UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
v.	)	Tallahassee, Florida
	)	May 11, 2023
JASON WEIDA, et al.,	)	
	)	9:00 AM
Defendants.	)	Volume III
_____	)	

TRANSCRIPT OF BENCH TRIAL PROCEEDINGS
BEFORE THE HONORABLE ROBERT L. HINKLE
UNITED STATES CHIEF DISTRICT JUDGE
(Pages 508 through 711)

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

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

APPEARANCES:

For Plaintiffs:

Lambda Legal
By: OMAR GONZALEZ-PAGAN
Attorney at Law
ogonzalez-pagan@lambdalegal.com
120 Wall Street
19th Floor
New York, New York 10005

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JENNIFER ALTMAN
Attorney at Law
jennifer.altman@pillsburylaw.com
600 Brickell Avenue
Suite 3100
Miami, Florida 33131

Pillsbury, Winthrop, Shaw, Pittman, LLP
By: JOSEPH LITTLE
Attorney at Law
joe.little@pillsburylaw.com
500 Capitol Mall
Suite 1800
Sacramento, California 95814

Lambda Legal
By: CARL S. CHARLES
Attorney at Law
ccharles@lambdalegal.org
1 West Court Square
Suite 105
Decatur, Georgia 30030

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

Florida Health Justice Project
By: KATHERINE JEAN ANN DEBRIERE
Attorney at Law
debriere@floridahealthjustice.org
3900 Richmond Street
Jacksonville, Florida 32205

APPEARANCES (continued):

For Plaintiffs (continued):

National Health Law Program
By: CATHERINE ANNE MCKEE
Attorney at Law
mckee@healthlaw.org
1512 East Franklin Street
Chapel Hill, North Carolina 27514

For Defendants:

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

P R O C E E D I N G S

(Call to Order of the Court at 9:00 AM on Thursday, May 11, 2023.)

THE COURT: Good morning. Please be seated.

Dr. Baker, you are still under oath.

Mr. Beato, you may proceed.

MR. BEATO: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. BEATO:

Q. Good morning, Dr. Baker.

A. Good morning.

Q. Just a few questions and I'll be brief.

A. And enunciating clearly.

Q. Yes, absolutely.

During your testimony yesterday, you opined on the cost of gender-affirming care coverage; is that correct?

A. Yes.

MR. BEATO: I'd like to pull up PX23, which is a stipulated exhibit.

BY MR. BEATO:

Q. Dr. Baker, are you familiar with this document?

A. Yes.

Q. What is it?

A. The GAPMS rule.

Q. I'd like to focus your attention to 4(a) through (f).

What does this section talk about?
A. It talks about the factors that the agency shall consider when determining whether a health service is consistent with generally accepted medical standards.
Q. Based on your review of this section, is cost expressly mentioned here?
A. No, it is not.
Q. Dr. Baker, you also talked about health insurance marketplaces on direct; is that correct?
A. Yes.
Q. When discussing health insurance marketplaces, you relied on data collected from Out2Enroll; is that right?
A. Yes.
Q. And Out2Enroll collected data from 33 states?
A. Yes.
Q. And you're affiliated with Out2Enroll?
A. Yes.
Q. How so?
A. I am the cofounder.
Q. And, Dr. Baker, you also talked about Medicaid coverage for gender-affirming care on direct?
A. Yes.
Q. Did you mention a 2016 Centers for Medicare & Medicaid Services decision memo on gender dysphoria and gender reassignment surgery?

A. No.
Q. Are you aware of this document?
A. Yes.
MR. BEATO: I'd like to pull up DX4, which is also a stipulated exhibit.
BY MR. BEATO:
Q. Dr. Baker, does this document look familiar to you?
A. Yes.
Q. And what is it?
A. It is a decision summary -- or decision memo on gender dysphoria and gender reassignment surgery.
Q. Do you know what this document concluded?
A. Yes.
Q. What did it conclude?
A. It concluded that there was not sufficient evidence in the Medicare population to take the relatively unusual step of creating a national coverage determination for treatment of gender dysphoria, specifically gender reassignment surgery.
Q. And you didn't use it to form your expert opinion in this case?
A. I --
Q. You didn't rely on --
A. I did. I'm familiar with it, yes.
Q. And just to finish up, just to clarify, you're not a medical professional?

A. I'm a health services researcher.
Q. Are you an endocrinologist?
A. No.
Q. Psychiatrist?
A. No.
Q. Surgeon?
A. No.
Q. So you can't opine as a medical professional on the medical appropriateness of gender-affirming care?
A. I can summarize the medical evidence, which is my training as a health services researcher.
Q. You just an expert on insurance?
A. And other things, but in this case, yes.
Q. Last few questions.
Have you written any articles criticizing Florida's actions on gender-affirming care?
A. I have written opinion pieces criticizing trends similar to Florida's.
Q. And Florida specifically?
A. No.
Q. You haven't written an article called "Florida's Ban on gender-affirming care is dangerous for us all"?
A. Can you show it to me?
Q. Would it help if I refresh --
A. Yes, sure.

Q. -- your recollection?

MR. BEATO: May I approach, Your Honor?

THE COURT: Sure.

BY MR. BEATO:

Q. You wrote this article?

A. I did.

Q. And this article criticizes the Florida Board of Medicine's rule?

A. Yes. And I apologize. I had my head in Medicaid, which confused me.

Q. Okay. What did you say in this article?

A. I said that this trend is inconsistent with -- medical evidence is inconsistent with historical trends, and that it concerns me greatly that there are efforts that are not based in medical science and evidence that would restrict access to care that has been shown to be safe and effective for the treatment of gender dysphoria.

Q. Did you state: *Florida's ban itself is not based on research - rather, it's fueled solely by misinformation and political punditry*?

A. May I look for that quote?

Q. Of course.

A. Yes, I said that.

Q. Oh, I'm sorry.

A. No, I realized I'm not allowed to read out loud.

MR. BEATO: No further questions, Your Honor.

THE COURT: Redirect?

MS. DUNN: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. DUNN:

Q. Dr. Baker, Mr. Beato asked you about a 2016 national coverage determination by Medicare?

A. Yes.

Q. What -- what happened with that national coverage determination?

A. There was a request from a community member, a Medicare beneficiary, to the Centers for Medicare & Medicaid Services asking them to establish a national coverage determination for gender reassignment surgery, I believe Medicare called it, and when Medicare receives such a request, they go through a process called a national coverage analysis, which is intended to determine whether a national coverage determination is needed.

The process took about a year, and they looked at the evidence, looked at standards of practice in the field, and concluded that a national coverage determination was not needed at the time. And in 2016, they issued the decision memo that said that they had concluded that a national coverage determination was not needed.

Q. Is it unusual for a surgical procedure or other health service to not have a national coverage determination?

A. No. Most do not.
Q. And what does -- as a result of that 2016 national coverage determination decision, how does Medicare approach requests or claims for gender-affirming surgeries?
A. Medicare covers gender-affirming care on a case-by-case basis. So when a request comes in from a beneficiary or from a provider, the Medicare program assesses that request according to the reasonableness standard, which is in the Medicare statute, and determines whether or not in this -- in any particular case any particular treatment or intervention is appropriate.
Q. And that national coverage determination looked specifically at the Medicare population.
Why is that important?
A. The Medicare population is fairly unique. I mean, we're talking about people over age 65, and Medicare wants to ensure that the information that they're putting out is specific to the Medicare population. So they really look to put together guidelines or to make decisions that are specific to that older, over age 65, population. So that's what they focused on.
Q. So that 2016 national coverage determination looked only at the evidence base related to the population of Medicare beneficiaries who would be older than 65?
A. It looked broadly at the evidence base, but it weighed very heavily on the population over age 65.

Q. The article that you were shown by Mr. Beato, was that article with reference to the AHCA-challenged exclusion that we are here on today, or was it related to the State Board of Medicine ban on the provision of gender-affirming care?
A. It was really focused on the decision by the State Board of Medicine.
Q. So it wasn't specific as to the rule that we're challenging today?
A. It was not specific to that rule, no.
MS. DUNN: All right. No further questions.
THE COURT: Thank you, Dr. Baker. You may step down.
(Dr. Baker exited the courtroom.)
THE COURT: Please call your next witness.
MR. GONZALEZ-PAGAN: Good morning, Your Honor. I'm ready to call our next witness.
I did want to, if it was amenable to the Court, just revisit a little bit the conversation at the end of the day yesterday and inform the Court of some of the rearrangements that we have made.
I apologize to the Court for us thinking that we would be calling the rebuttal witnesses out of order and the like. We have now contacted all of those witnesses, and we arranged their travel. Unfortunately, that cannot happen for tomorrow, but we can present all of them on Wednesday. So there may be a slight gap tomorrow, and I apologize to the Court for that. But we

wanted to make sure that, in response to the Court, we were presenting all of our case together. If it works for the Court, that's how we would suggest to proceed.

THE COURT: The people that may not be here tomorrow are people you thought you could call in rebuttal?

MR. GONZALEZ-PAGAN: Yes. And we would be -- are now calling them as part of the case-in-chief on Wednesday, as per our conversation yesterday.

THE COURT: All right. I get it.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

THE COURT: Meanwhile, call the next one.

MR. GONZALEZ-PAGAN: Thank you.

The plaintiffs call Dr. Johanna Olson-Kennedy, Your Honor.

(Dr. Olson-Kennedy entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

DR. JOHANNA OLSON-KENNEDY, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: My name is Johanna Olson-Kennedy, O-l-s-o-n, hyphen, K-e-n-n-e-d-y.

DIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Good morning, Dr. Olson-Kennedy.

A. Good morning.

Q. What is your profession?

A. I am a medical doctor.

Q. What type of medical doctor are you?

A. I'm board certified in pediatrics and subspecialty board certified in adolescent medicine.

Q. Where are you currently employed?

A. I'm an employee of the University of Southern California, but I work at Children's Hospital Los Angeles.

Q. What is your role within Children's Hospital of Los Angeles and USC?

A. I am the medical director of The Center for Transyouth Health and Development, and I'm also an associate professor of clinical pediatrics.

Q. And as the director of the trans youth center and professor, what are your responsibilities? What do you do?

A. I split my time, roughly equally, between doing research and providing clinical services for transgender young people and young adults.

Q. How many transgender young people and young adults do you provide care for, Dr. Olson-Kennedy?

A. I currently have an active panel of around 650; over the 17

years I've been doing this work, probably about a thousand.
Q. What are the ages of these patients that you provide care for?
A. I see patients between the ages of 3 and 25 or 26.
Q. And what is the condition for which you are providing care for to these transgender young patients and young adults?
A. Gender dysphoria.
Q. What, if any, is the care that you provide to prepubertal patients?
A. So for prepubertal patients, they do not get any medical intervention or surgical intervention. There is no medical intervention that's indicated or appropriate for prepubertal children.

For families that have young children like that, I provide information about trajectories -- developmental trajectories. I provide information about how to keep those young people safe, how to navigate difficult things that come out, maybe disclosure, talking to family members. It's pretty much support of those parents who need other parents of gender-nonconforming or diverse children.

Q. And what is the care that you provide to adolescent patients?
A. So adolescent patients may come in for a variety of different reasons. They're coming in to address their gender dysphoria. The recommendations that I make have a large range,

and those things range from puberty blockers to gender-affirming hormones, referrals for surgery, and sometimes no medical interventions.

