and Exercise" part of "Identifying and Treating Internet-Related Mental Health Problems: An Evidence-Based Approach" Clinical Perspectives. Annual meeting of the American Academy of Child and Adolescent Psychiatry, Toronto, Canada

October 24, 2014

"The Implications of the Pharmacological Treatment of Children" Michigan Drug Court Annual Conference, Lansing, Michigan
March 12, 2014

"Three rules to prevent and treat ADHD symptoms" as part of the Louisiana ADHD Symposium, organized by the Louisiana Department of Health and Hospitals ADHD Task Force, Baton Rouge, Louisiana
December 9, 2014

"Non-Pharmaceutical Interventions for ADHD", Invited Professorship: St George's University School of Medicine Complementary and Alternative Medicine Selective, St George's, Grenada, West Indies
August 28 – Sept. 3rd, 2014

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, San Diego, California
October 30, 2014

"The Management of Childhood Obesity" and "Disordered Eating in Children and Adolescents" Oregon Psychiatric Medical Association Conference, Portland, Oregon
February 27 and 28, 2015

"Rules of Thumb: 3 Simple Rules to Optimize Physical and Mental Health" National Alliance for the Mentally Ill Louisiana Annual Conference, New Orleans, Louisiana
April 17, 2015

"ADHD overdiagnosis in Louisiana, a child and adolescent psychiatrist's perspective" Preventing Overdiagnosis Conference, National Institutes of Health (NIH), Bethesda Maryland
September 2, 2015

"An alternative to diagnosis-based practice in pediatric mental health" Preventing Overdiagnosis Conference: National Institutes of Health NIH Bethesda Maryland
September 2, 2015

"Shell Shocked: Growing up in the Murder Capital of America". Discussant for Media Theatre, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Holly Peek, MD, Kristopher Kaliebe, MD San Antonio, Texas
October 29, 2015

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter,

Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, San Antonio, Texas
October 31, 2015

"What are they (we) Missing? When Electronic Media Displaces Sleep, Academics, and Exercise" Grand Rounds University of South Florida Psychiatry Department, Tampa Florida
November 12th, 2015

ADHD overdiagnosis in Louisiana, a child and adolescent psychiatrist's perspective, Louisiana Psychological Association, New Orleans, LA
May 20, 2016

"Rules of Thumb: 3 Simple Rules to Optimize Physical and Mental Health" Crohns and Colitis Association of America Regional Conference, New Orleans, LA,
June 12, 2016

"Evaluating and Assuring the Effective and Safe Use of Psychotropic Medications in Children" Webinar: National Council of Juvenile and Family Court Judges, with Judge Constance Cohen; Janie Huddleston and Dr. Joy Osofsky, Ph.D.
June 24, 2016,

"Psychotropic Medications 101: What Judges Need to Know for Effective Decision Making" Florida Child Protection Summit, with Melinda Sczepanski, Orlando FL
September 9, 2016

"Communicating With the Media and the Public as Child and Adolescent Psychiatrists Around Disaster and Highly Traumatic Events." Workshop, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Media Training Workshop, New York, New York
October 27, 2016

"Evolutionary Biology is a Basic Science for Child and Adolescent Psychiatry" Special Interest Group, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York
October 28, 2016

"Is War Ever Really Over? War-Affected Youth From Home to Host ountry", Discussant, Clinical Perspectives. Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York
October 28, 2016

"Psychotropic Medications 101: The pertinent essentials for all involved in the child welfare system" Florida Child Protection Summit, with Melinda Sczepanski, Orlando, Florida
August 30, 2017

"Safe Use of Psychotropic Medications in Children." 2017 Safe Babies Court Teams Cross Sites Meeting, Fort Lauderdale, Florida
August 17, 2017

"Health Promotion in Pediatric Mental Health" Discussant, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC
October 23, 2017

"New Technologies, New Laws, New Childhood" as part of "Clinical Guidelines for Navigating Media Use" Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC
October 24, 2017

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC
October 26, 2017

"The Business of News, the Role of Child and Adolescent Psychiatrists in the Media, and Risk Communication." Member Services Forum, Annual meeting of the American Academy of Child and Adolescent Psychiatry: Washington, DC
October 27, 2017

"Caught in the net: a child psychiatrist's guide for navigating the internet age.", Workshop, International Association for Child and Adolescent Psychiatry and Allied Professions, Prague, Czechoslovakia
July 27, 2018

Chair, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, "Caught in the Net: How Digital Media Shapes Mental Illnesses in Youth and How Psychiatrists Should Respond." Seattle, Washington
October 24, 2018

"Self-Care in the Child Welfare System" YMCA/Safe Children Coalition Conference, with Catarlyn Glenn, Sarasota Florida
April 18, 2019

"Psychotropic Medications 101: The pertinent essentials for all involved in the child welfare system" Florida Child Protection Summit, with Catarlyn Glenn, Orlando Florida
December 17, 2019

"Caught in the Net: How Digital Media Interacts with Mental Illness in Children and Adolescents", Annual Conference of the Florida Psychiatric Society, Tampa, Florida
September 21, 2019

"Effective Strategies for Higher Education and Beyond" Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Mastering Information Flow for Transitional-Age Youth (TAY): as part of "Promoting Digital Citizenship in Transitional-Aged Youth (TAY) and College Students", Chicago, IL
October 19, 2019

"Caught in the Net: How Digital Media Interacts with Mental Illness", virtually presented at the Andrew Weil Center for Integrative Medicine, Tucson, Arizona
April 1, 2020

"A deeper dive into child and adolescent psychopharmacology for families and professionals involved in the child welfare system" Florida Child Protection Summit, with Catarlyn Glenn. Orlando, FL
September 3, 2020

"Screenagers: Next Chapter – How Online Behaviors Affect Depression and Anxiety Disorders in Adolescents", Media Theater (virtual) Annual meeting of the American Academy of Child and Adolescent Psychiatry
October 19, 2020.

"Helping Child Psychiatrists Navigate the Internet Age", "Career Focus: Setup Your Own Telepsychiatry Practice", "COVID-19 Related Psychiatric Issues"
Oasis Child and Adolescent Psychiatry Conference, Charleston, SC
May 17, 2021

"Conversation about health information, COVID, news, and related topics", discussant and breakout group leader, Digital Media and Mental Health Research Virtual Retreat
May 24th 2021

"The Social Dilemma: Helping Families Navigate the Pull, Pulse, and Power of Social Media", Media Theater, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 29, 2021

"Appealing Applications for Adolescent Mental Health: Social Media's Transformation During the COVID-19 Pandemic", Discussant, Clinical Perspective, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 25, 2021

"Angry Young Men, Common Threads in Different Types of Extremist Groups" as part of Political Extremism & Hate Group Recruitment of Adolescents", Clinical Perspective, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 26, 2021

"Angry Young Men: Boys and Adolescent Males with Disruptive and Aggressive Behavior", "Nutritional Child Psychiatry" Oasis Child and Adolescent Psychiatry Conference, Charleston, SC
May 1st / 2nd, 2022

"Sexts, Lies & Videogames: Adolescent Boys, the Internet, & Mental Health" Chair and presenter on violence and young men: Clinical Perspective, Annual Meeting of the American Academy of Psychiatry Annual Meeting, New Orleans, LA
May 25, 2022

Clinical Activities or Innovation

Licensure:

Louisiana State Medical License, expires December 31st, 2022
Florida Medical License, expires January 31st, 2024

Federal DEA Controlled Substances License 12/31/2023
Louisiana license for Controlled Dangerous Substances expires 10/1/2022
Certification: ECFMG Certificate 0-573-532-9

Forensic Training:

Florida Forensic Examiner Training completed through the University of South Florida Department of Mental Health Law and Policy
August 15-17, 2019

Certifications in Psychotherapy:

Basic Practicum in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY
July 13, 2003

Advanced Practicum in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY
July 20, 2003

Associate Fellowship in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY,
July 15, 2005

Accelerated Resolution Therapy, Basic Training
April 1-3, 2017

Accelerated Resolution Therapy, Enhanced Training
Sept 31, October 1, 2018

Accelerated Resolution Therapy, Advanced Training
October 2,3, 2018

American Association of Medical Colleges Medical Education Research Certificate
October 13th, 2010

Scholarly Activity

Funded block grants

Co-investigator on the Mental and Behavioral Health Capacity Project from September 2012 to June 2017

Unfunded research

Supervisor mentoring Medical Students:

University of South Florida IRB: Faculty Advisor Co Investigator May 2021

What is the impact of coronavirus confinement on Japanese college students' mental health? Ivana Radosavljevic STUDY002335

University of South Florida IRB: Faculty Advisor Co Investigator May 2021
Changes in college aged students' metabolic health due to Covid-19 confinement Matthew Udine, STUDY002341

PI as student supervisor, STUDY004118, IRB approved as Exempt Status, Palliative Care Patients' Attitudes & Openness to Psilocybin assisted Psychotherapy for Treatment of Existential Distress, Julia Wang

Journal Publications:

Peer Reviewed

Kaliebe, Kristopher and Adrian Sondheimer. "The media: Relationships to psychiatry and children." *Academic Psychiatry* 26.3 (2002): 205-215.

Kaliebe, Kristopher "Rules of thumb: three simple ideas for overcoming the complex problem of childhood obesity." *Journal of the American Academy of Child & Adolescent Psychiatry* 53.4 (2014): 385-387.

Kaliebe, Kristopher. "Dr Kaliebe Replies", Journal of the American Academy of Child & Adolescent Psychiatry, (2014) 53:10 1134.

Kaliebe, Kristopher "The Future of Psychiatric Collaboration in Federally Qualified Health Centers." *Psychiatric Services* (2016): appi-ps.

Kaliebe, Kristopher, and Josh Sanderson. "A Proposal for Postmodern Stress Disorder." The American journal of medicine 129.7 (2016): e79.

Osofsky, Howard J., Anthony Speier, Tonya Cross Hansel, John H. Wells II, **Kristopher E. Kaliebe**, and Nicole J. Savage. "Collaborative Health Care and Emerging Trends in a Community-Based Psychiatry Residency Model." *Academic Psychiatry* (2016): 1-8.

Yeh, Y. Y. and **K. Kaliebe**. "Impact of Nutrition on Neurocognition." *Southern medical journal* 109.8 (2016): 454.

K. Kaliebe Expanding Our Reach: Integrating Child and Adolescent Psychiatry Into Primary Care at Federally Qualified Health Centers. J Am Acad Child Adolesc Psychiatry. 56.11 (2017)

Kass, R. and **Kaliebe, K**., Stress and Inflammation: New Perspectives on Major Depressive Disorder. JAACAP Connect, p.22. Winter 2020

Case Reports, Technical Notes, Letters

Books, Textbook Chapters:

Weigle, P., Kaliebe, K., Dalope, K., Asamoah, T., & Shafi, R. M. A. (2021). 18 Digital Media Use in Transitional-Age Youth: Challenges and Opportunities. Transition-Age Youth Mental Health Care: Bridging the Gap Between Pediatric and Adult Psychiatric Care, 357.

Papers in Press:

Accepted for publication: Prescribing Psychotropic Medications for Justice-Involved Juveniles, Journal of Correctional Health Care, A Tamburello, J Penn, R Negron-Muñoz, **K Kaliebe**

Invited Publications

"Telepsychiatry in Juvenile Justice Settings", **K Kaliebe**, J Heneghan, T Kim, Child and Adolescent Clinics of North America, 20 (2011) 113-123

American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues. Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017 Oct; 56(10):875-893. Epub 2017 Jul 25. PMID: 28942810.

Kaliebe, Kristopher and Paul Weigle. "Child Psychiatry in the Age of the Internet." (2017). Child and Adolescent Psychiatric Clinics of North America, April 2018Volume 27, Issue 2, Pages xiii–xv

Gerwin, Roslyn L., **Kristopher Kaliebe,** and Monica Daigle. "The Interplay Between Digital Media Use and Development." Child and Adolescent Psychiatric Clinics 27.2 (2018): 345-355.

Other Research and Creative Achievements:

Poster Presentations:

"Collaborative Child and Adolescent Psychiatry within Primary Care Clinics in Coastal Louisiana" Poster, Annual meeting of the American Academy of Child and Adolescent Psychiatry, **Kristopher Kaliebe MD**, Joy Osofsky, PhD; Howard Osofsky, MD, PhD; Lucy King, BA; Tonya Hansel, PhD, San Antonio, TX
October 29, 2015

"Benefits of Integrating Young Child Psychiatric Services Into Primary Care Clinics in Underserved Communities" Poster, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, NY Joy Osofsky, PhD; Howard Osofsky, MD, PhD; Lucy King, BA; Tonya Hansel, PhD, **Kristopher Kaliebe MD**
October 28, 2016

"Integrating child and adolescent psychiatry into community based primary care networks", Poster, International Association for Child and Adolescent Psychiatry and Allied Professions, Prague, Czechoslovakia **Kristopher Kaliebe MD**
July 25, 2018

" The Prevalence of the Adverse Childhood Experiences (ACE) in Florida Youth Referred to the Department of Juvenile Justice" Poster, Annual meeting of the American Academy of Psychiatry and the Law, Greg Iannuzzi, MD, Mark Greenwald, PhD, **Kristopher Kaliebe MD**
October 25, 2018

Other articles:

"LSU's *Breakfast Club* emphasizes education and recruitment into Child and Adolescent Psychiatry", American Academy of Child and Adolescent Psychiatry News,
January 2004

"Trix are for Kids!", American Academy of Child and Adolescent Psychiatry News,
May, 2013

Expanded Psychiatric Care Can Transform Federally Qualified Health Centers, American Psychiatric Association News,
...... Published online June 17, 2016

News Stories on Suicide, Fictional Content may Increase Risk for Contagion, Hansa Bhargava and **Kristopher Kaliebe**, American Academy of Pediatrics News, *Mastering the Media Column*,
Published online July 10, 2019

Webinars and creation of enduring materials:

Rules for Optimal Health, Webinar, University of South Florida Quality Parenting Initiative, Florida's Center for Child Welfare Information and Training Resources for Child Welfare Professionals, released
...... December 11, 2017

Florida's Center for Child Welfare Information and Training Resources, webinars series on pediatric mental health for child welfare professionals and caregivers, Kristopher Kaliebe with Catarolyn Johnson;
...... June 1, 8, 15, 22 and 29, 2020

"Don't just sit there- Adapt and Optimize in a post Covid world" University of South Florida Global Health Conversation Series, presented virtually
September 22, 2020

Service

Membership in Professional Organizations:

Member, American Academy of Child and Adolescent Psychiatry (AACAP),
2000 to present

AACAP Media Committee member
2003 –2021

C0-Chair, AACAP Media Committee
2013-2021

Media Committee Liaison to the Complementary and Integrative Medicine Committee of the AACAP
2012 to 2019

Liaison to the Committee on Communications and Media of the American Academy of Pediatrics, from American Academy of Child and Adolescent Psychiatry (AACAP)
2015 to present

Member Association for Behavioral and Cognitive Therapies
2004 – 2016

Member American Academy of Psychiatry and the Law
2004 to present

Member Zero to Three

2017 to 2021

Member Louisiana Council for Child Psychiatry (LCCP)
2003 to 2016

Louisiana Council for Child Psychiatry (LCCP)

Secretary-Treasurer
March 2010-March 2014

President
March 2014- June 2016

Member, American Psychiatric Association
2000 - 2012 , 2021 to present

LSUHSC Psychiatry Interest Group Faculty advisor
2008 to 2012

University of South Florida Medical School Integrative Medicine Student Interest Group faculty advisor
January 2020 to present

University of South Florida Medical School Mindfulness and Meditation in Medicine Group faculty advisor
January 2022 to present

University of South Florida Interdisciplinary (university wide) Psychedelics Interest Group faculty advisor
March 2022 to present

Editorial Posts and Activities:
Journal editorships, Reviewer

LSUHSC Institutional Review Board alternate reviewer 2008-2012

Safety Committee Member, Accelerated Resolution Therapy for Treatment of Complicated Grief in Senior Adults, University of South Florida
2017-19

Expert reviewer for *Adolescent Psychiatry* Thematic Special Issue: Coming of Age Online: Challenges of Treating the Internet Generation: (2), 4, 2014

Expert reviewer for *Academic Psychiatry* Media Column June 2018

Expert Reviewer for *Pediatrics* January 2021

Expert reviewer for *Academic Psychiatry* Media Column March 2022

Expert Reviewer for *Harvard Review of Psychiatry* May 2021

Co-editor: Kaliebe, Kristopher, and Paul Weigle. Youth Internet Habits and Mental Health, An Issue of Child and Adolescent Psychiatric Clinics of North America, E-Book. Vol. 27. No. 2. Elsevier Health Sciences. 2018

Member, Planning Committee for the Digital Media and Mental Health Research Retreat hosted by the nonprofit Children and Screens.
May 24th, 25th 2021.

Revised: October 2022

Appendix Attachment

13

**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.

SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

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

Declaration of C.G. (pseudonym) In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, C.G. (pseudonym) declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Complaint and Motion for a Preliminary Injunction.

2. Florida's Rule 59G-1.050(7) of the Florida Administrative Code disallows Medicaid coverage for medical and surgical interventions that "alter primary or secondary sexual characteristics."

3. Florida's Rule will prevent manipulation and coercion on the part of health care providers. Most importantly, this Rule will protect vulnerable children and young people from grievous harm.

4. Florida's new regulation will prevent the state funding of situations like mine in which a parent acceded to the requests of a vulnerable 15-year-old and placed me on the fast track to medical and surgical interventions which have left me at age 21 facing a lifetime of sterility with a mutilated body.

5. Like many detransitioning young people, I was a gender non-conforming child who is on the autism spectrum and suffered with depression and anxiety. I was often bullied at school. I began seeing therapists when I was 6 years old.

6. When I was about 8 years old, I began to think that I did not like stereotypical "boy stuff," such as athletics and rough play. Instead, I liked the ways girls behaved and was drawn to stereotypical "girl stuff."

7. I did not socialize well with male peers and believed that if the behavior and habits of my male peers were what it meant to be a boy then maybe I was not a boy. Those feelings were confirmed by postings on transgender websites

that told me I was a girl if I liked "girl things." I also began conversing with trans-identifying people through phone apps.

8. At age 14, I told a friend I was "trans" and wanted to be a girl. I believed that I was "a girl trapped in a boy's body."

9. I told my parent, who quickly celebrated my "trans" identity and arranged for me to see a "gender affirming" therapist. The therapist immediately affirmed my "trans" identity without any psychological testing or exploration as to why I believed I was "trans." My parent also bought a whole new female wardrobe and cut off relatives and family friends who did not affirm my new female identity.

10. My parent also arranged for me to see an endocrinologist who runs a gender clinic for children and young adults within a hospital in Providence, Rhode Island. The endocrinologist diagnosed me with gender dysphoria based only on my statements alone and immediately prescribed estrodial (estrogen) and spironolactone (a testosterone blocker) on the first visit.

11. The endocrinologist told me that the hormones would feminize my body, but downplayed the side effects, saying things like, "There is a minor risk of blood clots, but it's not a big deal because you don't see cis women dropping dead of blood clots every day."

12. I began the hormone regimen at age 15 with my parent's consent. My other parent eventually "came around" to support my female identity and transition.

13. I experienced significant negative psychological effects from the hormones. I became depressed to the point that I was not getting out of bed. I became too anxious to go anywhere or talk to people and skipped school for months on end. I ended up dropping out of school.

14. I also developed an eating disorder and addiction to the internet. I clearly was not functioning healthfully, but my parent and therapist continued to move me along the "gender affirmation path."

15. I was scheduled for surgery when I was 17. Once the time for the surgety came closer I had fears and doubts about the surgery that I mentioned to my doctor, but she told me it was nothing to worry about and that soon I would have a brand new (vulgar word for female genitalia). I also expressed some of these fears to my parent but was similarly told that the surgeries would be good for me and that I had nothing to worry about. Soon after turning 18 I got on a plane to travel to Washington DC where my testicles and penis were removed, I was given a vaginoplasty to create an artificial vagina, and I received plastic surgery on my face.

16. About a year into the treatments I started having doubts. I would talk myself out of the second thoughts.

17. Whenever I wanted a higher dose of estrogen the doctor complied and glossed over any negative side effects. She also put me on progesterone to give my body a more feminine appearance. During the time that she treated me her demeanor

was wholly unprofessional. I later learned that the high dose of estrogen could have caused blood clots.

18. I was never offered any alternatives to medication and surgery.

19. No one attempted to explore any underlying reasons for my depression and discomfort with being male. No one suggested to me that I could become comfortable just being a "feminine" male.

20. I was only told that I was "born this way." No medical professional asked deeper questions because apparently none thought they should.

21. I realized that the treatments had not improved my life and returned to living as a male at age 20.

22. I am 21 years old. My body is completely ruined. I do not have any good options. My body is going to be a "freak" no matter what I do.

23. Even, as was true in my case, when parents consent to the treatments, these hormone and surgical treatments put kids and young people on a path of harm.

24. I was not able to grow up in a healthy way. I have been deeply scarred by these treatments. My relationship with my parent, whom I wish would have protected me, is deeply strained.

25. I know from experience that this path leads to depression, suicide, or ending up like me, physically marred and out of place with everyone. At times I do

not even feel like a person, but more like a freak. Even if some may feel they want the treatments as I did, these treatments lead nowhere good. I do not want to see other young people similarly harmed.

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

Dated: October 3, 2022.

/s/ *C.G.*
C.G. (pseudonym)

Appendix Attachment

14

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. SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Defendants*.	Civil Action No. 4:22-cv-00325-RH-MAF

Declaration of Camille Kiefel In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, Camille Kiefel, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Preliminary Injunction and Complaint.

2. Florida Administrative Code § 59G-1.050(7), which prohibits Medicaid coverage for medical and surgical interventions meant to "alter primary or secondary sexual characteristics," is a necessary and potentially life-saving regulation that will protect vulnerable young people from physical and mental harm, irreversible physical changes, and deep regret that I have experienced.

3. The Florida regulation is particularly important to me in that my surgery was paid for by Medicaid. Had a regulation like Florida's been in place when I sought my surgery, it would have required me to pause before undergoing surgery and perhaps prevented me from the loss of health body parts I now regret.

4. I suffered a series of traumatic events while growing up that distorted my view of the sexes. My parents went through a difficult divorce in which my mom was emotionally dysfunctional and spiteful, while my dad was more stable. In fifth or sixth grade, I began to wear girly preteen fashion and my dad told me how men his age talked about girls my age. My dad told me later that he was concerned about me being promiscuous. Then my friend was raped by her brother and the police interviewed me. I found the whole experience traumatic.

5. I was diagnosed with ADHD and put on medication to which I reacted poorly. That made me further lose respect for my mom because she had put me on the medication.

6. I then began to dress masculine. Previously an avid writer, I developed writer's block. I then focused on Anime.

7. In high school, I changed my diet and stopped eating meat. I started to have depression. There is evidence that suggests a meatless diet can contribute to depression.

8. In college I was ostracized by the "call out" culture, because in that culture if you are not part of a group then you are worthless.

9. I have done all kinds of therapy over the course of 20 years, including talk therapy, hypnotherapy, EMDR (eye movement desensitization and reprocessing), DBT (dialectical behavior therapy), TMS (transcranial magnetic stimulation therapy), Somatic Experiencing, and medications.

10. In 2016, I started seeing a gender therapist and came out as nonbinary.

11. I was still dealing with anxiety and depression and in 2020 I was on my second set of TMS, trans-cranial magnetic stimulation, treatments which helped some but not as much as I felt I needed. So, I turned to top surgery for an answer.

12. I did not want to be a man or a woman but instead wanted out of all sex types. I had a double mastectomy with nipple grafts in August 2020, not to emulate either sex but to be non-binary.

13. I had seen "female to non-binary" "top surgery" on the internet and believed it was an accepted, proven treatment. I did not realize at the time that it is experimental and had discomfort around my breasts due to trauma.

14. I received two letters recommending surgery from two mental health professionals at gender clinics one in May 2020 and the second in July 2020. Although I had a number of mental health issues and years of treatment, these providers did not review or ignored my records nor did they do a psychological evaluation even though they acknowledged that I had trauma.

15. I developed complications from the surgery. I developed "Raynaud's Syndrome" in which one's capillaries shrink and caused my extremities to get cold and discolored. This caused great discomfort. I also developed a burning sensation in back of my neck, tinnitus (ringing) in my ears, musculoskeletal issues, skin discoloration, most likely bone spurs, and insomnia.