Q. What about adult patients?

A. So same thing for adult patients. They may want to go on to medications that block their endogenous hormones; they may want to take gender-affirming hormones; they may need referrals to surgery. Similar.

Q. Are there any clinical guidelines that you utilize in providing this care?

A. Yes, I look to the WPATH Standards of Care -- Version 7 was the majority of my career up until September of this past year when they shifted over to a Version 8 -- as well as the endocrine guidelines, and then I also utilize the UCSF, or University of California San Francisco, guidelines for care.

Q. You mentioned, I believe, the years, but just to make it a little bit clearer, how long have you been providing that care?

A. This will be my 17th year providing this care.

Q. And the trans youth center that you lead, is that a multidisciplinary center?

A. It is.

Q. Can you provide the Court with context about how care is provided within this center?

A. Sure. So within our center, we have five medical providers, including four medical doctors and one nurse

practitioner. We have one medical fellow who also is learning how to provide care. We have four social workers, two psychiatrists trained in adolescent and pediatric psychiatry. We have two Ph.D. psychologists.

And then on the other side -- they're not -- we're combined, but they're not technically housed in the same place -- we have a surgeon, a surgical social worker, and a nurse practitioner, as well as a physician's assistant that all work in the surgical section.

Q. And, Dr. Olson-Kennedy, you mentioned that your panel is about 750 patients?

A. 650 to 700, something like that.

Q. How many patients are being seen at the trans youth center at present?

A. I think we have about 2,400 active patients at the center right now.

Q. And are all the services that these patients need or utilize provided at the center, or do you work with other providers?

A. So we are highly networked, particularly with mental health providers that are in the area, A, because we have a large catchment area, but also because there are many professionals that are skilled in the care of transgender young people as far as mental health goes. So we work with outside psychiatrists and psychologists and social workers.

Q. And aside from the providers that you work with as part of this network, are you aware of how care is provided by other medical providers outside academic centers?
A. I think that people have a similar model in the sense that they have a multidisciplinary team, but it's not necessarily housed under one roof so -- such that maybe a medical provider that is operating in a solo practice or a group practice will be networked with professionals outside of their actual building.
Q. Can a provider who provides care to adolescents with gender dysphoria outside of an academic gender clinic do so in a careful and appropriate way, in a multidisciplinary way?
A. Yeah, such as I just described. I do think it's important for people to know the people that they're networked with and understand that they're skilled and trained, but that's absolutely necessary in this care because academic centers are not available to a large percentage of people in the country.
Q. Can you talk a bit -- a little bit about how care is provided for adults?
A. So I can't speak for the whole adult care provision world, but I can tell you, because my patients age out of my clinic into adult services, and sometimes it's because they are 18, I'm always sad to see them go, but I'm happy to see them go to college and other places. And so I help those young people find places where they can access care. Sometimes, if they're local, I will refer them to larger academic programs. Sometimes they

don't have access to those things because of where they're located or the type of insurance that they have, so they can disperse into a multitude of different places, and I try to help people with that process.

Q. Just to put a little bit of a finer point on this, is gender-affirming medical care only provided within academic gender clinics?

A. No, there are multiple types of ways that gender-affirming care is provided, particularly for adults. There are multiple centers where it's maybe a -- the way that medicine is, it's maybe a group practice where there's many -- multiple doctors, but one person is specializing in this work and, again, networked out with other people.

Q. And can this care be provided outside academic gender clinics in a manner that is consistent with Standards of Care and Clinical Practice Guidelines?

A. Yes, I believe so.

Q. You said that you spend your time sort of half and half between providing clinical care and doing research.

What are the areas of study that you research?

A. The primary area of study that I do research in is looking at the impact of medical interventions on both the physiologic and the psychosocial well-being of young people and young adults.

Q. Have you published any research or scholarly articles

related to the treatment of gender dysphoria?
A. I have, I think, around 30 manuscripts. Maybe four or five of those are not related to what we're talking about.
Q. Are these peer-reviewed publications?
A. They are.
Q. Have you ever served as a principal investigator?
A. I have, and I currently do right now. I'm the principal investigator for a large NIH-funded, multisite, longitudinal observational study that involves one cohort of young people who are new to puberty blockers and one cohort of young people who are starting gender-affirming hormones. That study started in 2015. It was extended for an additional five years, so we are in the process of actively still collecting follow-up data, as well as enrolling new participants.
Q. And just for clarity, these patients that you're following with regards to the provision of puberty blockers and hormones, are these transgender patients with gender dysphoria?
A. The ones in the study?
Q. Yes.
A. Yes.
Q. What has the research coming out of the NIH-funded study so far shown?
A. So we have published on a number of NIH aspects. A lot of what we have published has been regarding the protocol, the baseline data for our two cohorts. But the follow-up data that

we have published has demonstrated, particularly in the article we published earlier this year, an improvement in depression, an improvement in positive affect, and improvement in life satisfaction. We've also published a handful of manuscripts on the safety of gender-affirming hormones.

Q. Have you published any other articles pertaining to the treatment of gender dysphoria outside the context of this NIH-funded study?

A. I have.

Q. Can you tell us a little bit about those studies?

A. Sure. I published a manuscript looking at the efficacy comparing two different puberty blockers. That's a little strange because they're actually the same, but they're slightly different in the amount of medication they secrete on a daily basis. And I also have published a paper looking at the impact of chest surgery on chest dysphoria for young trans masculine individuals.

Q. Dr. Olson-Kennedy, did you submit a curriculum vitae as an attachment to your report in this case?

A. I did.

Q. And does that curriculum vitae accurately reflect your professional background and experience?

A. I think there's probably about five or six or seven or maybe ten additional lectures that I've given since that CV was submitted.

Q. But it otherwise accurately reflects your experience?
A. Yes.
MR. GONZALEZ-PAGAN: Your Honor, Dr. Olson-Kennedy's curriculum vitae has been admitted into evidence as Plaintiffs' Exhibit 361.
THE COURT: Plaintiff 361 is admitted.
(PLAINTIFFS EXHIBIT 361: Received in evidence.)
MR. GONZALEZ-PAGAN: Your Honor, at this time I will ask that Dr. Olson-Kennedy, as a physician and clinical researcher, be qualified as a -- to testify as an expert on the study, research, and treatment of gender dysphoria.
THE COURT: Questions at this time?
MR. JAZIL: No, Your Honor.
THE COURT: You may proceed.
MR. GONZALEZ-PAGAN: Thank you, Your Honor.
BY MR. GONZALEZ-PAGAN:
Q. Dr. Olson-Kennedy, I want to pivot a little bit and take a step back and talk a little bit about the history of gender-affirming medical care.
How long has the use of surgery to treat gender dysphoria been around?
A. I think the first surgeries were in around 1930.
Q. And can you tell us a little bit more about that history?
A. I think we heard a little bit of this yesterday from Dr. Schechter, who was talking about really the origins of

transgender experience being explored and written about primarily in Germany. This is not to suggest that there were not transgender people. There have been transgender people as long as people. There's anthropologic and archeologic evidence to suggest that.

But I think when it moves into the world of study, when it moves into the world of investigation and academia really starts around the late 1800s, and the person whose records we have the most understanding and knowledge of come from Magnus Hirschfeld, who is a scientist in Berlin, and he collected an enormous amount of data and wrote down an enormous amount of information about the community, published numerous books and manuscripts, and much of it was destroyed when his institute was burned down by the Nazis. So we lost a lot of that, which is very unfortunate because he did so much work in this area.

There was a physician named Harry Benjamin who studied with Magnus Hirschfeld and then came back to the United States and started doing academic work with transgender people, and he has also contributed greatly to the literature, and he really started doing his work in and around the 1940s, 1950s, and '60s.

Q. Dr. Olson-Kennedy, how long has the use of hormones to treat gender dysphoria been around?

A. Since shortly after we synthesized hormones. So that was in the late 1920s and early 1930s.

Q. Would it be accurate to say, then, that gender-affirming

hormone therapy and surgery have been around for a century or so?

A. That would be accurate.

Q. How long has the use of puberty-delaying medications to treat gender dysphoria been around?

A. So I think that puberty -- central blockers -- and I want to be clear, because we're talking about central blockers, gonadotropin-releasing hormone analogs were synthesized and introduced in the late 1970s, I think, but they were approved in 1990, I believe, early '90s.

And from what we know from the work that was going on in The Netherlands, puberty blockers or central blockers were being utilized right around that time for gender dysphoria based on a case study that was published by them entitled *A 22-Year Follow-Up*. I can't remember the exact date of that publication, but indicated that they had been using central blockers since the '90s.

Q. What about in the United States? How long has the use of puberty-delaying medications been around?

A. So there was a physician named Norman Spack who worked at Boston Children's Hospital, and Dr. Spack, who is a wonderful, amazing doctor, went over to The Netherlands to study with that team and then came back to the United States and started using central blockers in the early 2000s.

Q. Can you tell me a little bit about the history of providing

gender-affirming medical care to adolescents at your own institution?

A. So I was not there yet, but my boss, who is the head of the division -- his name is Marvin Belzer -- he was providing HIV services for young people, older adolescents and young adults. And in the early '90s, one of his patients who was receiving HIV care asked if he could do her hormone care, and he started providing hormone care at that time. And then that was followed by increasing numbers of patients.

Q. Dr. Olson-Kennedy, we've heard a little bit about the care that was being provided by the Dutch -- the Netherlands throughout this trial.

Are you familiar with the term "Dutch protocol"?

A. I am.

Q. Can you tell us a little bit about what that is?

A. Because the Dutch had been doing this care probably a little bit earlier than most people in the world, they published a manuscript that described their approach to care. So it included, you know, an assessment period and then a time period where people were on puberty blockers, followed by gender-affirming hormones, followed by surgical interventions.

MR. GONZALEZ-PAGAN: Your Honor, if I may, I'm going to show the plaintiff [sic] what's marked as Plaintiffs' Exhibit 141.

THE COURT: Is this something that should not be on

the public screen?

MR. GONZALEZ-PAGAN: It can be on the public screen, Your Honor.

THE COURT: All right.

THE WITNESS: Is it coming up here?

MR. GONZALEZ-PAGAN: It should.

THE WITNESS: Okay.

BY MR. GONZALEZ-PAGAN:

Q. Before I ask you about this, Dr. Olson-Kennedy, are there any research studies that document the care that was being provided at the Dutch clinic in Amsterdam?

A. Yes, they've published pretty extensively about the care that they've done, and this is one such article.

Q. And this article, Plaintiffs' Exhibit 141, is this -- can you tell us a little bit about this paper?

A. Yes. So this paper outlined the findings of 70 young people who were provided central puberty blockers, or what we see here -- as referred to as gonadotropin-releasing hormone analogs -- sorry. That's a mouthful -- and it talked about the psychological functioning of these 70 young people before and then after their course of puberty suppression as an only mechanism. So they were moving into the stage of gender-affirming hormones. So this was after their time on blockers as compared to before they started.

Q. Dr. Olson-Kennedy, I'm going to refer you to Table 1 of

this study on page 2278 of the paper, Bates stamp PLAINTIFFS006596.

Can you tell us a little bit about what this table tells about the demographics of the participants in this study?

A. Sure. So this table is a pretty common table that you see in research. It talks about the basic characteristics of the individuals that are participants, and it also gives some indication about the ranges of time between interventions. So what you can see here is that the people that were starting central blockers were -- ranged from the age of 11 to 18, and that by the time they were starting gender-affirming hormones, they were between the ages of late 13, so 13.9, and 19, and then kind of a time start between their time on central blockers and gender-affirming hormones.

And the Dutch, for some reason, feel compelled to always talk about IQ. I'm not sure why, but they do that. So it talks about that as well, in addition to some other demographic information.

Q. Thank you, Dr. Olson-Kennedy.

So would it be accurate to say, then, that there were no set ages at which any of the particular treatments that we've been discussing were provided at the Dutch clinic?

A. So while the Dutch protocol outlines basic ages of 12 for, you know, central blockers and 16 for gender-affirming hormones and 18 for surgery, they acknowledge that because the age of

consent in the Netherlands is 16, that that tends to be the age around which their participants generally average out.

However, as you can see from that article, the youngest person that was accessing gender-affirming hormones was just under 14.

Q. And what type of study was this study that we were just discussing?

A. This was a prospective longitudinal study.

Q. And was one of the authors of this study Annelou de Vries?

A. Yes.

Q. What did the study show with regards to the outcomes of these patients?

A. So this study that we were just looking at demonstrated that there was improvement in psychological functioning for those young people over the time that they were on puberty blockers.

What the study also demonstrated is that they -- this process of putting somebody on puberty blockers really pauses them, and so they're not -- they're kind of at a stopping point. They're not necessarily moving forward in a way that moves their body into alignment with their gender, but they are paused, so they are not moving in the other way either, which is what has been demonstrated repeatedly to be beneficial for young people.

Q. And when you say "moving in the other way," what do you mean by that?

A. So as somebody moves through their endogenous puberty, the puberty that the gonads that they have would bring them through, that is -- has been shown repeatedly to be very detrimental for people who identify as a gender other than the one that that puberty would bring them through. And so puberty blockers allow them to pause that process.

Q. I'm not a doctor, so I'm trying to get a little bit in layman's terms, if you will -- would that mean that there are no physical changes that would, therefore, cause distress to the person that -- further physical changes that would cause distress to the person?

A. Yes. So the process of going through puberty is the process where you develop secondary sex characteristics that would primarily make you perceived as male or female. And so if you are a girl and you go through puberty that makes you look like a boy, that's extremely difficult.

Q. Some of the defendants' experts have said that the Dutch research is not applicable to care provided in the United States because the protocols are purportedly different here.

What's your response to that?

A. A, I don't think that they're necessarily different. I think that most people that are going through this process have a similar basic trajectory through this time period in their life. I also think it's really important to understand that in the world of science and medicine, we adjust our -- the way that

we think about work as we get more and more data to help us refine that process.

But one of the things that's really important about that early study is demonstrating that while the Dutch protocol may be described as 12, 16, and 18, even from -- the studies that that Dutch protocol arose from demonstrate that there are people under those ages that are receiving these interventions.

Q. And we discussed a little bit one of the authors of that first Dutch study, Annelou de Vries.

Did Annelou de Vries have any involvement with the WPATH Standards of Care 8?

A. Absolutely.

Q. What was that involvement?

A. So Annelou De Vries has had -- played a big role in the development of -- she was a primary author on the WPATH SOC 8 as well as the endocrine guidelines.

Q. Defendants' experts also say that because the participants of the Dutch -- in the Dutch research had purportedly -- purportedly had gender dysphoria from early childhood and also have therapeutic support, that that research is not applicable to gender diverse and transgender youth that have not had those experiences.

What's your response to that?

A. It -- people that are coming into care for puberty blockers in early puberty have been experiencing gender dysphoria and

talking about it. I just want to be really clear about this, that in order for someone to get into services in the beginning of their puberty, they have experienced gender dysphoria in childhood.

And so the -- it is -- it's really important to understand that there are less than 5,000 people in the United States on puberty blockers. It is an incredibly small number, because most people do not engage in care when they are in that early prepubertal stage. It is incredibly rare.

Q. And just for the edification of those of us here today, can you tell us a little bit about how people begin to understand their gender identity or begin to experience gender dysphoria?

A. So remember that we have everything constructed in our world that anticipates that people are going to have a gender that aligns with their designated sex at birth. In other words, when babies are born, they have -- they are given a gender marker based on their external genitals or, perhaps, an ultrasound prior to birth. And so everything is organized around those two things being -- that someone's gender and their sex assigned at birth is going to align. It's unusual and it's a very rare occurrence when that does not happen, which is what we are talking about in this court case.

So you have to recognize that everything is organized around those things being aligned. So if they don't align, essentially people have to swim upstream to understand that

their gender is different than what they were assigned at birth.

So what that means is there's going to be a very small number of people who in childhood recognize that their gender is not the same as their sex assigned at birth. And so those very rare cases are really the cases of young people who, A, recognize it; B, talk about it; and, C, have parents or guardians who are going to listen to that information.

That is a lot of things that need to happen in order for someone to engage in the process of getting puberty blockers in early puberty.

Q. And given all of those obstacles, if you will, that somebody has to face, would you say that somebody that's presenting for care at that age, having already gone through all of that, is a strong predictor of persistence of their gender identity?

A. Absolutely. There is -- understand that because people who have a gender different from their designated sex at birth, they are swimming upstream. They have to overcome a lot of obstacles in order to understand, talk about, and then get care related to their gender. That's why it's so extremely rare that people go on blockers in early puberty, even in these time frames that we are talking about.

Q. Thank you, Dr. Olson-Kennedy.

You know, we've been talking a little bit about the provision of this care and some of the Dutch studies with regard

to adolescents.

Has gender-affirming care been studied throughout the decades that it has existed?

A. No. Because gender incongruence or the experience of having a gender that is different from what you were assigned at birth has been happening since people, and so there haven't been studies from -- you know, that go back thousands of years. The time that this particular occurrence starts being studied is really in the early 1900s when it moves into the world of medicine.

Q. And as a clinician and an investigator, are you familiar with the body of research that exists pertaining to the treatment of gender dysphoria?

A. I think so.

Q. Dr. Olson-Kennedy, I want to start off about -- talking about the existing research into the medical interventions to treat gender dysphoria.

Is there scientific research evaluating these medical interventions?

A. There is.

Q. And what are the type of studies that are out there assessing the efficacy of treatment for gender dysphoria in adolescents?

A. There are studies that address the use of blockers, puberty blockers, that we were talking about. There are studies that

address the impact of blockers -- blockers and gender-affirming hormones. There are studies that look at gender-affirming hormones. There are studies that look at surgical interventions, particularly chest surgery.

Q. And what about adults? Is there scientific research evaluating these medical interventions for the treatment of gender dysphoria in adults?

A. Yes.

Q. And what type of studies are out there assessing the efficacy of gender-affirming treatment for gender dysphoria in adults?

A. The studies range all the way from focus groups talking about experiences of adults all the way to assessing and evaluating the interventions that are available regarding medications, regarding surgical interventions. Those studies range from longitudinal studies to case studies to one-time-in-point studies. There's just -- there's gobs of research about transgender adults and the care.

Q. Dr. Olson-Kennedy, you've described a few of the types of studies that have been utilized to study treatment of gender dysphoria in adolescents and adults.

Dr. Olson-Kennedy, you heard the testimony of some of plaintiffs' experts stating that randomized controlled trials are neither feasible nor ethical in the context of gender-affirming medical care.

Do you agree with the opinions of Drs. Shumer, Schechter, and Antommaria in this regard?

A. I do.

Q. When looking at the body of research that exists about the efficacy of treatments for gender dysphoria, what is it that this body of research looks at?

A. So research can -- is variable in looking at the physiologic impacts of interventions. A lot of the research around gender dysphoria and interventions is concerned with the psychological impact of gender-affirming hormones, puberty blockers, surgical interventions.

There -- I think because the issue of safety has really been put to rest -- these are medications that have been used for decades -- their safety is not really something that is studied extensively anymore because those studies have been done.

Right now what people are primarily studying is the impact on people's life, quality of life, capacity to function. Those are the things that are studied.

I do want to say in my study we are looking at physiologic impact because it's always good to have additional data, but the safety of these medications has been studied extensively.

Q. And when looking at the impact on mental health and quality of life, what are the metrics of this study's use?

A. So there are multiple ways that we can look at the impact

of interventions on quality of life. We can -- there are multiple domains that go into that understanding. We can look at depression. We can look at anxiety. We can look at the things that I described in the previous study which have to do with, you know, general life satisfaction, capacity to function. There's -- there are so many things that we study. Even within my own study, we have 15 or 20 different measures of -- that really look at quality of life in one dimension or another.

Q. And just getting a little bit more granular into this, what are some of those scales that measure those outcomes?

A. So there are outlined measures that the NIH provides, such as emotional function that looks at anger, looks at sadness; it looks at loneliness. It looks at some of the things that we just saw in the study that you presented on the screen that looked at overall general life satisfaction and different domains of that.

Q. And what do these measures tell us about the efficacy of treatment for gender dysphoria?

A. If you look at the body of evidence, it -- the evidence is pointing to improvement across all domains of life. There are certain things that we look at that are inherent to the experience of transgender people, like anxiety, that are impacted by the world in which people live. But the psychological pieces about people's self esteem, their feelings about themselves and the way that they move around in the world

are -- all demonstrate improvement across the body of literature.

Q. And you've referenced when we look -- when we look at the research as a whole, or when we look at the entirety of the research.

Can you explain to us why it's important to look at the body of the research as a whole as opposed to any individual study?

A. An individual study can only really address a limited number of people and a limited number of findings. This is related to the fact that, for example, there are around maybe slightly less than 5,000 people in the United States who are utilizing puberty blockers for the purpose of addressing their gender dysphoria. But all 5,000 of those people are not in one place. And so maybe one place that has 40 people can do one piece of that work, and another place that has 100 can do that piece of that work.

And just like as a physician I don't evaluate somebody's pinky to tell me about their entire body, we to look at the entire collective of evidence.

Q. I want to ask you some specific questions about the research into the efficacy of puberty-delaying medications.

Is there specific research on the efficacy of puberty-delaying medications to treat adolescents with gender dysphoria?

A. Yes.
Q. What do the studies evaluating the efficacy of puberty-delaying medications to treat gender dysphoria show?
A. So the study that we just looked at in particular, which was published in 2011 from the Dutch team, demonstrated that there was improvement in global psychological functioning, that there was improvement in depression. And for those young people, because they were paused, they have no movement around their experience of gender dysphoria, but these other elements of their functioning are improving, which is very similar to what we see in the clinical population.
Q. Are there any other particular studies that you would point to that specifically assess the efficacy of puberty-delaying medications?
A. So just to back up, I do want to say, in the -- that same study, the follow-up of that study where they -- those young people go onto gender-affirming hormones, you do see improvements in gender dysphoria. That's a really important follow-up to understand that puberty blockers are just putting a pause on that development.

Yes, there are other studies that look at the efficacy of puberty blockers. Another study from The Netherlands that actually enrolled something like 250 -- I can't remember the exact numbers, but looked at -- tried to address this issue of what does an untreated population look like? And so they

compared -- so a lot of the studies that are done look at the psychosocial functioning of people before they start puberty blockers and then compare it to after, because of what we've talked about, that an untreated control group is not an ethical approach to this research. But they do have natural cohorts of people who have not yet started puberty blockers.