16. My suicidal ideation worsened. I became terribly sleep deprived and my anxiety worsened. I became deeply depressed and distraught over time after the surgery. I knew something was going wrong with my body. My mother had to lay down with me to help me sleep. I had many physical problems and made many trips to the ER. The doctors were stymied. My mother talked to me about psychiatric hospitalization.

17. Rather than fixing my problems, the surgery made my physical and mental health worse.

18. I began to focus on holistic treatments through my own research with the help of a naturopathic doctors, bodywork practitioners, and trained staff certified in functional hyperbaric medicine who did treatments that helped restore balance to my nervous system. The holistic treatments helped me a great deal, and as my physical health improved so did my mental health. I began a slow progression to reconnect with my female body and womanhood.

19. I began looking at different information that offered different perspectives than I had received from internet transgender sources.

20. I detransitioned in 2022 when, after the effective holistic treatments, I was at peace with the realization that I am a woman.

21. I hate that I underwent the surgery. I can never breast feed if I have children. For many years I did not want a family because I felt so poorly physically and mentally. Now I want to marry and have kids. I can't fit clothing the same way again.

22. I believed that I was doing everything I was supposed to do. Now I realize that I was having a number of physical and mental health problems that no professionals investigated or addressed before prescribing a treatment that caused me to lose a part of my body.

23. Surgery is such a drastic, irreversible step. As I experienced, we do not truly know what these surgeries will do to the body – they are experimental. They are doing surgeries for a state that does not exist in nature. Those undergoing the surgeries are putting their bodies at risk and subjecting their bodies to trauma.

24. I am quite concerned that doctors are not running the right lab tests or doing the right holistic medical assessments to find out what is truly causing gender dysphoric patients their dysphoria and the desire to surgically remove parts of their body.

25. I have significant concerns about the experimental nature of the surgery. There is no biological blueprint for the surgery. There are no controlled studies. As I have experienced, because of the experimental and unpredictable nature of these surgeries the medical care one receives afterward is abysmal because they don't know what to do for you. These surgeries should not be funded by tax dollars.

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

Executed on October 3, 2022.

/s/ *Camille Kiefel*
Camille Kiefel

Appendix Attachment

15

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. SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Defendants*.	Civil Action No. 4:22-cv-00325-RH-MAF

Declaration of Carol Freitas In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, Carol Freitas, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for Preliminary Injunction and Complaint.

2. Florida's Rule 59G-1.050(7) of the Florida Administrative Code prohibits Medicaid coverage for medical and surgical interventions meant to "alter primary or secondary sexual characteristics." This rule is a much needed regulation that will protect dysphoric young people from focusing on treatments that may ultimately seriously harm their physical and emotional health and that overlook untreated mental health issues and negative social influences and displace other more effective and less intrusive options.

3. As a youth, I was what some describe as "gender non-conforming," but I lived in a household where gender expression was strictly aligned with cultural stereotypes. I was not allowed to wear boys' clothes or play boys' sports.

4. At puberty I realized I was same-sex attracted with crushes on girls. I became depressed and anxiety-ridden as fear what "being gay" might mean to how I lived my life and my family relationships. I later dropped out of high school.

5. At age 20 I began to meet other LGBT youth and my life stabilized. However, I also learned that many masculine females, like me, felt that they were "born in the wrong body" and were transitioning, so I adopted that persona.

6. I went to a gender therapist who diagnosed me with gender dysphoria and told me that transition was the only treatment that would alleviate my discomfort and anxiety.

7. However, at that time there were gatekeeping standards for gender transition, which required that I first live as man for six months, including using a male name, showing a male appearance, and using male spaces. I had very large breasts and could not pass for a male in male spaces, so I did not pursue testosterone at that time. I viewed myself as a male trapped in the "wrong body," but my mental health otherwise was stable.

8. In 2014, I revisited the idea of transitioning, believing it would make me feel better because I was undergoing trauma in various forms. My grandmother who had practically raised me died. I had suffered severe abuse and neglect in childhood, and in retrospect believe I was experiencing symptoms of PTSD from that. I had just become a new mother a couple of months before my brother-in-law committed suicide.

9. I spiraled downward and wanted out. I couldn't commit suicide because I was a mother, so I returned to the idea of transition, believing it would help me feel better. By that time the requirements for testosterone had lessened. I went to Planned Parenthood for testosterone and was given it right away. I was not given any information on uterine atrophy, vaginal atrophy, or other effects of testosterone and the staff did not talk about any of my emotional or mental health issues.

10. Four months after starting testosterone, I went to a plastic surgeon for a double mastectomy. I needed a letter from a therapist and received one from the

therapist who had affirmed me and originally recommended transition. As was true with testosterone, I was not given any information about the procedure. Instead, I had a consultation with the surgeon, who said "this is what we are going to do," drew on my chest, took pictures and asked me what I wanted out of the surgery. He said, "we'll create a masculine looking chest, you'll look great."

11. During the first four months on testosterone menstruation stopped, my sex drive went way up, my voice deepened, and facial and body hair came in. As I continued on testosterone, my personality changed drastically and my verbal abilities declined. Testosterone lowered and muted my emotions and empathy, but also gave me a lot of energy and a sense of a high. My depression and anxiety worsened to the point that I was having such severe panic attacks that I could not leave home. I told my doctors that I thought the testosterone was making the anxiety worse, but they said no.

12. I went to a psychiatrist to deal with the depression and I was provided with an anti-depressant that really worked. I felt mentally stable and able to address the trauma that led me to transition.

13. Within a month of starting the anti-depressant, I realized that I had not needed to transition. It was the biggest mistake I had ever made. I did not detransition for a year because I couldn't believe that it was so easy, i.e., that anti-depressants alleviated my depression and enabled me to think clearly and reason better. This

allowed me to address my internalized homophobia and childhood abuse through therapeutic means.

14. Meanwhile, my health began going downhill. Before going on testosterone, I had no health problems. After being on it for four years, I was pre-diabetic, had high cholesterol, and had a high red blood cell count to the point that doctors were recommending that I donate blood to reduce the volume.

15. I stopped taking testosterone and four months later my blood work was back down to normal. I thought to myself "How do they [doctors] not know about this?" Going off testosterone allowed me to finally sleep. I felt like I never slept all the time that I was taking testosterone. Going off testosterone also helped with empathy and other emotions. My personal relationships, including my relationship with my wife, were better.

16. I believe that healthcare providers did not ask me about mental health issues because they believed that those issues were caused by gender dysphoria and that transitioning would fix the problem. In fact, the opposite was true.

17. Florida's Rule is necessary and essential because it will give gender dysphoric people the chance to work through and address their underlying issues such as depression, trauma, or PTSD effectively without doing their body harm and undermining their health. I would have been spared physical, psychological, and emotional losses if I had received a proper diagnosis and treatment for PTSD and

depression instead of undergoing years of medical and surgical interventions. Prioritizing treatments focused solely on gender dysphoria caused my doctors to miss the real mental health issues that should have been treated by other more effective, less destructive means.

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

Dated: October 3, 2022.

/s/ *Carol Freitas*
Carol Freitas

Appendix Attachment

16

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.

SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

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

Declaration Of Chloe Cole In Support Of Plaintiffs' Opposition to Defendants' Motion For Preliminary Injunction.

I, Chloe Cole, declare as follows:

1. I am 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Preliminary Injunction and Complaint.

2. Florida Administrative Code § 59G-1.050(7), which prohibits Medicaid coverage for medical and surgical interventions meant to "alter primary or

secondary sexual characteristics," is a necessary and potentially life-saving regulation that will protect vulnerable young people from the heartbreaking regret, irreversible physical changes, and emotional pain that I have experienced.

3. Starting around the age of 12, I began to believe that I was transgender. This belief was not organic. All the media I consumed as a kid showed me how stupid and vulnerable being a girl was. All the sexualized images of women gave me an unrealistic expectation of womanhood.

4. I spent a lot of time online and quickly saw all the praise coming out as "trans" got on Instagram and other social media. I was a bit awkward in school and had some trouble making friends.

5. Like many dysphoric children, I also suffered from a variety of mental health conditions, such as ADHD, so I easily fell prey to the narrative that if I felt different, and did not want to be a highly sexualized girl, that I must be a boy.

6. I obsessed over becoming a boy. I believed that all of my insecurities and anxiety would magically disappear once I transitioned. The mental health professionals did not try to dissuade me of this delusional belief.

7. I was fast-tracked into medical transition after I was diagnosed with Gender dysphoria. In my home state of California, a child can pick their gender identity and a care provider cannot question that choice because it would be regarded as illegal conversion therapy. This wasn't a misdiagnosis, it was mistreatment.

8. I was diagnosed with gender dysphoria by a "gender specialist" when I was 12. The gender specialist told my parents that children know their gender from a young age, and I know what's best for myself. The specialist cited the suicide rate and said, "If you don't affirm your child she will commit suicide." The specialist asked them, if they would they rather have a "dead daughter or live son." My parents complied because they were not offered any other treatment solution for my distress. My distraught parents wanted me alive, so they listened to my doctors.

9. I started receiving puberty blockers at age 13. A month later I was put on testosterone. I stayed on puberty blockers for a year and on testosterone for three years. At the time I received the hormones, the endocrinologist cited some of the risks, including vaginal atrophy and inability to have children. However, I did not really understand what that would mean and didn't realize that could involve other pelvic structures. I was in 8th grade. I had no concept of what it would someday mean to me as an adult to have children. I cannot imagine a doctor asking a child this and expecting them to make a mature judgment.

10. While taking the hormones I began having severe hot flashes, like women in menopause. My entire body got very itchy. After a while I would sometimes hear loud cracks in my neck and back.

11. The hormones caused atrophy of my urinary track. I suffered from urinary track infections and blood clots in my urine. I did not want to discontinue

testosterone because I wanted to continue to be treated as a boy. I also developed digestive problems.

12. I also experienced a very heightened libido which was very difficult to deal with at such a young age. This caused me to make a lot of regrettable sexual decisions.

13. The treatments seemed to worsen my mental health the longer I was on them. My anxiety got worse, and I became prone to making rash and regrettable decisions. And as discussed below, I also became suicidal.

14. I was approved for a double mastectomy at 15. I had been binding my breasts for about two years. I had been groped by a classmate in 8th grade and wanted to make sure that did not happen again. From the time I began seeking a mastectomy to having my breasts removed was only six months. There was no psychological evaluation. I was simply referred to a surgeon by a gender specialist.

15. During the surgery, the nerve endings and blood vessels in my breast tissue were severed and my nipples were removed and grafted onto another part of my chest to make my chest appear more masculine. So I will not have normal sensation.

16. I have had serious complications from the surgery. After 2 years the skin at the surgical site started to regress and the top layer of skin is failing to heal.

The tissue continually emits fluid, such that I have to wear bandages. I was given the impression that the grafts would heal in nine months, but that is not true.

17. The surgery has also affected me mentally as I am really struggling with the fact that I will not be able to breast feed my future children. I was told about this, but no teenager is able to grasp what that means.

18. About 11 months after my surgery I began experiencing grief. I realized this was a mistake, that I had lost a part of my body that will mean that I will not be able to bond in an important way with any future children and might not be able to even have children.

19. I started to become suicidal for the first time. I was not suicidal prior to the treatments. I was beginning to feel growing alienation. I began to experience increasing suicidal thoughts. Although I did not act on them, they were taking a toll on me.

20. I broke down one night as it all came to a head and made the decision to stop the testosterone. I also dropped the male identification and began to identify again as a female.

21. At first some things got worse as I had more UTIs, more blood clots in my urine, and worse digestive issues. I was very emotionally volatile, and my suicidal ideation got worse. I became very sick and lost a lot of weight. My overall

mental health got worse. I had to drop out of school and get a GED because I couldn't perform at school.

22. Over time my body began to readjust. My features resoftened. The fat in my body and body shape began to return to a female form and I have regained the weight.

23. Currently my mental health is stable. The treatments were just band aids for my mental health issues. I still struggle, but my depression and anxiety have improved.

24. At no point in my journey did anyone explore why I did not want to be girl.

25. More and more kids are falling for the false promise of happiness if they transition. Gender clinics in the United States are turning a blind eye to European countries, who are pumping the brakes on this experiment on youth.