And so there was a study by van der Miesen, et at., so van der Miesen and colleagues, that looked at the psychosocial functioning of people that were new -- they had not yet started blockers -- compared to a larger cohort of people who had been on blockers, demonstrating similar findings, improvement in psychosocial functioning.

Q. You mentioned van der Miesen. What was the author of the other study you were discussing?

A. The one from 2011 was Annelou de Vries and her colleagues.

And then there have been -- there have been numerous other studies, but one that comes to find is a study by Costa, et al., that was done in the United States, and also demonstrated a similar -- a similar process, where half of the cohort they concluded was immediately available to go onto blockers, and the other half of the cohort was a delayed start on blockers and had psychological intervention only. Both groups improved for the first 6 months. But between 6 and 12 months after, the blocker group continued to demonstrate improvement in psychological functioning, but the psychological intervention arm did not.

Q. So it's safe to say that the psychological intervention did not at least treat as effectively the gender dysphoria in these adolescents?
A. That's correct, over the time of a 12-month period.
Q. Are there any limitations to these studies?
A. Of course. All studies have limitations.

Thinking about the cost of the study, for example, that had 50 people in it, it -- you know, this is -- when you are talking about a very rare intervention, such as puberty blockers, where we only have around 5,000 people in the country on puberty blockers, it is common that people are not going to have large sample sizes in those studies. That's one of those things -- one of the limitations.

One of the other limitations is time of follow-up, right. So puberty blockers used for gender dysphoria is a relatively -- when you look at the larger body of medicine, a relatively newer intervention.

And so the -- yes, we are continuing to collect longitudinal data, as are the Dutch and many other places around the world. So we are a little bit limited just by the fact that this particular intervention has only been available for, you know, 20 years or so.

Q. Has this intervention been limited also in terms of studying the long-term effect, even in older adults, with regards to central precocious puberty, for example?

A. Absolutely. So you have a medication that gets approved for use in 1993. You are not going to have somebody who is 70 to look at yet.

Q. When you look at the whole body of research pertaining to the efficacy of the use of puberty-delaying medications to treat gender dysphoria, what is the full picture that you get?

A. The data -- the body of evidence that exists right now demonstrates the positive impact of the use of puberty blockers in youth with gender dysphoria.

Q. Thank you.

Does this research that you've been discussing -- how does it compare to your clinical experience?

A. So I have been providing puberty blockers and gender-affirming hormones for -- this will be my 17th year. I desperately wish that I could have enrolled all of my patients into studies to demonstrate how they benefit from these interventions.

So these studies line up. But I think what studies sometimes don't capture is the euphoria that people experience when they do not have to progress through their endogenous puberty and develop secondary sex characteristics that are not in alignment with their gender. We don't capture euphoria, unfortunately, in our studies. We capture these metrics that we know are proxies for that experience.

Q. So you would say from your clinical experience, then, that

your patients have experienced a positive affect in accessing puberty-delaying medications?

A. Absolutely.

Q. Turning to hormone therapy specifically, is there specific research on the use of gender-affirming hormone therapy to treat gender dysphoria?

A. Yes, there is.

Q. Are there studies that focus on the treatment of adolescents with gender dysphoria you are seeing in hormone therapy?

A. Yes, there.

Q. What are some of those studies that assess the efficacy of hormone therapy as treatment for gender dysphoria in adolescents?

A. So there are several. I can focus on a few of them.

One is the follow-up study from de Vries and her team that was published in 2014, demonstrating continued improvement across psychological functioning and domains. That was an important study because it's probably one of the oldest studies that enrolled people between 2000 and 2008.

Of importance is that all of those 70 young people that went onto blockers continued onto gender-affirming hormones in an upward trajectory of their psychological functioning.

There is another larger cross-sectional study that looks -- only is measuring one point in time that -- from the

United States that was -- that looked at -- I think it was about just under 12,000 LGBTQ individuals, youth. Particularly, they isolated about -- I think just under 6,000 trans or nonbinary young people in that study.

And what the study assessed was for the people who had access to gender-affirming hormone therapy versus the people who did not but wanted it, there was a significant difference in the psychological functioning of those two groups. So in the -- I don't know -- 1300 or something like that people who had access to gender-affirming hormones, their psychological profile was better than the several thousand people who wanted access but did not have it.

Q. And who is the primary author of that study, do you remember?

A. Greene.

Q. And you've mentioned a study that was published as a result of your NIH funded study --

A. Yes.

Q. -- is that right?

Can you tell us a little bit about that study?

A. So I'm the senior author on that study, but the first author is Diane Chen, who is an investigator at Lurie Children's Hospital in Chicago.

That study looked at the psychological findings from people who had been on hormones for two years, demonstrated an

improvement in positive affect, in life satisfaction, improvement in depression symptoms.

And that study is important because it is pulling participants from four sites around the United States. True, they are urban centers, gender centers, where this work is the primary focus of the center, but those were also important findings from a cohort of 314.

Q. Dr. Olson-Kennedy, I'm going to apologize for this couple of questions, but some of the defendants' experts have brought up that there were two subjects who, during the course of this longitudinal study, died by suicide.

My first question is: What are you at liberty to tell us about these subjects? And, separately, how does this play into or have any effect on the validity of your study?

A. So we did, unfortunately, lose two participants. They -- you know, gender-affirming care does not address everybody's entire life circumstances.

But what I can tell you is that their gender dysphoria improved, that they had peace and felt comfortable in their body, but they were not existing in a world that was supportive of them.

I'm so sorry.

Just because people receive gender-affirming care does not mean they are in a gender-affirming world.

Q. Do you need a break, Dr. Olson-Kennedy?

A. Yeah.

MR. GONZALEZ-PAGAN: May the Court be amenable to a short two-minute, five-minute break?

THE COURT: We can take a break and -- if we need to. If we just need to be at ease here for a minute, we can probably do that.

MR. GONZALEZ-PAGAN: Dr. Olson-Kennedy, just take your time.

THE WITNESS: No, it's okay. We can go.

MR. GONZALEZ-PAGAN: Your Honor, may I approach with water?

THE COURT: Surely.

THE WITNESS: Thank you.

THE COURT: Doctor, we are in no hurry. Take your time.

BY MR. GONZALEZ-PAGAN:

Q. And, Dr. Olson-Kennedy, again, I apologize this had to be brought up.

I thank you for your candor in sharing those experiences and speaking to the circumstances of those people.

The study that we are talking about, was that study published in a peer-reviewed journal?

A. Yes.

Q. What was that journal?

A. That study was published in the *New England Journal of*

Medicine earlier this year.
Q. And was it peer reviewed?
A. Yes.
Q. And, again, what were the findings of the study with regards to the efficacy of hormone treatment for gender dysphoria?
A. So over two years of gender-affirming hormone treatment, we saw an increase in positive affect, in life satisfaction, and a decrease in depression.
Q. When you look at this whole body of research pertaining to the efficacy of gender-affirming hormone treatment for adolescents, what does the whole body of research tell us?
A. The body of research continually tells us that people's lives are improved when they have access to this care.
Q. Are there any studies that assess the efficacy of hormone therapy to treat adults with gender dysphoria?
A. There is a large body of evidence that looks at this question and has for many decades looked at various aspects of people's lives.
Q. And would you consider -- in your estimation as a clinical researcher, how you would characterize the quantity of research that exists out there with regards to adults?
A. In my research language, I would say significant. In my layperson's language, enormous.
Q. How do the results that you just discussed with regards to

adolescents, with regards to the whole body of research being treated with hormone therapy, compare to that of the general body of research that exists in adults?

A. This is a growing body of research. I think it's really critical to think about, when interventions become available -- you know, trans adults start as trans kids. They start as trans kids; they become trans adolescents, and they grow into trans adults. And so as interventions have become available for adolescents, they are going to be utilized at an increasing rate. And so when people have access to that care, as that increases over time, we're going to have a growing body of literature. It is still a very significant body of literature at this time.

Q. And does the body of literature with regards to adults similarly show that the treatment is efficacious?

A. Yes.

Q. How does this research that you just have discussed with regards to the efficacy of hormone therapy to treat gender dysphoria compare with your clinical experience?

A. The clinical experience that I have working with young people -- I've probably taken care of a thousand young people over the course of my career, and what I see over and over again is that people improve -- their whole life improves. There are people who feel like their life has not started until they have their gender addressed and they're able to move around in the

world in a way that feels authentic to them.
Q. Can you tell us a little bit about what you've seen with your patients who have been -- how have they been impacted or what you've seen them do following their access to gender-affirming medical treatment?
A. I was thinking about this last night, and I was thinking that when I first started doing this work, I was really happy when my patients graduated high school. And now 17 years later having patients become doctors and lawyers and get Ph.D.s and move forward in their lives in a way that I would want for my own child, but also for any child and young person and young adult moving through the world, it's been incredible. I think it's just really changed the trajectory of people's lives.
Q. You've mentioned that they've become lawyers and doctors.
I apologize to even ask it in this way, but would you say that somebody being transgender doesn't affect their ability to contribute to society?
A. No, absolutely not. If somebody has access to early interventions, I anticipate them to have the same chance at a robust and thriving life as anybody.
Q. And would you say that that is the case when somebody's gender dysphoria is treated and managed?
A. Yes, absolutely.
Q. I'm going to pivot a little bit and talk about surgery.
Is there research specifically evaluating the efficacy of

surgical treatments for gender dysphoria?
A. Yes.
Q. Overall, what do the studies on the efficacy of chest surgery in adolescents tell us?
A. Chest surgery is a critical intervention for transmasculine people. It is absolutely imperative, and all of the research to date has demonstrated that chest surgery is one of the most efficacious interventions for people.

And just speaking about this from a regular person's perspective, the process of having to bind your chest is incredibly uncomfortable, even painful. It is something that young people have to do for hours in a day, and being able to do that means that people can go through their life freely without being, literally, bound up. It is incredibly uncomfortable to wear a chest binder. Some people utilize tape -- duct tape; some people utilize Ace bandages to flatten their chest.

So when people have chest surgery, they are free of that, and that's a whole different way of living. That's why chest surgery is such a profound intervention and is demonstrated to be in the existing research.
Q. You spoke earlier about a study of yours that specifically pertained to chest surgery in adolescents and young persons.

Can you tell us a little bit about what that study specifically showed?
A. So over the years of my practice, I had repeatedly heard

similar things from my patients. Things like, I avoid taking showers because of my chest; things like, I avoid going to public places to swim or to the beach; things like, I feel like my life hasn't started because of my chest.

I collected these things into a measure so that I could see what the impact of chest surgery was for young people, and my study, like some of the follow-up studies after that, has demonstrated that those elements are significantly -- like, profoundly improved after people have chest surgery. It is one of the most profound interventions that's available for transmasculine people.

Q. And you said that you developed a measure -- or would it be safe to call it a scale?

A. Yes.

Q. You said that you developed a scale to measure the dysphoria that arises out of somebody -- out of their chest -- having a chest incongruent with their identity.

Has this scale been used in studies conducted by others?

A. Yes. So the chest dysphoria scale was utilized in a handful of follow-up studies that had remarkably similar results to the ones that I had in my study and correlated chest dysphoria to anxiety and depression.

Q. And can you tell us what a couple of those studies may be?

A. So there's -- I think one that really sheds light into the nuances of this experience was -- let me try and think of --

remember the name of the author. But it was a qualitative study where they had 20 young people in a focus group and really asked them about the impact of their -- female chest contour on their lives as nonbinary or transmasculine individuals, and demonstrated -- out of that study came very similar things to what is in the chest dysphoria scale.

There have also been two studies that looked at young people prior to chest surgery utilizing that scale, correlating it to anxiety and depression, and then that same group of researchers, after those young people had chest surgery, demonstrating similar findings to what I had in my study.

Q. And, again, the findings were findings of improvement?

A. Yeah, so a reduction in chest dysphoria after surgery.

Q. Given that some studies used this scale and that -- had similar findings, would you then agree that your study is reproducible?

A. I think that the study is reproducible. It has been reproduced in the studies that I just mentioned. And I also think that scales have what's called face validity, which means that the items on the scale are tested informally in processes where you take care of patients.

And what I can tell you is I had 67 young people in that study who had chest surgery and 67 people who didn't, but the findings and the -- of that scale -- the results on that scale mirror what I see in clinical practice. They demonstrate the

relief that people experience after chest surgery.

And I now have hundreds of patients in my practice who have undergone chest surgery who have similar positive responses.

Q. We've been talking about the existence of research and studies regarding the efficacy of gender-affirming medical treatments and the relation to mental health.

Is there longitudinal data that shows the benefits of gender-affirming medical treatments for patients with gender dysphoria?

A. Yes.

Q. What is that data?

A. When did you say, or what?

Q. What is that data?

A. So are you talking about as a whole -- the body as a whole?

Q. What are the types of longitudinal data that exist showing the efficacy of treatment?

A. There's a lot of longitudinal data, especially in the adult population. So there are so many elements of the experience of gender dysphoria and the experience of the alleviation of gender dysphoria. There are so many studios I couldn't even review all of them right now.

But in youth, obviously, it's a more limited dataset because we've only been doing youth care for 20 or 30 years, as opposed to a hundred. So that body of evidence is growing and expect it to have similar findings to what we've seen so far.

Q. We've been speaking a lot about research and in some instances about how it accords with your own clinical experience.

Can you tell us what role clinical experience plays in helping -- determining the efficacy of treatment?

A. Yes. I think it's really important to talk about the elements that go into understanding evidence-based care, but it is not only research studies that help guide us in this care. It's clinical experience as well, and it's also patient experience. Those three things together are what inform decision-making in this work.

It is profoundly difficult to do scientific studies. It takes time; it takes money; it takes willingness of participants, as opposed to clinical care. Our clinical care outpaces our research. I've taken care of a thousand young people over the course of my career, and they have not all been involved in research.

And so we absolutely, in all areas of medicine, lean on our clinical experience to help us -- to help guide us in making decisions that are the best for people's outcomes.

Q. And does that clinical experience also inform what research is -- should be done?

A. It does. I think that people approach research from a variety of perspectives. Sometimes that research is to support what they're doing or to get those findings down on paper, and

sometimes it's exploratory.

Q. Shifting gears a little bit, I'm going to ask you a few questions of what is sometimes referred to as desistance in the literature.

Are you familiar with the term "desistance"?

A. I am.

Q. What does this term refer to?

A. Desistance commonly refers to people whose gender or experience of their gender pivots.

Q. Some of the defendants' experts suggest that as many as 98 percent of minors with gender dysphoria come to identify with their sex assigned at birth, and those don't need treatment.

I guess my question is, is it true that the overwhelming majority of adolescents with gender dysphoria come to identify with their sex assigned at birth?

A. No.

Q. How so?

A. It's really that these different cohorts of people are distinguished is really critical in understanding the existing literature.

So the research that that particular assertion relies on is, A, old. It's very old research. That's the first thing. It's research that happened even before the criteria for a diagnosis of gender dysphoria were in their current iteration. And so it is true that there are a lot of prepubertal children

whose gender expression is variable. So, for example, there are a lot of cisgender or nontransgender boys who like to wear dresses when they're children or whatever, do things like that.

The experience of gender dysphoria as it's defined today that leads to medical interventions, extraordinarily rare for desistance to occur.

Q. Do you think that these studies that you just discussed support the claims that defendants' experts are making about them?

A. Absolutely not about adolescents at all. In fact, the data has demonstrated that if people reach adolescence and they still have gender dysphoria, that it is not going to desist.

Q. Dr. Olson-Kennedy, are you familiar with the term "detransition"?

A. I am.

Q. What do you understand this term to mean?

A. That means somebody that stops being in a gender role and goes back to living in a gender role that they were designated at birth.

Q. Within the medical literature, what are some of the things that may lead someone to detransition?

A. The predominant reasons that people detransition have to do with their experience of trying to get along in a hostile world, in a world that is hostile to trans experience.

So, in other words, there are -- it just reminds me of a

patient I had that came in and said, You know, I'm going to stop taking hormones.

And I said, Why are you going to stop taking hormones?

It's just too hard.

This was a person that started their transition after they had gone through their endogenous puberty; they had acquired all of their male secondary sex characteristics. That is an extremely difficult scenario, and what she told me was, It's just too hard. Like, I can't walk in the world and not have to answer questions all the time about my selfhood, and so I'm going to stop.

Q. Are there some people who detransition because they come to actually identify with their sex assigned at birth?

A. A very, very small number.

Q. What is the percentage of people who detransition that do so because they come to identify as their sex assigned at birth?

A. About 1 to 2 percent.

Q. And what do you rely on for this assertion?

A. There's a limited number of data that demonstrate this, my clinical practice as well, and --

Q. Does the fact that some people detransition mean that gender-affirming medical care is ineffective or experimental?

A. No.

Q. Does the fact that someone detransitions mean that they regret receiving gender-affirming medical care?

A. No. The regret rates are actually even lower than the detransition rates.
Q. What is the percentage of people who receive gender-affirming medical treatment who experience regret?
A. 1 percent.
Q. And if someone regrets their medical treatment for whatever reason, does that mean that they no longer identify as transgender?
A. No.
Q. The defendants' experts argue that in some studies evaluating medical treatments for adolescents with gender dysphoria there were no findings of mental health improvements for some of the interventions.
Is that accurate?
A. That's just not true. The resounding body of data demonstrates improvement across multiple domains of function.
Q. Would a lack -- does the fact that a study didn't -- a particular study may not have found statistical significance with regards to the improvement -- does that mean that there was no improvement?
A. No. Statistical improvement is a number. It's a number. So if -- just because somebody doesn't meet a threshold that is a mathematical consideration does not mean they didn't experience improvement in their symptoms.
Q. And when looking at the body of research about the efficacy

of gender-affirming medical interventions to treat adolescents with gender dysphoria, what does that research show?
A. I'm sorry. Could you repeat the question?
Q. Sorry. When we look at the body of research about the efficacy of gender-affirming medical treatments to treat adolescents with gender dysphoria, what does that research show?
A. Improvement across multiple domains of psychological functioning.
Q. Are you familiar with the term "rapid-onset gender dysphoria"?
A. I am.
Q. What do you understand the concept of rapid-onset gender dysphoria to mean?
A. Rapid-onset gender dysphoria was introduced by Lisa Littman as a way to characterize how parents of some transgender young people talked about the experience with their young person; in other words, that this assertion of a different gender came out of the blue or came on very quickly.
Q. To your knowledge, does Lisa Littman provide gender-affirming medical care?
A. No, sir.
Q. To your knowledge, had Lisa Littman prior to this one study published any literature pertaining to gender-affirming medical care?
A. No.

Q. Is it unusual -- is it unusual that there are parents who would express surprise at learning that their adolescent is transgender?
A. No.
Q. Why not?
A. Young people are, in general, very -- have very strong feelings about potentially being rejected for who their authentic self is. So it is often the case that young people will keep this part of themselves from their parents as a safety measure, but also -- so let me give you an example.

If you don't tell anyone that your gender is different from what they think it is and they continue to use your birth name and the pronouns associated with that, it is way less painful than if you tell someone, and they continue to use your birth name and your pronouns.

And so that perspective is really important for both adolescents and adults, that there's an assessment of what's going to happen if people disclose this information to, particularly, their parents or caregivers.

Q. And the fact that they -- that adolescent doesn't feel free to come out to their parents, guardians, or family, does that mean they're not experiencing gender dysphoria?
A. Absolutely not.
Q. Is rapid-onset gender dysphoria recognized as a mental health diagnosis?

A. It is not.
Q. In conducting research about the experiences of trans adolescents, is it important to take into account their own narrative when conducting that research?
A. Yes.
Q. Did Lisa Littman's study look at all into the experience of the adolescence question?
A. No.
Q. When you're evaluating patients for assessment in making a diagnosis of gender dysphoria, do you consider social influence in your assessment?
A. Could you clarify what you mean by "social influence"?
Q. Sure. What do you take into account when making an assessment of an adolescent and whether they have gender dysphoria?
A. So even though we only talk about, I feel like in the lay community, about this one event of somebody coming out, there is the more critical piece of what I affectionately call coming in. So it's that process whereby somebody is undergoing some kind of research, some kind of quest to understand what they're experiencing. And so maybe it starts with a question like, Oh, I don't really feel like a girl. What does that mean?
And then it's going into the worlds that they're surrounded with, right. So for a lot of young people, that's online communities, seeking information -- What if I'm not a girl?

What if I'm not a boy -- and gathering a lot of information. People do a lot of information gathering before they ever invite anyone else into that question. And so maybe that's books; maybe it's online content; maybe the next step is finding other people with a similar situation.

And so we all do that as humans. We find people who have similar experiences, and we ask questions, and we -- sometimes maybe young people will create an avatar in the gender that they identify with and do online gaming in that avatar and see how that feels. There is a process of exploration before anyone comes out. And, generally, young people will talk about this with their peers before they talk about it with their parents or caregivers or teachers or anybody like that. It's a process whereby people are understanding what's going on for them around their gender.

Remember that our world is organized for cisgender people. Before you are even born, you have a nursery with according colors. Then you come into that nursery, and then the world is funneling you down a cisgender pathway. So if you are a trans person, you have to swim upstream in that world, which is also why some people don't come out until later, because what you have access to and what's in your world is going to determine some of how you understand this to be your truth.