26. Fortunately, Florida regulators are not turning a blind eye. Enacting the regulation that bans Medicaid payment for these treatments is an important step in the state doing no harm to its citizens through these treatments. It should not have been an option for me to be prescribed hormone treatments that caused me harm and may have affected my fertility, or to have my healthy breasts removed at the age of 15. This regulation will help decrease the chance that it will be an option for

vulnerable teenage girls in Florida. Taxpayer money should not go toward paying for child mutilation and child sterilization.

27. Even for adults, these treatments are at best cosmetic. They do not enhance function, but actually take away functions from the body. They are elective. The state should not be paying for treatments that actually remove or distort normal bodily functions, and yet do not bring long-term relief.

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

Executed on October 3, 2022.

/s/ *Chloe Cole*
Chloe Cole

Appendix Attachment

17

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.

SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

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

Declaration of KathyGrace Duncan In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, KathyGrace Duncan, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of

Defendants' opposition to Plaintiffs' Motion for Preliminary Injunction and Complaint.

2. Florida's Rule 59G-1.050(7) of the Florida Administrative Code (the "Challenged Exclusion") prohibits Medicaid coverage for medical and surgical interventions meant to "alter primary or secondary sexual characteristics." This Rule is an appropriate and necessary regulation that will protect young people and patients of any age from the regret of false promises, untreated trauma, and irreversible physical changes and lost previously healthy body parts.

3. From a very young age, I was what is called today "gender non-conforming." I preferred male clothing, I thought I was a "boy" and I wanted to live as one.

4. I grew up in a dysfunctional family in which my mother was often the victim of my father's emotional and verbal abuse. As a result I internalized the message that "my dad would love me if I were a boy."

5. Sexual abuse by a family member between the ages of 10 and 12 further convinced me that being a girl meant being unsafe and unlovable.

6. In sixth grade, I learned about female to male transsexuals. I believed that my distress was caused by not having the "right" body and the only way to live a normal life was to medically transition and become a heterosexual male.

7. At age 19, I began living as a man named Keith and went to a therapist who formally diagnosed me with gender dysphoria. I began testosterone and a year later had a double mastectomy. At the time, I believed it was necessary so that what I saw in the mirror matched what I felt on the inside.

8. I never viewed my condition as touching on mental health issues, and neither did the therapist who diagnosed me. The question of whether my self-perception and desire to transition was related to her mental health issues was never explored.

9. After 11 years passing as a man and living what I thought was a relatively "happy" and stable life (which included having a number of girlfriends), I realized that I was living a lie built upon years of repressed pain and abuse. Hormones and surgery had not helped me resolve underlying issues of rejection, abuse, and sexual assault. I came to understand that my desire to live as a man was a symptom of deeper unmet needs.

10. With the help of life coaches and a supportive community, I returned to my female identity and began addressing the underlying issues that had been hidden in my attempt to live as a man. I experienced depression that I had repressed for years and grieved over the irreversible changes to my body.

11. If someone had walked with me through my feelings instead of affirming my desire to transition, then I would have been able to address my issues more effectively and not spend so many years making and recovering from a grave mistake.

12. Florida's Rule is necessary and essential because it will give gender dysphoric young people (and even older adults) a chance to work through their feelings, which can be overwhelming and deeply confusing, and address their underlying issues effectively without being pulled onto the affirmation medical conveyor belt.

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

Dated: October 3, 2022

/s/ *KathyGrace Duncan*
KathyGrace Duncan

Appendix Attachment

18

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.

SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

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

Declaration of Sydney Wright In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, Sydney Wright, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Preliminary Injunction.

2. Florida's Rule 59G-1.050(7) of the Florida Administrative Code (the "Challenged Exclusion") prohibits Medicaid coverage for medical and surgical interventions to "alter primary or secondary sexual characteristics." This Rule is

needed to protect vulnerable young people from being misled and from physical harm like what I experienced.

3. I'm a 23-year-old woman who spent a year as a "transman" after taking mega doses of testosterone at age 18.

4. I began to identify as transgender in 2017 during counseling after reading about transgenderism on the internet. I had not experienced feelings of gender dysphoria prior to this time.

5. A neighborhood boy engaged in sexually touching with me from age 5 to 12. This awakened sexual feelings at too young an age and caused me to feel unsafe.

6. I was very tomboyish growing up and was sometimes bullied. I began having same-sex attractions as a teen. I was raised in a strict religious home, where homosexuality was frowned upon. When my father learned that I had same-sex attractions he kicked me out of his house (my parents divorced when I was 12) and I went to live with my mother.

7. I was first introduced to transgenderism on social media at around age 18. I began to question if I was really a man because I was attracted to girls.

8. I cut my long blond hair, which caused me to look more masculine. This made me want to move quickly through transition.

9. I started seeing a counselor on June 13, 2017. I disclosed to the counselor that I had been sexually molested for years as a child, about my parents' contentious divorce, and about my dysfunctional relationship with both parents. I also disclosed that I was in a dysfunctional marriage to a physically abusive woman who bought and sold drugs.

10. The counselor did not explore how any of this history might be contributing to my dysphoria, but simply asked some questions and diagnosed me with gender dysphoria and gave me a recommendation to a physician for testosterone treatment within five weeks of our first meeting.

11. My frame of mind at the time, at age 18, was that I believed I might have been "born in the wrong body" and needed to correct it. But I was also unsure, confused, and in need of guidance. Had a professional told me the truth and helped me explore why I was distressed by being a girl (and a lesbian) in a nonjudgmental way, I would not have proceeded with testosterone.

12. However, that was not the case, and I met with the doctor in Atlanta Georgia to whom the counselor referred me. The visit lasted about 10 minutes. He asked me for my "hormone letter," but did not open it or read it. He did not ask any questions to confirm that I had gender dysphoria or any questions concerning my medical history or past or present physical condition or symptoms.

13. I told the doctor that I was nervous, and he simply asked, "Do you want to do this?" and told me I could pick up the testosterone that day. I asked the doctor if he would administer the injections in the office. He said no and told me to go home and look on You Tube to find out how to give myself the shots, indicating "There's no wrong way to do it." I later learned that the shots were supposed to be administered intramuscularly after administering them subcutaneously in my stomach which caused pain and bubbles to form under the skin.

14. My voice began to deepen, which I have found out is going to be a permanent, irreversible change.

15. I gained over 50 pounds and became pre-diabetic. When I mentioned this to the physician during a follow up appointment, he just told me to start working out.

16. After about a year on testosterone, test results revealed that my blood was starting to thicken, my red blood cell count was too high, and I was developing a blood disorder that could lead to a heart attack or stroke if not controlled. I did some research and believe this was polycythemia. I began experiencing chest pains and was told I had developed a blood clot in my lungs because of the thickening blood. I also developed tachycardia.

17. I began suffering excruciating and constant abdominal pain and could not eat. Testing did not reveal any disorders. I was later diagnosed with irritable bowel syndrome, which I continue to suffer with.

18. The pain was becoming so excruciating that I became suicidal. My mental health was deteriorating as I was suffering from depression, irritability, insecurity, and exhaustion.

19. The changes brought on by the testosterone caused my family tremendous emotional distress. Finally, my grandfather sat me down with tears in his eyes and asked me to stop what I was doing to myself. That was a saving grace. I would have let the treatment kill me before admitting that I had made a mistake. My grandfather's intervention saved my life.

20. I stopped taking testosterone and resumed living as a female. My physical and mental health have improved, but I continue to suffer adverse effects from the treatments, including a deepened voice and digestive issues that I've been told will be permanent.

21. I also suffer extreme regret for the choices I made as a teenager. I trusted the doctors' advice. They were the experts, who was I as a confused and scared 18-year-old not to listen to them?

22. But telling an I8-year-old girl that mega-doses of testosterone would fix her mental health problems? They didn't even talk to me about other treatment

options. No doctor or therapist suggested I give myself time to grow up, or suggested counseling for what was causing my feelings - no doctor or therapist told me most young people outgrow their feelings of wanting to be the opposite sex. The only advice I got was to take mega-doses of testosterone.

23. Unfortunately, there are more and more young people like me being deceived every day, being told that the solution to their insecurity and identity problems is to get a "sex change." The problem is a person's sex can't really be changed. You can take hormones and have cosmetic surgeries, but that doesn't really change your sex, or solve your problems. I wish I knew that when I was younger.

24. Florida's Rule is a critical and necessary regulation that will help spare Florida citizens from being similarly misled and suffering the distress I am continuing to suffer because of the availability of medical interventions to young people like me. This Rule will save a lot of pain and may even save lives.

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

Dated: October 3, 2022.

/s/ *Sydney Wright*
Sydney Wright

Appendix Attachment

19

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.

SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendants.

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

Declaration of Zoe Hawes In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, Zoe Hawes, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Complaint and Motion for Preliminary Injunction.

2. Florida Administrative Code § 59G-1.050(7), which prohibits

Medicaid coverage for medical and surgical interventions meant to "alter primary or secondary sexual characteristics," is a necessary and potentially life-saving regulation that will protect vulnerable young people from the regret of false promises, deteriorating mental health and loss of life.

3. I'm a 23-year-old wife and expectant mother who would have been deprived of motherhood if state funding of medical and surgical interventions had been available when I was a traumatized teenager looking for a quick fix to relieve my pain.

4. A series of traumatic events, including my parents' divorce when I was 8 years old, my mother's mental health struggles, including her suicide attempts, and being molested by a classmate at school, left me with significant mental health problems by the age of 15.

5. I was diagnosed with major depression, anxiety, complex PTSD and Obsessive-Compulsive Disorder by different doctors at mental hospitals. I saw several therapists and psychiatrists.

6. When I was 16 years old, I was attracted to women and began researching the LGBTQ community online. I came across a book, "Some Assembly Required," which was a memoir of a female to male transgender young person. I was extremely depressed at the time and immediately resonated with the young person's story. It became the explanation I clung to for the pain in my life.

7. My mom found a gender therapist who did the bare minimum required to be able to write a letter approving me for hormones. I saw her for three months, but she asked me very few questions. I was desperate to get the hormones, so I was willing to say anything to get the letter. I was diagnosed with gender dysphoria and encouraged to pursue medical transition.

8. Once I received the letter from the gender therapist, an Endocrinologist prescribed testosterone for me at age 16 with my mom's consent. At first, my mother did not know what to think, but I was so suicidal that she was willing to go along.

9. I was on testosterone for nearly 4 years. At age 16, I was absolutely convinced that I was a male in a female body, and that transitioning from female to male was the only thing that would bring me peace.

10. My body started to masculinize pretty quickly after I began testosterone injections. I developed a more male musculature. My hips seemed narrower. My jaw seemed more angular. Facial hair grew. Every change in my body that made me appear more masculine made me euphoric. I was quickly able to present socially as male without people recognizing I had been born female.

11. I also became more angry and developed debilitating anxiety while on testosterone. I felt tired and gained a lot of weight. My mental health was

negatively affected by the testosterone. The initial euphoria would wear off and I would still have the same problems.

12. I was introduced to the LGBTQ community. I joined an LGBTQ group for young people in my city, where I was "love bombed" and affirmed in my new identity. The group encouraged me to cut off anyone who did not affirm my male identity, new name, and new pronouns. I followed that advice and became estranged from my father and his family, who would not affirm the male identity. I did not talk to my father's family for over four years.

13. I was also binding my breasts, which was causing chest pain and headaches.

14. My mental health was terrible while I was on testosterone. I was hospitalized six times while on testosterone and in each case the doctors affirmed my male identity. I was also in outpatient programs multiple times. In 2018, I tried to commit suicide and was again hospitalized. Finally, I began to do the inner work I needed to do to start to heal.

15. At age 20, I stopped taking testosterone and my body began to regain its female characteristics. I am no longer on any mental health medications or receiving therapy. I believe the gender dysphoria was brought on by trauma and culture – by people and medical professionals encouraging me to believe that becoming a man was an option and transitioning would bring me peace.

16. I reconciled with my father's family, who remained an anchor to reality and affirmed me as the woman that I am and who have helped me on the long journey to learn what is means to be a woman, a daughter, and now a wife and mother.

17. At the time that I was taking testosterone, between ages 16 and 20, I desperately wanted gender transition surgeries. I wanted a double mastectomy because I was binding and it was very uncomfortable, so much so that I once had threatened to take a knife to my chest. I also wanted a hysterectomy because at that age I did not want to have to worry about periods or ever getting pregnant.

18. The only reason I did not get the surgeries was that I did not have the money to pay for them. If the state had been willing to pay for them through Medicaid, then I absolutely would have had them, and would have never found the peace with my female body I now enjoy and would not be able to experience being a mother or breastfeeding my son.

19. If access to these treatments is easily affordable, then it could do great damage to a young person that may not be able to be undone.

20. I am convinced that funding these treatments is funding a false chemical or surgical promise – that these chemicals or surgery will bring lasting peace to what is truly causing body dysphoria. This would mask a great deal of

mental illness. It would likely result in increased suicides, as these treatments almost did to me.

21. By not having state funding available for these procedures, I was saved, as was my future child. This regulation will save lives.

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

Dated: October 3, 2022.

/s/ *Zoe Hawes*
Zoe Hawes

Appendix Attachment

20

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. SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Defendants*.	)	Civil Action No. 4:22-cv-00325-RH-MAF

Declaration of Yaacov Sheinfeld In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, Yaacov Sheinfeld, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Complaint and Motion for Preliminary Injunction.

2. Florida's Rule 59G-1.050(7) of the Florida Administrative Code (the "Challenged Exclusion") states that Florida Medicaid does not cover services for the treatment of gender dysphoria.

3. Florida's Rule will prevent manipulation and coercion on the part of health care providers and from that of their own distressed and confused children to comply with demands for medical and surgical interventions aimed at "affirming" a young person's professed discordant gender identity under threats of alienation or loss of a child to suicide. Most importantly, this law protects vulnerable children and young people from grievous harm and even death.

4. Had a law like Florida's Rule been in effect Massachusetts my daughter might still be alive today.

5. My daughter, S. had been in counseling for depression since age 15, but had never said anything about gender dysphoria to her counselor.

6. At age 17, S.'s mother told me that S. was transgender. I did not think it was a good idea to pursue transitioning, nevertheless, I told S. that I would help her in any other way.

7. S. had suffered a lot of rejection in school and was seeking affirmation. Five of her friends announced that they were transgender. When S. said she was transgender too it was seen as fashionable and she finally had the peer acceptance she had not previously experienced in high school.

8. When S. went to college at age 18, unbeknownst to me, she began taking testosterone. When I met with her at school, I noticed she was very depressed.

9. A social worker who was also present at my meeting with S., Shannon Sennott, told me that S. was going to get a double mastectomy.

10. When I objected to her taking such a drastic step at such a young age, the social worker told me I was an "Israeli chauvinist", a typical chauvinist male, who doesn't love his child enough. Her approach was that this is what we're going to do and you need to just get on board.

11. The social worker assured me that everything would be fine if I just loved my daughter.

12. After this meeting S. refused to talk to me and began threatening that she would kill herself if she did not get the surgery she wanted. She had a double mastectomy at age 19.

13. I witnessed distressing physical and emotional changes in S. The changes in her because of the testosterone were so distressing that I even considered suicide at one time. S. gained and lost lots of weight, had pain all over her body, suffered from mood swings, could not concentrate, and described herself at times as "barely alive." At one point she was hospitalized in a psychiatric hospital for depression and suicidal thoughts.

14. S. was deeply depressed and taking a significant number of medications along with testosterone. It did not appear any medical professional was monitoring all these medications or even understood their possible interactions. I kept assuring her that I would do whatever I could to help her.

15. S.'s pain became so intense that she began taking Fentanyl.

16. S. was found dead on August 6, 2021 with Fentanyl and alcohol in her system. She was 28. S. had been identifying as a male and taking testosterone for ten years.

17. Florida's Rule and similar laws to not cover services for the treatment of gender dysphoria are critically important because young people, especially those with mental health issues such as S, cannot make clear decisions about their future, particularly when neither they nor their parents are provided with full information about the effects of these interventions. We know from research that the brain is not fully formed until a person reaches her mid-20s, so even a healthy 18-year-old does not have the mental maturity to make life-altering decisions such as taking cross-sex hormones or surgeries that will significantly alter their bodies and impact their mental health.

18. The medical interventions that were promoted to my daughter with a promise that they would relieve her problems, in fact, increased them and led to her death.

19. Parents should not be put in the position to support decisions for their child that can result in infertility or other life-long harms, especially when the young person has mental health issues that are not being addressed.

20. Florida's Rule protects parents from being coerced into supporting these decisions through manipulation and threats like the one leveled at me that my daughter would commit suicide if she did not get the intervention she demanded. Most importantly, it will save the lives of vulnerable young people like my daughter.

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

Dated: October 3, 2022.

/s/ *Yaacov Sheinfeld*
Yaacov Sheinfeld

Appendix Attachment

21

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*,	)	Civil Action No. 4:22-cv-00325-RH-MAF
v.	)	
SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Defendants*.	)	

Declaration of Julie Framingham In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, Julie Framingham, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for Preliminary Injunction and Complaint.

2. Florida's Rule 59G-1.050(7) of the Florida Administrative Code (the "Challenged Exclusion") states that Florida Medicaid does not does not provide coverage for hormonal and surgical interventions to "alter primary or secondary sexual characteristics."

3. Florida's Rule will protect vulnerable young people like my son from grievous harm. This rule will prevent the State from facilitating further harm to vulnerable young people like my son by paying for life-altering and irreversible treatments that will not address their underlying mental health issues and will likely cause such young people to forego needed mental health treatment.

4. My son, T., was an Eagle Scout, martial arts student who at age 22 decided he was transgender. After six years of social transitioning and hormone treatments T. has lost a great deal of weight, is anorexic and extremely underweight, sometimes not eating for days, and has significant mental health problems.

5. T. was depressed as a teenager. He kept his feelings inside and wouldn't see a therapist. T. was not comfortable with his looks and was seen as a geeky, small boy. He showed signs that he hated himself, including refusing to brush his teeth so that they rotted away.

6. There were trans-identified kids at T.'s high school but he showed no interest in them at that time. He attended community college in Tallahassee and

Florida State University, which were very progressive campuses. He was around others who were trans-identifying.

7. At age 19 or 20 T. began wearing girls' accessories. He saw a social worker in Tallahassee for a couple of months, and she gave him information about where to get hormone treatments.

8. He began taking estrogen and spirolactone (lowers testosterone). He got the prescriptions from an endocrinologist at Tallahassee Memorial Hospital and the FSU medical group. I do not know whether any of the practitioners did a psychological evaluation prior to prescribing hormones.

9. T. was binding his testicles for a time in an effort to appear more feminine. However, he developed health problems related to the binding in that it cut off oxygen and permitted infection to develop. As a result T. stopped binding and began to just wear loose-fitting clothing.

10. T. began seeing a therapist when he was 23. He said the therapist was very helpful with dealing with anxiety, but T. refused to talk with the therapist about this trans identity. T. had spent a lot of time online listening to trans advocates who affirmed his trans identity and he would not stay in therapy.

11. The therapist diagnosed T. with borderline personality disorder. Patients with borderline personality disorder often hate themselves and will engage

in self-harm. She explained that T. had let his teeth rot away because he hates himself.

12. T. has not undergone any surgeries because he hasn't been able to pay them.

13. T. has not received any treatment for his underlying borderline personality disorder. His father and I are concerned that if the state were to pay for surgery to remove his penis and testicles he will not get the treatment he needs for his actual underlying mental illness. That is a great concern because so long as he has untreated mental illness he will continue to engage in self-destructive behavior and to decline. The trans identification and hormone interventions operate as a vehicle for self-harm. Adding irreversible surgery on top of that would only compound the harm.

14. Florida's Rule 59G-1.050(7) will prevent the state from enabling vulnerable young people like my son to receive life-altering irreversible treatments that result in the loss of healthy body parts and bodily functions and yet will not actually treat what is causing their mental health problems. We are concerned that without this Rule underlying mental health issues such young people are experiencing will go untreated.

15. For T. and many others like him, the regulation would very likely save their lives and a life-time of regret.

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

Dated: October 3, 2022.

/s/ *Julie Framingham*
Julie Framingham

Appendix Attachment

22

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. SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Defendants*.	)	Civil Action No. 4:22-cv-00325-RH-MAF

Declaration of Jeanne Crowley In Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction

I, Jeanne Crowley[1] declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of

[1] Declarant is submitting this Declaration using a pseudonym to protect the privacy of her children and other family members.

Defendants' opposition to Plaintiffs' Complaint and Motion for Preliminary Injunction.

2. Florida's Rule 59G-1.050(7) of the Florida Administrative Code (the "Challenged Exclusion") states that Florida Medicaid does not does not provide coverage for hormonal and surgical interventions to "alter primary or secondary sexual characteristics."

3. This Rule is necessary to prevent parents such as myself from being subjected to coercion, manipulation, alienation from their child and help support parental rights to make medical and mental health decisions that will protect their children's developing bodies and long-term physical and mental health.

4. My husband and I were repeatedly told that the puberty blockers our pre-teen daughter, M., was clamoring for were the answer for her anxiety and distress about her changing body. We were advised that children like M. had high rates of suicide and self-harm and that puberty blockers would help by stopping the development of secondary sex characteristics that cause children distress and "give the children time to explore their identity."

5. Gender-affirming mental health and medical professionals assured us that acceding to our daughter's demand for puberty blockers was necessary for her mental health. We were repeatedly assured that the puberty blockers were nothing more than a "pause button" and completely reversible. We were not told that these

treatments could cause harm to our child's developing bones or that there were no clinical studies establishing them to be safe and effective as a "treatment" for gender dysphoria in children.

6. Based on these assurances we consented to M. receiving a long-lasting puberty-blocking implant. Once the implant was in place, there was no follow up. I had to initiate contact with the clinic to replace the implant and get necessary lab work.

7. M. previously had psychological evaluations that revealed depression, Autism Spectrum Disorder (ASD) with sensory issues, dyslexia, and dysgraphia. M. had also experienced social trauma. However, none of these issues was addressed by health care professionals once they determined M. had gender dysphoria. Nor did they offer any other treatment options.

8. I learned through my own research that puberty blockers were shown to cause loss of bone density and diminished cognitive development. Healthcare professionals did not inform my husband and me about those harms. When we raised the issue, the doctors responded that they have been prescribing the blockers for many years to treat precocious puberty and the reported bone loss was "nothing to worry about."

9. I had a bone density scan done for M. It revealed that M. has an 11 percent loss of bone density in one hip, 14 percent loss in the other, and a 7 percent

loss in the lumbar region. She has developed osteopenia at a time in her life when her bone density should be increasing and her body building a reservoir of strong developing bones as an important protection against osteoporosis in adulthood.

10. When my husband and I confronted the physician to have the puberty blocker implant removed, the doctor recommended that M. continue on to cross-sex hormones, *i.e.,* testosterone. We were not informed this would very likely *sterilize* our child. I declined, pointing out to the doctor that it is estrogen, not testosterone, that improves bone density.

11. Throughout the time that M. was on puberty blockers, we had difficulty finding a therapist to explore M.'s underlying mental health issues. Therapists were unwilling to address anything other than affirming M. as transgender. After we had the blocker removed M. worked with a psychotherapist that was willing to explore the underlying issues with M. However, she continues to have loss of bone density that will significantly affect her physical health and growth and having lasting effects possibly for the rest of her life.

12. The availability of these medical interventions for a pre-teen girl distressed by changes in her body meant that neither M. nor her healthcare providers would consider other alternatives.

13. Florida's Rule will help prevent coercive manipulation and potential harm against vulnerable children like our daughter and should be upheld for the protection of children and their families.

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

Dated: October 3, 2022.

/s/ *Jeanne Crowley*
Jeanne Crowley (pseudonym)

Doc. 58

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

AUGUST DEKKER, et al.,

Plaintiffs,

v.

SIMONE MARSTILLER, et al.,

Defendants.

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

PLAINTIFFS' REPLY TO DEFENDANTS'
OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs reply to Defendants' Response in Opposition to Motion for Preliminary Injunction ("Response"), and state as follows:

INTRODUCTION

Resorting to rhetoric comparing gender-affirming care to eugenics, Defendants ask this Court to ignore decades of medical and clinical research supporting the provision of gender-affirming care, along with the prevailing opinion of every major medical organization in the country.