Q. Thank you, Dr. Olson-Kennedy.

Can adolescents experience gender dysphoria because of peer

pressure to identify as transgender?
A. No. That doesn't make any sense. The majority of people are not transgender. The majority of people are cisgender.
Q. Some of the defendants' experts actually argue that adolescents identify as transgender because of a desire to fit in or be popular.
What's your response to that?
A. Well, if someone can explain to me the reward for being transgender, undergoing medical interventions and potentially surgery, then I might have a better understanding of that. But there is no reward for being trans. There is no peer reward, and there is no reward in the world. It's very hard to be a transgender person in the world as it is constructed right now.
Q. Some of the State's experts have pointed to reports from government entities in other countries, specifically the UK, Finland, and Sweden, as demonstrating a lack of evidence of the effectiveness of gender-affirming medical interventions for adolescents.
Are you familiar with those arguments?
A. I am.
Q. Do any of the reports referenced by the defense experts recommend banning treatment or coverage of gender-affirming medical interventions?
A. They do not.
Q. And, to your knowledge, are any of these reports peer

reviewed?
A. They are not.
Q. What is the purpose of peer review?
A. The purpose of peer review is to try to minimize bias in the reporting of findings.
Q. Is it common in medicine to have -- strike that.
Do you or people in your field typically rely on nonpeer-reviewed governmental reports in assessing the efficacy of medical treatment?
A. No.
Q. We've been talking a lot about the research regarding the efficacy of gender-affirming medical treatments to treat gender dysphoria.
Is there any research demonstrating the effectiveness of other treatments to treat gender dysphoria?
A. No, not that I'm aware of.
Q. I think this is answered, but to be a little bit more specific, is there any research demonstrating the efficacy of the use of psychotherapy alone to treat gender dysphoria?
A. No.
Q. We've heard a little bit throughout this trial about the rising number of people who have been presenting to gender clinics for treatment.
What are your thoughts on that?
A. I think that as interventions become available for

adolescents, it is -- absolutely makes sense that people -- more people are going to show up for care. Again, trans adults start as trans kids that become trans adolescents and then trans adults. And so it stands to reason that when interventions become available for people at a younger age and the national discourse changes on this experience, that more people are going to seek care related to this.

Our bodies have more hormone receptors when we are younger. If you can establish care and get care at a younger age, you are going to have more changes, those physiologic changes that are going to align with your gender that create a sense of peace for people. And so if people can access care in adolescence, they are going to have vastly different results than if they access this care later on.

Q. Can the rising numbers be attributable or -- be attributable -- let me restart that.

Can the rising numbers be attributable to the rising number of people experiencing gender dysphoria?

A. I don't think so. I think that just access to services and a more profound national discourse about this experience is very similar to other situations where people now see themselves reflected in the world and opportunities and pathways for addressing this distress.

Q. You mentioned other situations.

Are there any particular analogies that you consider

helpful in this regard?

A. One that I've thought of before is related to handedness, right, so left-handedness. For a long time the approach to this, if somebody was left-handed, was to tie their left hand behind their back so that they were forced to use their right hand, and even, like, people would get hit on their left hand so they didn't use it.

And so from an external lens looking in at that, it's like, oh, there are so few people that are left-handed. Well, yeah, because it wasn't -- these were the punitive measures, because people who were left-handed were considered to be less than or somehow, you know, problematic.

As that changed over time, it wasn't that more people became left-handed, it's that we no longer created punitive environments for left-handed people.

It feels very similar -- it feels very -- like a very similar situation.

Q. So any rise in the number of people that identified as left-handed was just people feeling freer to be left-handed. And did that plateau in any way?

A. Yeah. We haven't reached a point where everybody is left-handed, no.

Q. What is the effect of delaying medical treatment for gender dysphoria when it is medically indicated?

A. So I think we can -- when I think about this, I think about

the physiologic and the mental health piece of this.

So from a physiologic perspective, I've already made mention of the fact that the younger you are, the more hormone receptors you have, so that interventions when you're younger are going to have more physiologic impact in your body.

But the probably more devastating piece is untreated gender dysphoria. And the literature is very clear on this, that people with untreated gender dysphoria struggle in multiple domains of their life. So the longer that that goes untreated, the worse people are going to be.

Q. Just a few concluding questions, Dr. Olson-Kennedy.

As a clinician and researcher, do you consider the use of puberty-delaying medications to treat gender dysphoria to be experimental?

A. No.

Q. Do you consider it to be safe?

A. Yes.

Q. Do you consider it to be effective?

A. Yes.

Q. As a clinician and researcher, do you consider the use of hormone therapy to treat gender dysphoria to be experimental?

A. No.

Q. Do you consider it to be safe?

A. Yes.

Q. Do you consider it to be effective?

A. Yes.
Q. As a clinician and researcher, do you consider surgical treatment for gender dysphoria to be experimental?
A. In general, yes -- no, it is not experimental.
Q. Sorry. Just to clarify, do you consider surgical treatment for gender dysphoria to be experimental?
A. No.
Q. Is it safe?
A. Yes.
Q. Is it effective?
A. Yes.
Q. Just one concluding question, Dr. Olson-Kennedy.

We have talked a lot about research and statistics surrounding treatment -- medical treatment for gender dysphoria during your testimony and this trial.

As a healthcare provider, as a clinician, can you tell us a bit about why this care is so important for the patients that you care for?
A. So for the past 17 years, I have been doing gender care, and what I can tell you is that it is life changing for people. It is life changing for people to be able to live authentically, not just internally, but externally. Walk in the world and be perceived as their gender accurately is a lifesaving intervention. It is absolutely, without a doubt, one of the most profound interventions. This is one of the reasons that I

have devoted my career to it.

Q. Thank you, Dr. Olson-Kennedy.

MR. GONZALEZ-PAGAN: No more questions, Your Honor.

THE COURT: That makes this the time for the morning break.

Let's take 15 minutes. We'll start back at 10:55 by that clock.

Doctor, if you'd be back on that stand in 15 minutes.

Thank you.

(Recess taken at 10:41 AM.)

(Resumed at 10:55 AM.)

THE COURT: Please be seated.

Dr. Olson-Kennedy, you are still under oath.

Mr. Jazil, you may proceed.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good morning, Doctor.

As I understood your testimony, you devote your practice to working with transgender individuals; right?

A. That's correct.

Q. You work with patients who have gender dysphoria as well?

A. The majority of people that I see in adolescence and young adulthood have gender dysphoria.

Q. And you testified that you write about treatments for gender dysphoria as well?

A. Yes.
Q. You are a member of WPATH, right?
A. I am.
Q. And you've been a member since 2020?
A. That's correct.
Q. So, Doctor, to your knowledge what is the age of the youngest person that you know who has received puberty blockers?
A. 8.
Q. Okay. And, Doctor, to your knowledge, what is the age of the youngest person who received cross-sex hormones?
A. Can I just clarify? Because puberty blockers are used for another indication in children who are younger than that.
Q. I'll ask you another question.
A. Okay.
Q. Maybe a more specific one.
To your knowledge, what is the age of the youngest person diagnosed with gender dysphoria who received puberty blockers?
A. 8.
Q. What is the age of the youngest person diagnosed with gender dysphoria who received cross-sex hormones?
A. That I know, 12.
Q. And what is the age of the youngest person who has been diagnosed with gender dysphoria who received some kind of surgical intervention for that diagnosis?
A. I think there have been one or two people that had chest

surgery at 13.
Q. Now, Doctor, you talked about psychotherapy alone not being enough to treat gender dysphoria.
Do you recall that testimony?
A. Yes.
Q. You also testified that prepubertal children do not get medical interventions, which I understood to mean cross-sex hormones, puberty blockers, or surgeries?
A. That's correct.
Q. Do you recall that?
So is it your testimony that psychotherapy alone for prepubertal children does not help with their gender dysphoria?
A. I think that therapy is helpful for people in a lot of ways. Does it change their gender dysphoria? Does it change their gender? No.
Q. Can we agree that for prepubertal children psychotherapy alone can be helpful to help with their gender dysphoria?
A. Sure.
Q. Doctor, you also talked about the 1 to 2 percent detransition rate for adolescents.
Do you recall that testimony?
A. Not specific to adolescents.
Q. So who was it related to, the 1 to 2 percent?
A. It depends on what study we are talking about.
So in the studies that have been done of transgender people

or people with gender dysphoria as a whole.
Q. Okay. And these studies look at someone from their initial diagnosis, regardless of whether or not they were prepubertal to adulthood?
A. It depends on which study you are talking about. There are not, that I know of, lifetime studies of people over the entire course of their life.
Q. Okay. So the 1 to 2 percent number that you discussed with my friend, that was related to the entire transgender population as a whole?
A. No. That comes from studies. There is no study that studies every single trans person or person that's undergone interventions.
Q. Okay. Then as a follow-up question to my friend when you threw out the 1 to 2 percent number, I think you said -- and correct me if I'm wrong -- that there is limited data to support that 1 to 2 percent detransition rate that you discussed?
A. In the context of -- you can't do a study that looks at every single person. But I also think it's relevant to say that those studies are at one point in time. So there are people who move in and out of transition, and that's not characterized either.
So clinically the people who may stop interventions and then go back on them I've had a handful of people like that in my practice, who stopped interventions. I'll give you one

example. So I had a young person who went on blockers his parent died, and he got put into foster care with somebody who held very specific ideas about gender and had to stop his process. And then when he was able to get into care, taken with somebody who did not share those views, came back for care. And so that person moved in and out of gender-affirming medical care.

And so it's -- when we characterize people in one way, we don't take account of the movement that they might experience throughout their lifetime.

Q. Understood.

Doctor, I'd like to switch gears for a moment and talk about cross-sex hormones.

You testified that you are familiar with the literature concerning cross-sex hormones?

A. That's correct.

Q. And based on the literature, the percentage of adolescents put on puberty blockers that then go on to receive cross-sex hormones is as high as 98 percent; right?

A. Yes.

Q. And you also prescribe cross-sex hormones to adolescents in your practice for gender dysphoria; right?

A. I do.

Q. Before prescribing those cross-sex hormones, you discuss with your patients the risks associated with the medication;

right?
A. Yes.
Q. As you're discussing the risks, it's my understanding of your testimony -- and tell me if I'm wrong -- that you follow the WPATH Standards of Care as part of that discussion; right?
A. Yes.
Q. Doctor, I'd like to point you to the chapter in the WPATH Standards of Care that deal with hormone therapy.
MR. JAZIL: Your Honor, may I approach?
THE COURT: You may.
MR. JAZIL: This is Defendants' Exhibit 16.
BY MR. JAZIL:
Q. Doctor, I'd like to point you to Chapter XII, which begins on page 112 on the Bates numbering on the bottom right.
This is the chapter on hormone therapy in WPATH Version 8; right, Doctor?
A. Yes.
Q. Doctor, I'd like to move us to page 114, bottom right.
If we look at the first paragraph on the left, there is a sentence there that says: *TGD individuals treated with testosterone may also have increased adverse cardiovascular risks and events, such as increased myocardial infarction, blood pressure, decreased HDL-cholesterol, and excess weight.*
Do you see that, Doctor?
A. I don't see it exactly, but I know what you are talking

about.

Thank you. That's super helpful.

Thank you.

Q. Doctor, you discuss these risks with your patients before you prescribe the cross-sex hormones?

A. I do.

Q. Doctor, let's go to page 120 of this document.

The first sentence under Statement 12.12, if we go down some. It says: *Pubertal suppression and hormone treatment with sex steroid hormones may have potential adverse effects on a person's future fertility.*

You discuss fertility issues with your patients, Doctor?

A. I do.

Q. If we go to the column on the right, there is a sentence that begins: *Nonetheless, there are major gaps in knowledge, and findings regarding the fertility of trans feminine people who take estrogen and antiandrogens are inconsistent.*

Do you see that, Doctor?

A. I do.

Q. Do you tell your patients about these major gaps when you discuss cross-sex hormones with them?

A. Yes.

Q. Doctor, if we look down to the next paragraph, second sentence: *There are also major gaps in knowledge regarding the potential effects of testosterone on oocytes and subsequent*

fertility of TGD patients.

Am I correct that you also discuss these issues your patients?

A. Yes.

Q. And just so the record is clear, oocytes are cells in the ovary?

A. That's correct.

MR. JAZIL: Can we go onto the next page?