Defendants do not dispute—they cannot—that (1) Plaintiffs are transgender people with gender dysphoria—a serious medical condition—and that (2) Florida Medicaid has covered the medical treatment for their gender dysphoria. Instead, Defendants ask the Court to disregard the prevailing medical opinion and their

previous longstanding practice of providing coverage so that the State can disrupt the status quo and upend access to medically necessary care for transgender Medicaid beneficiaries like Plaintiffs.

Doing so is a violation, *inter alia*, of the Fourteenth Amendment and Section 1557, and would cause irreparable harm to transgender Medicaid beneficiaries across Florida, including Plaintiffs, without offering any benefit to the public.

ARGUMENT

A. The Challenged Exclusion is not Based in Science.

The Challenged Exclusion prohibits coverage for "medical treatment that conforms with the recognized standard of care for ... gender dysphoria," even though such care is "supported by medical evidence that has been subject to rigorous study." *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 670 (8th Cir. 2022) (cleaned up). Its purpose "is not to ban a treatment but to ban an outcome that the State deems undesirable." *Id.* (cleaned up).

To reach their desired conclusion, Defendants replaced scientifically supported and prevailing standards of care by cherry-picking five consultants, all of whom disagree with the generally accepted medical standards for treating gender dysphoria. *See, e.g.*, Schechter Supp. Dec. ¶4. Even the GAPMS Memo and Defendants' experts acknowledge that their views are outliers, far outside the medical mainstream. The GAPMS Memo concedes that 300 Florida health care

professionals with expertise in the treatment of gender dysphoria support use of the treatments. Def. App. 033. And the American Medical Association, American Psychiatric Association, Endocrine Society, and American Academy of Pediatrics, among others, uniformly support the use of these gender-affirming treatments. Courts have adopted the generally accepted views of these national medical organizations as well. *Kadel v. Folwell*, 2022 WL 3226731, at *32 (M.D.N.C. Aug. 10, 2022); *see also Eknes-Tucker v. Marshall*, 2022 WL 1521889, at *8 (M.D. Ala. May 13, 2022). But with the Challenged Exclusion, Defendants seek to simply push these standards aside.

B. Plaintiffs Remain Likely to Succeed on the Merits.

Defendants' Response avoids any meaningful confrontation with the reasoning of *Bostock v. Clayton Cnty., Georgia*, 140 S.Ct. 1731 (2020): "it is impossible to discriminate against a person for being … transgender without discriminating against that individual based on sex." *Id.* at 1741. While *Bostock* was decided under Title VII, it is beyond peradventure that sex discrimination is barred by the Fourteenth Amendment; Defendants cite nothing supporting the notion that transgender people are strangers to its protections.[1] Instead, Defendants rely on *Geduldig v. Aiello*, 417 U.S. 484 (1974), and *Dobbs v. Jackson Women's Health*

[1] Federal courts' analysis of disparate treatment sex discrimination claims under the Equal Protection Clause often mirrors the Title VII analysis. *See*, *e.g.*, *Naumovski v. Norris*, 934 F.3d 200, 212 (2d Cir. 2019).

Org., 142 S.Ct. 2228 (2022).[2] But neither support Defendants' conclusions. Plaintiffs already explained why *Geduldig* does not affect the requisite scrutiny here, and Defendants arguments do not respond in any meaningful way. (ECF 11, at 29 n.25.)

Defendants admit the Challenged Exclusion distinguishes based on a diagnosis of gender dysphoria (ECF 53, at 17), and "[d]iscrimination against individuals suffering from gender dysphoria is also discrimination based on sex and transgender status." *Kadel*, 2022 WL 3226731, at *20; *Brandt v. Rutledge*, 551 F.Supp.3d 882, 889 (E.D. Ark. 2021), *aff'd*, 47 F.4th 661.

The classification in *Geduldig* was not premised on a sex stereotype like the one presented here. *See Knussman v. Maryland*, 272 F.3d 625, 638 (4th Cir. 2001) (distinguishing *Geduldig*). Indeed, "[t]he very acts that define transgender people as transgender are those that contradict stereotypes of gender-appropriate appearance and behavior." *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011); *see also Boyden v. Conlin*, 341 F.Supp.3d 979, 997 (W.D. Wis. 2018); (ECF 11, at 23).

Moreover, the plain language of *Geduldig* and *Dobbs* call for the application of heightened scrutiny and hold that rational basis scrutiny is inappropriate when the regulation is a mere pretext meant to effect invidious discrimination. *Dobbs*, 142 S.Ct. at 2245-46; *Geduldig*, 417 U.S. at 496 n.20.

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[2] *Dobbs* merely repeats *Geduldig*'s holding. *Dobbs*, 142 S.Ct. at 2235.

The Challenged Exclusion is a pretext for discrimination, not borne out of concern for persons experiencing gender dysphoria. To determine whether treatment is experimental, Defendants' must undertake a balanced, scientific inquiry, seeking out reliable, unbiased evidence and opinions and then assigning proper weight to that information. Here, Defendants ignored that process and instead employed a sham rulemaking process, amplifying the voices of unqualified and unreliable purported "experts."[3] This occurred at the same time Florida's government sought to degrade the rights of transgender people on multiple fronts. (ECF 1, ¶126; ECF 11, at 14.) This context underscores the Challenged Exclusion's discriminatory pretext. Facts like these, that demonstrate discriminatory animus, were missing in *Geduldig* and *Dobbs.*[4]

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[3] Defendants' proposed experts are unqualified and unreliable. "Expertise in one field does not qualify a witness to testify about others." *Lebron v. Sec'y of Fla. Dep't of Child. & Fams.*, 772 F.3d 1352, 1368 (11th Cir. 2014). And *none* of Defendants' experts have experience providing gender-affirming care or treating gender dysphoria. A court has given Dr. Cantor very little weight based on his lack of experience with gender-affirming care, *Eknes-Tucker*, 2022 WL 1521889, at *5, and his qualifications were recently challenged in another case. *See B.P.J. v. West Virginia State Bd. of Ed.*, 21-cv-00316, ECF 320 (S.D.W.V. May 12, 2022) (Altman Ex. M). Likewise, Dr. Lappert was disqualified from testifying in a case about virtually anything beyond surgical risks and having encountered "de-transitioning" persons. *Kadel*, 2022 WL 2106270, at *15; Altman Ex. N. And Dr. Laidlaw has no experience providing or studying gender-affirming care. *See infra*; Altman Ex. O. By selecting "experts" that do not possess the requisite knowledge, Defendants failed to comply with the necessary process to analyze the efficacy of the care they have irresponsibly banned.

[4] *Arlington Heights* does not help Defendants, as the Complaint and Motion are

At bottom, the authorities cited by Defendants do not change the fact that the Challenged Exclusion is subject to heightened scrutiny.

C. The Balance of the Equities Favors Plaintiffs.

Defendants do not dispute that transgender Medicaid beneficiaries like Plaintiffs will lose access to health care as result of the Challenged Exclusion and that such loss constitutes irreparable harm. (*See* ECF 11, at 32-34.) Rather, Defendants attempt to balance Plaintiffs' irreparable harm with perceived harms to the public. But Defendants do not address how the preliminary injunction will harm the public—as the standard requires. *See Scott v. Roberts*, 612 F.3d 1279, 1290 (11th Cir. 2010). Rather, they disingenuously argue, in contravention to the prevailing medical consensus of health care providers and major medical organizations, that the treatments themselves are potentially harmful.

1. An Injunction Would Not Harm the Public.

Defendants misquote Justice Roberts' opinion in *Maryland v. King*, 567 U.S. 1301 (2012), when they say, "the State is irreparably harmed 'when it cannot effectuate its laws.'" (ECF 53, at 26-27.) The decision says: "[A]ny time a State is enjoined by a court from effectuating *statutes enacted by representatives of its people*, it suffers a form of irreparable harm." *Maryland*, 567 U.S. at 1303 (emphasis added). The Challenged Exclusion is not a "statute enacted by representatives of the

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replete with facts regarding each factor of its test.

people" but rather an administrative rule adopted over objections from the public and a legion of health care professionals with actual expertise. (ECF 11, at 13-14); *see also Eknes-Tucker*, 2022 WL 1521889, at *6. The public had little, if any, say in it.[5]

Defendants summarily conclude the Challenged Exclusion "serves the public interest" without explaining why. (ECF 53, at 32.) Plaintiffs assume their reasoning is captured in the bullet points immediately above, which summarize their "expert" declarations. *See id.* at 30-32. However, none of those declarations—save one—talk about how the treatments will harm the public, much less how the preliminary injunction, which preserves the status quo and allows Medicaid beneficiaries to continue care Florida Medicaid previously covered, will harm the public.

Nor is the fact that medical treatments have risks and side effects a sufficient reason to *disrupt* already established care. *See Flack v. Wisconsin Dep't of Health Servs.*, 331 F.R.D. 361, 374 (W.D. Wis. 2019).[6] That rationale would eliminate virtually all medical care, as none are without risk.

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[5] The Challenged Exclusion was adopted in circumvention of the legislature after it refused to adopt similar bills. *See* HB 1365 (2021); SB 1864 (2020); HB 935 (2021).

[6] Defendants express concern that gender-affirming treatments will cause infertility. This showcases their lack of understanding. Puberty blockers do not cause infertility. (ECF 11-2, ¶101.) Hormones do not necessarily either. (*Id.* ¶107.) Indeed, one of defendants' witnesses, who was purportedly on testosterone for four years, is now expecting a child. Def. App. 913. Most surgeries (like top surgery) do not cause infertility either. (ECF 11-2, ¶45.)

The Florida Medicaid program has covered these treatments for years. (ECF 11, at 36.) Defendants do not argue otherwise. And, over the years, the research and clinical evidence in support of these treatments has only grown. Only in the past several months have Defendants changed their stance on gender-affirming treatments, not coincidentally, amidst a wave of other actions by Florida's government attacking the rights of transgender persons.

2. Defendants Do Not Rebut the Irreparable Harm Caused by the Challenged Exclusion.

a. *Treating physicians are not required to show irreparable harm*.

Defendants take issue with the lack of medical records and testimony from Plaintiffs' treating physicians. But they do not explain why that is relevant or dispositive. Plaintiffs aver as to the harms they will suffer, and this testimony is consistent with Plaintiffs' expert testimony. Moreover, it is well-established that, *as a matter of law*, the loss of coverage or access to care constitutes an irreparable harm. (ECF 11, at 32.) Several decisions—cited in Plaintiffs' Motion—found irreparable harm based on evidentiary records like this one. In *Brandt*, the district court relied on the plaintiffs' testimony and expert testimony to conclude that a ban on hormone treatments would cause "physical and psychological harms to the Patient Plaintiffs by terminating their access to necessary medical treatment." 551 F.Supp.3d at 892. Likewise, in *Eknes-Tucker*, the district court relied on witness and expert testimony to conclude that "without transitioning medications, Minor Plaintiffs will suffer

severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality." 2022 WL 1521889, at *12. Moreover, putting the question of records aside, Defendants do not dispute, nor could they, that the gender-affirming care Plaintiffs received prior to Defendants' adoption of the Challenged Exclusion was determined medically necessary *by Defendants* under Florida's Medicaid program as well as by their treating physicians or they would not have received such care.

Defendants do not address these decisions, nor any other decision cited in the Motion where Plaintiffs established irreparable harm. *See* (ECF 11, at 33.) Instead, Defendants rely on a single case, *Doe v. Snyder*, 28 F.4th 103 (9th Cir. 2022), to imply that medical records and physician testimony are always necessary to establish irreparable harm. But *Doe*, an outlier decision, is easily distinguishable and does not establish a bright-line evidentiary standard for purposes of this injunction.

In *Doe*, the plaintiff requested a "mandatory injunction" that would have forced Arizona's Medicaid agency, which had excluded coverage of gender-affirming care for over 30 years, to "take an affirmative action" and go "well beyond the status quo." 28 F.4th at 108. The district court subjected that request to "heightened scrutiny" and would only grant it upon a showing of "extreme or very serious damage" to the plaintiff. *Id*. The district court ultimately found that this "heightened burden" was not met. *Id*. at 11; *see also Hennessy-Waller v. Snyder*, 529

F.Supp.3d 1031, 1045-46 (D. Az. 2021). The Ninth Circuit narrowly affirmed, finding that the district court's decision was not "illogical, implausible, or unsupported by the record," but faulted the district court for its failure to apply heightened scrutiny to Plaintiffs' Equal Protection claim and for its "erroneous" reading of *Bostock*. 28 F.4th at 113.