BY MR. JAZIL:

Q. The first full paragraph, it says: *Treating a TGD adolescent with functioning testes in the early stages of puberty with a GnRHa not only pauses maturation of germ cells but will also maintain the penis in a prepubertal size. This will likely impact surgical considerations if that person eventually undergoes a penile-inversion vaginoplasty as there will be less penile tissue to work with. In these cases, there is an increased likelihood a vaginoplasty will require a more complex surgical procedure, e.g., intestinal vaginoplasty.*

Doctor, do you discuss these issues with your transgender patients who you think might progress to surgical intervention as well?

A. Absolutely.

Q. Doctor, I'd like to discuss some of the studies that my friend talked to you about.

First was Littman article. Do you recall that?

A. Yes, basically. I don't have intimate knowledge of all of it.
Q. Understood, Doctor.
Doctor, in your expert report, you criticize Littman article by saying that parental reports are not necessarily a reliable basis for understanding a particular youth's experience with their gender, let alone whether Littman youth has gender dysphoria.
Do you recall writing that?
A. That sounds like something I would write.
Q. I just want to understand what you are saying there. Are you saying that parental reports would not serve as a basis to exclude a diagnosis of gender dysphoria under Littman *DSM-5*?
A. Yes.
Q. Doctor, you also discussed with my friend your paper on chest dysphoria. You talked to him about how you developed a scale for measuring chest dysphoria.
Do you recall that?
A. Yes.
Q. And Littman participants for Littman study where you used to develop Littman scale were from your practice? Did I understand that right?
A. Yes.
Q. Do you recall the sample size of the study that you undertook?

A. I think that I had 67 young people who had undergone surgery and 67 people who had not.
Q. Okay. And then the participants in the study, they were asked to help generate the questions used to come up with the scale; right?
A. Not per se in that way. I developed the scale from things that I had heard all of my patients talking about over the time I'd been doing the work.
Q. So the participants had input in the questions that were used to develop a scale.
Is that a more accurate way to put it?
A. Indirectly through my time providing services for them.
Q. And the scale, at its core, measures happiness with surgical treatment that they've undergone; right?
A. The scale in and of itself measures the experiences of having a female chest contour while identifying as something other than female.
Q. So satisfaction with the surgery, is that --
A. No. So the items on the scale include things like, I often avoid taking baths or showers because of my chest. I feel like my life hasn't started because of my chest. I feel like -- it's items like that that are related to having a female chest contour that are impairing people's capacity to do everyday, average things.
Q. Got it.

Doctor, I'd like to move on to the deVries study.

MR. JAZIL: Plaintiffs' Exhibit 141, please.

BY MR. JAZIL:

Q. This is one of the studies that you talked to my friend about.

Isn't that right, Doctor?

A. Yes.

MR. JAZIL: I'd like to go to Table 1 in the study, which is on Bates page 6596.

BY MR. JAZIL:

Q. Doctor, am I correct that there were 70 participants in the study?

A. That's correct.

MR. JAZIL: If we could go to Bates page 6600, the last paragraph before "Conclusions" on the left side.

Q. It says that: *Finally, this study was a longitudinal observational descriptive cohort study.*

Do you see that, Doctor?

A. I do.

MR. JAZIL: We can take that down.

BY MR. JAZIL:

Q. Doctor, I'd like to compare the longitudinal observational cohort study to the van der Miesen study that you discussed with my friend.

As I understood your testimony about the van der Miesen

study, there were 250 participants in that study; right?
A. I can't remember the exact numbers. If we could look at it, that would be helpful, and I could describe the cohorts more completely.
Q. Can you approximate for me? Was it more than 70?
A. Yes.
Q. And when you were discussing that study with my friend, you talked about how there was a natural cohort built into the study; right?
A. To the best of their ability, they had a cohort that was -- that was coming in for intervention, so baseline.
Q. So the study was comparing, as I understood it -- and you tell me if I'm wrong -- people who had not started on puberty blockers yet with people who had started on puberty blockers; right?
A. That's correct.
Q. So the natural cohort was analogous to a control group in that instance; right?
A. It's not analogous to a control group in the sense that there had been a process of intervention that happened for the group that we're defining as being on blockers.

So what they're trying to do is, as close as possible, create an untreated control group. It's not identical because in an untreated control group in a randomized controlled trial, you have people starting at the same point, and some of them are

treated and some of them are not. They're randomized into those interventions.

But for reasons that we've talked about previously in this court hearing, that -- it is not ethical to assign people to an untreated control group when we know that treatments exist that are beneficial to people. So, in this case, they're trying to present as close as possible to an untreated control group.

Q. And so, Doctor, am I correct that the authors' attempt, as close as possible, to come up with an untreated control group improves the quality of the study if we were using the GRADE methodology to grade it. Right?

A. Maybe.

Q. Doctor, can we go to Plaintiffs' Exhibit 164, please? It will pop up on your screen.

And, Doctor, is this the January 2023 *New England Journal of Medicine* article that you were discussing with my friend?

A. Yes.

Q. And, Doctor, in the "Background" section of this article, it says that: *Limited prospective outcome data exist regarding transgender and nonbinary youth receiving gender-affirming hormones.*

Is that correct?

A. That is correct.

Q. If we go on to the next page, the second paragraph, last sentence, it says that*:* *Evidence has been lacking from*

longitudinal studies that explore potential mechanisms by which gender-affirming medical care affects gender dysphoria and subsequent well-being.

And that's right, Doctor?

A. Yes.

MR. JAZIL: If we can go to page 247 of this study -- it's Bates stamp label 6567 -- last paragraph on the right.

BY MR. JAZIL:

Q. Doctor, here the paper discusses certain limitations and it says that*: Because participants were recruited from four urban pediatric gender centers, the findings may not be generalizable to youth without access to comprehensive interdisciplinary services or to transgender and nonbinary youth who are self-medicating with GAH.*

You'd agree that that was a limitation to the study?

A. Yes.

Q. And, Doctor, I'd like to piggyback on that point.

Is -- I understand from your resume you've worked at clinical centers at universities for most of your career; right?

A. That's correct.

Q. And you yourself have never worked in a rural setting providing medical care to transgender youth; right?

A. That's correct.

Q. If we can go back to the paper, the next sentence says: *In addition, despite improvement across psychosocial outcomes on*

average, there was substantial variability around the mean trajectory of change. Some participants continued to report high levels of depression and anxiety and low positive affect and life satisfaction, despite the use of GAH.

And that was one of the conclusions from the study, Doctor?

A. That's correct.

Q. Doctor, you were a co-author of this study?

A. I'm the senior author on this study.

Q. You're the senior author on this study. Thank you.

Doctor, I'd like to go to Plaintiffs' Exhibit 176.

Doctor, is this the Dr. Green article that you mentioned in your discussions with my friend earlier?

A. Yes.

Q. Now, Doctor, I'd like to point you to the first sentence under "Purpose" right there. It says that*: There are no large-scale studies examining mental health among transgender and nonbinary youth who receive gender-affirming hormone therapy.*

Is that your understanding as well?

A. In this case, what this -- I believe what this author is talking about is the fact that because gender-affirming hormone care is relatively rare in the United States, that large-scale studies such as the one that this author performed -- she's talking about having a broader catchment area because -- we talked about people on blockers, there only being about 5,000

people. Youth on gender-affirming hormones is limited to just under 15,000 people in the United States. So doing large-scale studies is very difficult, if not impossible, except through mechanisms such as Amy Green is talking about in this study.

Q. Okay. Let's look at some of those mechanisms.

MR. JAZIL: If we can go to page 6677.

BY MR. JAZIL:

Q. Under "Methods," "Procedure," the second sentence there says: *Youth were recruited via targeted ads on Facebook, Instagram, and Snapchat.*

It goes on to say near the bottom of the paragraph: *Youth were able to select 'decline to answer' for any questions in the survey* and they -- *that they did not want to answer. Respondents were eligible to be entered into a drawing for one of 100 gift cards worth $50 each by providing their email addresses after being routed to a separate survey.*

That was the method by which the authors of this study recruited participants. Is that understanding correct, Doctor?

A. Yes, this was part of their recruitment strategy.

Q. Understood.

MR. JAZIL: If we could go to page 6681 of this document.

BY MR. JAZIL:

Q. Under "Limitations," second sentence, it says that: *First, causation cannot be inferred due to the study's crossectional*

design.

Do you see that, Doctor?

A. I do.

Q. Do you agree with the authors of the study that causation --

A. I think that's often a limitation in research.

Q. Understood.

Doctor, I have in my notes a quote from you from your direct. You said that: *We should change our approach based on further research.*

Do you recall saying something to that effect?

A. Yes.

Q. If further research urges caution in the use of puberty blockers or cross-sex hormones or gender-affirming surgery, do you think that we should follow that approach?

A. If research demonstrated, you mean, that it was not effective in the care of gender dysphoria? If there were compelling research, we should, yes.

Q. Understood.

MR. JAZIL: Thank you, Your Honor. No further questions.

THE COURT: Redirect.

MR. GONZALEZ-PAGAN: Just a couple of questions, Your Honor.

REDIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Olson-Kennedy, you were just asked a little bit about some of the risks associated with hormone therapy for the treatment of gender dysphoria that were outlined in the WPATH Standards of Care 8.

Do you recall that?

A. Yes.

Q. Are those risks specific -- specifically associated because hormones are being used to treat gender dysphoria, or are those risks just general risks associated with the use of hormone therapy regardless of the --

A. Those are general risks related to the use of those medications even outside of the world of gender-affirming care.

Q. And those are risks that are -- that you discuss with your patients?

A. Of course.

Q. Dr. Olson-Kennedy, you were asked about a statement contained within your report regarding the -- how informative or indicative the parent reports may be with regards to transgender adolescents' experiences.

Do you recall that testimony?

A. I do.

Q. Do you consider what a parent reports when you're diagnosing or assessing a patient?

A. Yes, of course.

I just want to -- I want to provide some clarity about this because I think it can be confusing. So parents, just like young people, go through a process of understanding what's happening with their kid. They don't start out knowing all of it.

Their young person goes through a process that I call coming in, figuring out what's going on with their gender. They tell their parents, and their parents start back here because they haven't had all the data. So the young person has engaged in a process that then comes to the point of disclosure, because you can't get any interventions if you're a minor unless you disclose to your parent or caregiver.

And then the parent starts at Step 1. And so there are stages where parents are, like, What do you mean? What are you talking about? This is new information. All the way up to, Oh, I completely understand what's going on with your gender. Let's move forward with you getting care.

There is a very long process that is often disregarded when we're talking about this care.

Q. And providing the care -- it is the parents or guardians who provide the consent; is that correct?

A. In the case of people who are under 18, yes.

Q. Dr. Olson-Kennedy, you were asked a couple of questions about the recruitment strategy utilized by the Green study.

Does the fact that participants were recruited to participate in the study invalidate its results?
A. Not at all. When you recruit for a large-scale study like that, you have to go where the youth are, and the youth are online. So that's where you get large-scale studies such as the one described by Green.
Q. And is online recruitment actually something that is used not just in this field, but throughout medicine?
A. Absolutely, yes.
Q. And is -- the use of rewards to participate in a study, is that something that is common in research?
A. Yes.
MR. GONZALEZ-PAGAN: Thank you.
THE COURT: Doctor, I want to make sure I understood some details about one of the things you said.
You had a number, I think, just under 5,000 of people on puberty blockers in the United States and just under 15,000 for people in hormone therapy in the United States.
Are those people on those treatments for gender dysphoria?
THE WITNESS: Yes.
THE COURT: And on -- for the puberty blockers, at one point in the discussion you said something about early adolescence or outset of adolescence, something like that.
THE WITNESS: Uh-huh.