Here, by contrast, Plaintiffs seek a "prohibitory injunction," intended to preserve the status quo. Plaintiffs are not asking Defendants to take any affirmative action but instead to refrain from action until the court decides the merits. *See, e.g.*, *K.G. ex re. Garrido v. Dudek*, 839 F.Supp.2d 1254, 1260 (S.D. Fla. 2011). Their request is not subject to the heightened scrutiny applicable to mandatory injunctions like the one in *Doe*. And unlike in *Doe*, Defendants here have previously covered the gender-affirming care Plaintiffs seek. Having done so, they cannot now claim that Plaintiffs have not provided sufficient evidence that those services are necessary. *See Eknes-Tucker*, 2022 WL 1521889, at *12 ("The risk of suffering severe medical harm constitutes irreparable harm.")

b. The Court should disregard Dr. Laidlaw's opinions.

Defendants rely on Dr. Laidlaw's report to argue Plaintiffs will not suffer irreparable harm if the Motion is denied. But Dr. Laidlaw never reaches that conclusion; nor does he opine on the irreparable harms discussed in Plaintiffs' declarations. *See* (ECF 11, at 33-34.) Rather he speculates as to the "increased risks"

Plaintiffs could hypothetically face if their treatments continue based on his review of a partial set of medical records. He does not address the central issue: what harm will result if the treatments are *dis*continued. And he never opines on how to treat Plaintiffs' gender dysphoria.

Nor could he. Dr. Laidlaw has never treated any of the Plaintiffs, nor does he treat any transgender patients for gender dysphoria. *See* Altman Ex. O. His report is based on his general experience as an endocrinologist, his "evaluation" of a "detransition," and his review of an incomplete portion of the Plaintiffs' medical records. Def. App. 771. He simply does not—and cannot—opine on the harm Plaintiffs or any other transgender Medicaid recipient will face as a result treatment coverage loss. Olson-Kennedy Supp. Decl., ¶¶25-28; Karasic Supp. Decl., 23.

In any event, his opinions are outweighed by the collective decisions made by each Plaintiff's health care team. *See* (ECF 11, at 15-19); *see also Flack*, 331 F.R.D. at 374 ("While all medical treatment has risks, an individual patient and their doctor would seem substantially better able to weigh those risks than the state, much less this court, and so the risk of a negative outcome does not weigh in defendants' favor either.").

c. The declarations of out-of-state opponents to gender-affirming care are irrelevant.

Defendants submitted multiple declarations from lay persons, all of whom are

out-of-state opponents[7] of gender-affirming care who purportedly had individual experiences with gender-affirming care or are parents who do not support their adult children's transgender identification.[8] None of them are transgender Medicaid beneficiaries in Florida nor do they have any medical expertise relating to the issue at hand; none of them address the irreparable harms caused by the Challenged Exclusion; and none identify any public harm stemming from the preliminary injunction. Defendants offer no basis as to why these individuals have any bearing on the issues before the Court.

The fact that a particular treatment was ineffective for a single individual does not mean it is not medically necessary for others or experimental. *See Flack*, 331 F.R.D. at 374. Medical decisions are made on a case-by-case basis by those who are qualified to make those determination, not random lay persons with no direct or personal knowledge or physicians with no relevant expertise.

D. The Preliminary Injunction Should Apply Statewide.

There is no rule that a statewide preliminary injunction is improper absent class certification as alleged by Defendants. "Once invoked, the scope of a district court's equitable powers ... is broad, for breadth and flexibility are inherent in

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[7] Some joined an *amicus* in *Brandt* supporting defendants. 47 F.4th at 661.

[8] The declarations are irrelevant and inadmissible under Federal Rules of Evidence 401 and 403, and to the extent they offer opinions, inadmissible under Rule 701.

equitable remedies." *Brown v. Plata*, 563 U.S. 493, 538 (2011) (cleaned up); *see also City of Chicago v. Barr*, 961 F.3d 882, 917 (7th Cir. 2020) ("[A] court that in its discretion determines that the equities of the case and the substance of the legal issues justifies an injunction, should not be limited to imposing that relief only as to those few persons who could obtain attorneys or present themselves in court. Nor is the presence of the vehicle of a class action a realistic alternative in such a case. The difficulties, expense and delay inherent in pursuing a class action would render it inadequate for the type of situation presented …."). Plaintiffs facially challenge a newly adopted rule of general applicability. The proper remedy is to enjoin the rule *facially* to preserve the status quo. *See Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 485 F.Supp.3d 1, 64 (D.D.C. 2020) ("[U]nlawful agency regulations are ordinarily vacated universally, not simply enjoined in application solely to the individual plaintiffs.").

Defendants rely on a cherry-picked quote from a vacated decision from the Eleventh Circuit to suggest that a statewide injunction is inappropriate. (ECF 53, at 27.) Defendants fail to acknowledge that, "in the case of a constitutional violation, injunctive relief must be tailored to fit the nature and extent" of the violation. *Georgia Advoc. Off. v. Jackson*, 4 F.4th 1200, 1209 (11th Cir. 2021), *vacated on mootness grounds*, 33 F.4th 1325 (11th Cir. 2022). Indeed, the "scope of injunctive relief is dictated by the extent of the violation established." *Califano v. Yamasaki*,

442 U.S. 682, 702 (1979). A statewide injunction is appropriate here because the Challenged Exclusion violates the constitutional rights of transgender Medicaid beneficiaries statewide. *See Flack*, 331 F.R.D. at 374; *Planned Parenthood of Southwest and Central Florida v. Philip*, 194 F.Supp.3d 1213, 1224 (N.D. Fla. 2016) (enjoining Secretary of AHCA and others from enforcing certain statutes statewide).

"[B]ecause the burdens that would fall on the plaintiffs upon the Final Rule's implementation would also fall on those similarly situated, a [state]wide preliminary injunction of the Final Rule is justified." *D.C. v. U.S. Dep't of Agric.*, 444 F.Supp.3d 1, 51 (D.D.C. 2020).[9]

CONCLUSION

Plaintiffs respectfully request the Court preliminarily enjoin the Challenged Exclusion.

Respectfully submitted this 7th day of October 2022.

[9] Defendants suggest a preliminary injunction is inappropriate with a pending en banc decision in *Adams v. Sch. Bd. of St. Johns Cnty., Fla.*, 9 F.4th 1369, 1372 (11th Cir. 2021). But Defendants chose to alter the status quo notwithstanding the pending en banc review. They cannot now suggest the proper course is to wait. The Court should follow the court in *Eknes-Tucker* and preliminarily enjoin the Exclusion.

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CERTIFICATE OF WORD COUNT

According to Microsoft Word, the word-processing system used to prepare this Reply, there are 3191 words contained within the Reply.

/s/ Jennifer Altman
Jennifer Altman

CERTIFICATE OF SERVICE

I hereby certify that, on October 7, 2022, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system.

/s/ Jennifer Altman
Jennifer Altman

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

AUGUST DEKKER, et al., *Plaintiffs*, v. SIMONE MARSTILLER, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

SECOND DECLARATION OF ATTORNEY JENNIFER ALTMAN IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Jennifer Altman, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am over the age of eighteen and make this declaration from my own personal knowledge. If called as a witness, I could and would testify competently to the matters stated herein.

2. I am an attorney with Pillsbury Winthrop Shaw Pittman in Miami, Florida, and I have been retained by Plaintiffs as co-counsel in the above-captioned matter.

3. I make this Second Declaration in support of Plaintiffs' Motion for Preliminary Injunction.

4. Attached as **Exhibit M** is a true and correct copy of the plaintiff's

Memorandum of Law in Support of Motion to Exclude the Expert Testimony of James M. Cantor, in *B.P.J. v. West Virginia State Bd. of Ed.*, Case No. 21-cv-00316, ECF 320 (S.D.W.V. May 12, 2022).

5. Attached as **Exhibit N** is a true and correct copy of the plaintiffs' Memorandum of Law in Support of Motion to Exclude Expert Testimony of Dr. Patrick W. Lappert, in *Kadel et al. v. Folwell et al.*, Case No. 19-cv-00272, ECF 209 (M.D.N.C. Feb. 2, 2022).

6. Attached as **Exhibit O** is a true and correct copy of a deposition transcript for Dr. Michael Laidlaw, in *C.P. et al. v. Blue Cross Blue Shield of Ill.*, Case No. 20-cv-06145 (W.D. Wash. Sept. 2, 2022).

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

Executed on October 7, 2022

By: */s/ Jennifer Altman*

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EXHIBIT M

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

B.P.J. by her next friend and mother, HEATHER JACKSON,

Plaintiff,

v.

WEST VIRGINIA STATE BOARD OF EDUCATION, HARRISON COUNTY BOARD OF EDUCATION, WEST VIRGINIA SECONDARY SCHOOL ACTIVITIES COMMISSION, W. CLAYTON BURCH in his official capacity as State Superintendent, DORA STUTLER in her official capacity as Harrison County Superintendent, and THE STATE OF WEST VIRGINIA,

Defendants,

and

LAINEY ARMISTEAD,

Defendant-Intervenor.

Civil Action No. 2:21-cv-00316

Hon. Joseph R. Goodwin

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF MOTION TO EXCLUDE THE EXPERT TESTIMONY OF JAMES M. CANTOR

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STATEMENT OF THE CASE AND FACTUAL BACKGROUND

Plaintiff, a twelve-year-old girl who is transgender, challenges the legality of H.B. 3293, a law that categorically bars Plaintiff and any other female athletes who are transgender from participating on girls' and women's sports teams in West Virginia. B.P.J. contends that the law violates her rights under the Equal Protection Clause of the Fourteenth Amendment and discriminates against her based on sex in violation of Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, et seq.

As part of their defense of H.B. 3293, Defendants identified and disclosed an expert report from Dr. James M. Cantor. Dr. Cantor disagrees with the views of the mainstream medical community and offers testimony that providing gender-affirming care to transgender youth, including permitting social transition for children and puberty-delaying medication and hormone therapy when indicated for adolescents, does not produce better mental health outcomes and is not the accepted standard of care. As discussed below, Dr. Cantor's testimony about the proper medical treatment for transgender youth is not relevant to the claims in this litigation, Dr. Cantor is an adult psychiatrist who is not qualified to present himself as an expert on transgender youth, and his speculative opinions have no grounding in reliable scientific principles and methods.

As the Fourth Circuit recognized in *Grimm*, the standards of care for treating gender dysphoria "[d]eveloped by the World Professional Association for Transgender Health (WPATH), the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (7th Version 2012) . . . represent the consensus approach of the medical and mental health community." *Grimm v. Gloucester Cnty. Sch. Bd*, 972 F.3d 586, 595–96 (4th Cir. 2020), *as amended* (Aug. 28, 2020), *cert. denied,* 141 S. Ct. 2878 (2021). "There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical

professional groups." *Id.*; *see also Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019) (quoting *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1125 (D. Idaho 2018)).

Each of Dr. Cantor's proffered opinions is excludable for one or more of three reasons. First, Dr. Cantor's opinions are irrelevant because the opinions he offers about treatment for transgender youth fall outside the scope of the parties' dispute, which is simply whether a law can categorically bar transgender girls and women from girls' and women's sports teams in West Virginia. Second, Dr. Cantor is not qualified to offer opinions about the treatment of pre-pubertal transgender children or transgender adolescents as he does not work with and has not meaningfully studied this population. Third, Dr. Cantor's remaining opinions must be excluded because they are unreliable—they are not based on scientific methodology but rather untested hypotheses, pure speculation, and beliefs that lack any support besides Dr. Cantor's own *ipse dixit*. Because Dr. Cantor's opinions should be excluded pursuant to *Daubert* standards, and because any probative value offered by his testimony is substantially outweighed by the danger of unfair prejudice, confusion of the issues, waste of time, and undue delay under Federal Rule of Evidence 403, this Court must exclude them. Dr. Cantor's testimony is not "relevant to the task at hand." *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 597 (1993). Dr. Cantor does not possess the "full range of experience and training" to provide expert testimony in this case. *Belk, Inc. v. Meyer Corp., U.S.*, 679 F.3d 146, 162 (4th Cir. 2012), *as amended* (May 9, 2012) (quoting *United States v. Pansier*, 576 F.3d 726, 737 (7th Cir. 2009)). And Dr. Cantor's testimony is not "the product of reliable principles and methods[.]" Fed. R. Evid. 702. Therefore, Dr. Cantor's proffered opinions do not qualify under Federal Rule of Evidence 702 as admissible expert testimony.

Plaintiff B.P.J. respectfully submits this memorandum of law in support of her motion to exclude the proffered expert testimony of James Cantor, Ph.D. from consideration at summary judgment or trial as inadmissible under Federal Rule of Evidence 702.

LEGAL STANDARD

Federal Rule of Evidence 702 places "a special gatekeeping obligation" on a trial court to ensure that an expert's testimony is "relevant to the task at hand" and "rests on a reliable foundation." *Daubert*, 509 U.S. at 597; *Sardis v. Overhead Door Corp.*, 10 F.4th 268, 281 (4th Cir. 2021) (quoting *Nease v. Ford Motor Co.,* 848 F.3d 219, 230 (4th Cir. 2017)); *see* Fed. R. Evid. 702 advisory committee note to 2000 amendments (amendment "affirms the trial court's role as gatekeeper," and that "all types of expert testimony present questions of admissibility for the trial court in deciding whether the evidence is reliable and helpful"). The party offering the expert carries the burden of establishing the admissibility of testimony by a preponderance of the evidence. *Cooper v. Smith & Nephew, Inc.*, 259 F.3d 194, 199 (4th Cir. 2001).

A trial court must also determine whether the proposed expert is qualified to render the proffered opinion. In doing so, a trial court considers an expert's professional qualifications and "full range of experience and training[.]" *Belk, Inc.*, 679 F.3d 162. If the purported expert lacks the knowledge, skill, experience, training, or education on the issue for which the opinion is proffered, the trial court must exclude the expert. *See, e.g., Thomas J. Kline, Inc. v. Lorillard, Inc.*, 878 F.2d 791, 799 (4th Cir. 1989); *Mod. Auto. Network, LLC v. E. All. Ins. Co.*, 416 F. Supp. 3d 529, 537 (M.D.N.C. 2019), *aff'd*, 842 F. App'x 847 (4th Cir. 2021). Even if the expert is deemed qualified, the trial court must consider the relevancy of the expert's testimony as "a precondition to admissibility." *Sardis,* 10 F.4th at 282 (quoting *Daubert*, 509 U.S. at 592). To be relevant, the testimony must have "a valid scientific connection to the pertinent inquiry." *Id*. at 281 (quoting

Belville v. Ford Motor Co., 919 F.3d 224, 232 (4th Cir. 2019)) ("Simply put, if an opinion is not relevant to a fact at issue, *Daubert* requires that it be excluded.").

If the opinions offered by the expert are deemed relevant and the expert is qualified to offer testimony, a trial court will inquire if the opinion is based on a reliable foundation, which focuses on "the principles and methodology" employed by the expert to assess whether it is "based on scientific, technical, or other specialized *knowledge* and not on belief or speculation." *Id.* at 281 (citations omitted). When evaluating whether an expert's methodology is reliable, a court considers, among other things:

> (1) whether the expert's theory can be and has been tested; (2) whether the theory has been subjected to peer review and publication; (3) the known or potential rate of error of the particular scientific technique; and (4) whether the technique is generally accepted in the scientific community.

Id.; *see also Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 149–50 (1999); *Daubert*, 509 U.S. at 593–94. While trial courts have "broad latitude" to determine reliability, they must engage in the gatekeeping process and not simply "delegate the issue to the jury." *Sardis*, 10 F.4th at 281 (quoting *Nease,* 848 F.3d at 229). When addressing an expert whose methodology is grounded in experience, courts use three factors: "1) how the expert's experience leads to the conclusion reached; 2) why that experience is a sufficient basis for the opinion; and 3) how that experience is reliably applied to the facts of the case." *SAS Inst., Inc. v. World Programming Ltd.*, 125 F. Supp. 3d 579, 589 (E.D.N.C. 2015), *aff'd* 874 F.3d 370 (4th Cir. 2017); *see also Nat'l Ass'n for Rational Sexual Offense L. v. Stein*, No. 17 Civ. 53, 2021 WL 736375, at *3 (M.D.N.C. Feb. 25, 2021).

Finally, because "[e]xpert evidence can be both powerful and quite misleading because of the difficulty in evaluating it[,]" "the judge in weighing possible prejudice against probative force under Rule 403 . . . exercises *more* control over experts than over lay witnesses." *Daubert,* 509 U.S. at 595 (emphasis added) (quoting Weinstein, Rule 702 of the Federal Rules of Evidence Is

Sound; It Should Not Be Amended, 138 F.R.D. 631 (1991).) "As such, 'the importance of [the] gatekeeping function cannot be overstated.'" *Sardis*, 10 F.4th at 283 (quoting *United States v. Barton,* 909 F.3d 1323, 1331 (11th Cir. 2018)).

ARGUMENT

This is a discrimination case about the ability of girls and women who are transgender to participate on school-sponsored athletic teams. Although the fact that B.P.J. and many other girls and women who are transgender have had puberty-delaying medication or other endocrine care is relevant in responding to the State's argument that they have an athletic advantage rooted in physiology, Dr. Cantor does not purport to offer any testimony regarding these issues. And as this Court previously recognized in its decision issuing a preliminary injunction, "what is or should be the default treatment for transgender youth is not the question before the court." (Dkt. No. 67 (PI Op.) at 3 n.4.)

On their face, Dr. Cantor's opinions are irrelevant to the purported justifications of H.B. 3293. Dr. Cantor's opinion that providing gender-affirming care to transgender youth does not produce better mental health outcomes and is not the accepted standard of care is not relevant to this Court's consideration of whether West Virginia can categorically ban transgender girls and women from girls' and women's sports teams. In fact, even if the testimony about gender-affirming care provided to adolescents were relevant, Dr. Cantor offers irrelevant testimony about the treatment of prepubertal children and the treatment of adults. With respect to prepubertal children, Dr. Cantor's testimony and report focus on irrelevant debates about "desistance" and about the appropriateness of social transition for transgender youth. When discussing transgender adults, his testimony focuses on irrelevant and inaccurate theories about paraphilias and other causes of "transgenderism."

Dr. Cantor's testimony should thus be excluded.

A. Dr. Cantor's Primary Opinions Have No Relevance To This Case Because They Address Issues Beyond The Scope Of The Dispute.

The "court must satisfy itself that the proffered testimony is relevant to the issue at hand, for that is 'a precondition to admissibility.'" *Sardis*, 10 F.4th at 282 (quoting *Daubert*, 509 U.S. at 592). To be relevant, the testimony must have "a valid scientific connection to the pertinent inquiry." *Id*. at 281 (quoting *Nease,* 848 F.3d at 232–33). "[I]t is axiomatic that 'expert testimony which does not relate to any issue in the case is not relevant [and] non-helpful.'" *Knight v. Boehringer Ingelheim Pharms., Inc.*, 323 F. Supp. 3d 837, 846 (S.D.W. Va. 2018) (quoting *Edwards v. Ethicon, Inc.*, No. 12 Civ. 09972, 2014 WL 3361923 (S.D.W. Va. July 8, 2014)). In order to be relevant, an opinion needs to "fit" with the facts at issue. *Bourne ex rel. Bourne v. E.I. DuPont de Nemours & Co.*, 85 F. App'x 964, 966 (4th Cir. 2004).

Dr. Cantor's opinions are simply not relevant to any purported justification Defendants have offered for H.B. 3293, which focus on athletic opportunities and notions of protecting women in sports. *See, e.g.*, W. Va. Code § 18-2-25d(a)(5) (2021) (offering sole justification of "promot[ing] equal athletic opportunities for the female sex"); (Dkt. No. 290 (Pl's Statement of Undisputed Facts ("SUF")) ¶ 48) (State's purported justifications are limited to "protect[ing]" women in sports and complying with Title IX). Indeed, Dr. Cantor disclaimed any intent to offer opinions about those issues. He is offering no opinion regarding the extent to which a person assigned male at birth purportedly has any athletic advantage, (Swaminathan Decl., Ex. B at 161:4-8); the extent to which transgender women or girls have any supposed athletic advantage, (*id*. at 223:3-10); or whether H.B. 3293 should apply to college athletics, (*id*. at 178:18-23.)

Instead, Dr. Cantor's opinions in this case focus on issues not relevant to this case: the standards of care for treatment of transgender youth. For example, Dr. Cantor proposes to offer the opinion that "[a]ffirmation of a transgender identity in minors who suffer from early-onset or adolescent-onset gender dysphoria is not an accepted 'standard of care.'" (Swaminathan Decl., Ex. A at 3 ¶ 8(e).) But this opinion is unrelated to any interest proffered by the State. (Pl's SUF ¶ 59.) And as this Court already has recognized, "what is or should be the default treatment for transgender youth is not the question before the court." (PI Op. at 3 n.4.) Accordingly, Dr. Cantor's disagreement with the established standard of care in this Circuit—untethered to any governmental interest proffered by Defendants—does not "fit" with the facts at issue and has no relevance here.[1]

B. Dr. Cantor Is Not Qualified To Offer Opinions About The Treatment Of Transgender Adolescents In This Case.

To render expert testimony, the witness must possess the requisite "knowledge, skill, experience, training, or education" that would assist the trier of fact. *Kopf v. Skyrm*, 993 F.2d 374, 377 (4th Cir. 1993); *Wright v. United States*, 280 F. Supp. 2d 472, 478 (M.D.N.C. 2003) ("A witness may testify as to his specialized knowledge so long as he is qualified as an expert based on any combination of knowledge, skill, experience, training, or education."). If not qualified, the expert's testimony is unreliable. *Reliastar Life Ins. Co. v. Laschkewitsch*, No. 13 Civ. 10-BO,

[1] Dr. Cantor's other opinions about adults are even farther afield. For example, Dr. Cantor opines on "adult-onset gender dysphoria" and mental health issues in transgender adults, which is completely irrelevant to the issue of whether a twelve-year-old transgender girl should be able to participate on the girls' cross-country team at her school. (Swaminathan Decl., Ex. A at 12–14); *see, e.g.*, *Edwards v. Ethicon, Inc.*, No. 12 Civ. 09972, 2014 WL 3361923, at *15 (S.D.W. Va. July 8, 2014) (excluding expert opinion about complications future patients might experience as irrelevant to the plaintiff's claims).

2014 WL 1430729, at *1 (E.D.N.C. Apr. 14, 2014); *see, e.g.*, *Mod. Auto. Network, LLC*, 416 F. Supp. 3d at 537 (affirming the district court's exclusion of an expert because they lacked experience relevant to the matters at issue); *Lebron v. Sec'y of Fla. Dep't of Child. & Fams.*, 772 F.3d 1352, 1369 (11th Cir. 2014) (holding expert witness was properly excluded who did not propose to testify about matters growing naturally and directly out of research he had conducted independent of the litigation).

Dr. Cantor is not qualified to offer his opinions regarding treatment protocols for transgender youth. "[A]n expert's qualifications must be within the same technical area as the subject matter of the expert's testimony; in other words, a person with expertise may only testify as to matters within that person's expertise." *Martinez v. Sakurai Graphic Sys. Corp., No. 04 C 1274*, 2007 WL 2570362, at *2 (N.D. Ill. Aug. 30, 2007); *see also Lebron*, 772 F.3d at 1369. "Generalized knowledge of a particular subject will not necessarily enable an expert to testify as to a specific subset of the general field of the expert's knowledge." *Martinez*, 2007 WL 2570362 at *2. "For example, no medical doctor is automatically an expert in every medical issue merely because he or she has graduated from medical school or has achieved certification in a medical specialty." *O'Conner v. Commonwealth Edison Co.*, 807 F.Supp. 1376, 1390 (C.D. Ill. 1992), *aff'd*, 13 F.3d 1090 (7th Cir. 1994); *see also, e.g.*, *Hartke v. McKelway*, 526 F.Supp. 97, 100–101 (D.D.C. 1981), *aff'd*, 707 F.2d 1544 (D.C. Cir. 1983).

Dr. Cantor's primary area of expertise is the study of hypersexuality and paraphilias,[2] and nearly one hundred percent of his clinical practice focuses on adults. (Swaminathan Decl., Ex. B

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[2] "The term 'paraphilia'…[m]ost broadly[] refers to the highly atypical sexual interest that dominate a person's life and interact with or prevent them from having an otherwise typical sexual life." (Swaminathan Decl., Ex. B at 139:20–25.)

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