THE COURT: But the number for puberty blockers, that's everybody on puberty blockers for gender dysphoria regardless of what age they started?

THE WITNESS: Yes.

THE COURT: Now, I want to understand a little better the progression.

I think I understand that, ideally, if the patient comes to you early enough, puberty blockers start right at the outset of puberty.

THE WITNESS: Yes.

THE COURT: How does it go from there to hormone therapy? What age or what part of the puberty cycle does that happen?

I guess the puberty blockers stop when the hormone therapy starts. I want to make sure I understand that correctly and then what the age of the stage of puberty is when those things happen.

THE WITNESS: So people start puberty blockers anywhere from Tanner Stage 2, which is the first stage -- Tanner Stage 1 is no puberty; Tanner Stage 2 is the beginning of puberty; and Tanner Stage 5 is considered adult development.

So there are people who are started on puberty blockers across 2 through 5 at any point in that process, because the use of puberty blockers is -- has multiple purposes. The first one is if somebody is 9, and they started puberty and

they have gender dysphoria, we're not going to put them on gender-affirming hormones, A, because they're 9 and because the cognitive capacity for people to understand an intervention that has permanent impact really isn't intact until about 12 -- 11 or 12.

So we have this intervention that allows people to push the pause button. They're not going through their puberty and developing secondary sex characteristics that they, then, are going to have to reverse, have surgery for, et cetera. So it gives people this pause until they are two things: Peer concordant in their puberty -- really, we don't want anyone going through puberty at 9. It's a really hard age to start your puberty process, but for kids with gender dysphoria, it gives them time to be more peer concordant and have cognitive development so that they can make better and informed decisions about permanent interventions. That's one thing.

The majority of people going on puberty blockers, though, are not 8, 9, and 10. The majority of people going on puberty blockers in Tanner Stage 2 is 11 -- about 11 on average, at least in my practice.

But there are also people who are 12, 14, 15, 16, who are going on puberty blockers as well. And for those people who have already gone through puberty, what puberty blockers allowed them to do is, for example, stop having a period, like that would be a good reason for somebody to go on a puberty blocker.

There is other mechanisms to do that, but this is one of the strategies.

And so among those 5,000 people, it's not 5,000 9-year-olds, right. They are ranging from -- the earliest cases -- because the early end of puberty for people with ovaries is 8. If they start puberty before that, they are going on puberty blockers for a different reason, for precocious puberty. But if they're starting at 8 and they're going on puberty blockers for gender dysphoria, they are not going to go on to hormones at 8.

THE COURT: And so in just an average case, if somebody's 11 and they go on puberty blockers at that age, when are they likely, then, to move to hormone therapy?

THE WITNESS: So there is a whole host of factors that play a role in that decision-making. So it's certainly not one way for every person.

So if somebody goes on puberty blockers at 11, it's highly likely that they've experienced gender dysphoria in early childhood and continue to experience it. Put them on puberty blockers to halt their endogenous puberty and then try to match their peers with puberty, because there's pretty compelling data that demonstrates when you are late to puberty compared to your peers, it's -- causes psychosocial issues.

So maybe somebody goes on puberty blockers at 11, let's say, and then two years later, we will add hormones. That

was another thing. We generally add hormones to puberty blockers because we don't want someone to go from no puberty to a lot of puberty. We want to mimic what their body would go through like their peers. And so they need to have puberty blockers on board, because we're not going to give somebody a whole bunch of hormones right away, right. We want to escalate them in a way that their peers would be.

THE COURT: So somebody starts puberty blockers at 11. Then maybe 13 you start -- that they're still on puberty blockers, but you start hormones -- cross-sex hormones?

THE WITNESS: Yes.

THE COURT: And then gradually stop the puberty blockers and increase the hormones until they are all the way through puberty?

THE WITNESS: Yes.

THE COURT: You've had people -- a couple of instances of chest surgery for trans boys at 13.

THE WITNESS: Uh-huh.

THE COURT: What's the average age -- assuming that you've got a patient who wishes to get the aggressive treatment, who has signed onto this, getting parental support, everything is going in favor of the treatment, what would be the average age for a person like that to get chest surgery?

THE WITNESS: Probably 16 or 17. It's very rare that people get surgery under that age.

THE COURT: All right. Questions just to follow up on mine?

MR. GONZALEZ-PAGAN: Just one brief question, Your Honor, if I may.

FURTHER EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Olson-Kennedy, you spoke a little bit about having a puberty that matched your peers.

And within the gender-affirming care model, is the plan or the process to begin the provision of hormones to stop the use of puberty blockers, if necessary, so that it occurs within the normal window of puberty for an adolescent?

A. It's probably important to clarify that the window for puberty in people with ovaries is between 8 and 14, and for people with testes it's between 9 and 14ish. You know, it's slightly later.

Q. So on average it would be mean that most folks would be starting hormones sometime at least before 14 so that they -- folks that have been on puberty blockers sometime before 14 so that they start puberty with exogenous hormones within the normal time window?

A. Yes. But I really want to draw attention to the fact that it is extraordinarily rare that somebody is presenting for gender care in early puberty that's then going to go on to hormones. That's going to be a person who has a long-standing

history of gender dysphoria.

But that is not the majority -- the majority of patients in my clinic that are accessing services are 16. So most people don't have the incredible opportunity to have their endogenous puberty blocked. That's why I feel very strongly about this intervention, because it is critical for people to, if they can, avoid those secondary sex characteristics that are incongruent with their gender. It's a total game changer in the clinical world.

Q. And, Dr. Olson-Kennedy, you were asked a little bit about the instances in which somebody has presented and necessitated chest surgery, a trans male adolescent, as early as -- on rare instances as early as 13.

Those are instances in which the individual has gone through their endogenous puberty and, therefore, has a good amount of dysphoria because of advanced chest development; is that correct?

A. That's correct. People don't get chest surgery if they don't have chest development. That's the incredible benefit of not ever getting that particular change.

But the -- just for clarity, the two 13-year-olds that were in my study were actually not my personal patients. I've actually never had any of my patients have chest surgery, I think, maybe even younger than 15, possibly 14. But the -- there are many people with ovaries that are done with their

puberty at 12 years old.

So we talk about these as chronologic ages, but when we think about the developmental stages of puberty, it's not uncommon that people will have a lot of chest tissue by 12 or 13 years old.

MR. GONZALEZ-PAGAN: Thank you.

THE COURT: Mr. Jazil?

MR. JAZIL: No further questions, Your Honor.

THE COURT: Thank you, Doctor. You may step down.

(Dr. Olson-Kennedy exited the courtroom.)

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Yes, Your Honor. Ms. Coursolle will be calling the next witness, and it will be one of the plaintiffs.

It would be Ms. Jane Doe.

MS. COURSOLLE: Your Honor, we are calling -- the plaintiffs call Ms. Jane Doe to the stand, please.

(Ms. Doe entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing raise your right hand.

JANE DOE, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state the name that you will be using during this proceeding.

THE WITNESS: Jane Doe.

THE COURT: And for the public and for the record, there will be a filed reference sheet within the record that will be sealed that will match up the name Jane Doe to her actual name.

DIRECT EXAMINATION

BY MS. COURSOLLE:

Q. So, Ms. Doe, I think maybe we've made this clear, but you're participating in this lawsuit under a pseudonym; is that right?

A. Yes.

Q. Ms. Doe, where do you live?

A. Brevard County.

Q. And who lives with you?

A. My husband and two children.

Q. How old are your children?

A. My son is 16 and my daughter is 13.

Q. And your 13-year-old daughter, is she a plaintiff in this lawsuit?

A. She is.

Q. Is she also participating in this case under a pseudonym?

A. She is.

Q. And is that pseudonym Susan Doe?

A. Yes, Susan Doe.

Q. How did Susan come into your life?

A. I adopted Susan through foster care through the State of

Florida.
Q. How old was she when you adopted Susan?
A. 2.
Q. And what is a medical adoption, exactly?
A. She was under medical foster care. It's specialized. She had some health issues, and so she went to a foster care parent, so it's a little different.
Q. Is it -- in your experience is it difficult for Florida to find placements for children for medical foster care?
A. It is. It requires a little bit more care or -- I'm sorry.
Q. Take your time.
A. Just it takes a little bit more effort and can support -- these children need more support.
Q. Is Susan enrolled in Medicaid?
A. She is.
Q. Do you know why she's eligible for Medicaid?
A. All children adopted through foster care in Florida are eligible for Medicaid.
Q. Did your son also come into your life through adoption?
A. Yes, he did.
Q. And is he also eligible for Medicaid?
A. He is, yes.
Q. Tell me about Susan. How would you describe her?
A. She's funny and energetic and very friendly and outgoing.
Q. What does she like to do?

A. She likes to -- she loves to swim. She loves to hang out with her friends. She's learning to surf. And she likes -- you know, she loves being a Florida girl.
Q. What was Susan's birth-assigned sex?
A. She was male. She was assigned male at birth.
Q. Is Susan transgender?
A. She is. She's a transgender girl.
Q. What is her gender identity?
A. A girl. She's female.
Q. When did Susan first tell you that she identified as a girl?
A. The first time she told me, she was 3 years old. I was sitting on the couch. She was just playing with her toys beside me. And she just said -- she's like, Mommy, when I was born, I was born a girl. And I was a little taken aback because that's kind of surprising to hear from a 3-year-old. And I tried my best to stay neutral and just, you know, not say anything negative or positive, just to stay neutral and, Thank you, you know. Like, Okay, I hear you, and just left it at that at that time.
Q. What was she like when she was 3?
A. Well, she was -- she was a very cheerful child. She liked to play with typical -- what you would call typically girl toys. She liked dolls. She liked her princess dresses. She loved her -- she actually had, like, two or three dollhouses. That

was the things that she liked to play with.
Q. Did Susan tell anyone else that she was a girl?
A. At that time, no. It was just me.
Q. What kind of clothes did Susan like to wear when she was 3?
A. She preferred her princess dresses.
Q. At some point did Susan start to show signs of distress because her gender identity did not match her sex assigned at birth?
A. At 6 years old when she was in first grade is when she started having distress because the other children were -- she always played with stereotypically girl toys and girl behaviors and the other children noticing, and they were making fun of her.
Q. How did you -- what did you observe about her distress at that time?
A. She would just be upset when she got home. I mean, as soon as she would get home, she would change out of her school clothes and put on her girl clothes when she was home, and she would be much happier.
Q. It must have been hard to see that distress?
A. It was. I talked to her teachers. I tried to kind of restart -- when we realized this was not going away, we tried to get as much information as we could and tried to get the support from her educators also.
Q. Is there anything else that you did in response at this

time?
A. At that time we bought her clothes -- like, she would wear clothes to school that -- they would be from the girl's section, but they weren't necessarily overtly girl clothes. She would just know that they were girl clothes, and it would help her feel more confident or more secure in herself.
Q. Did you seek out a therapist at any point?
A. Yes, we did. I initially sought off -- sought out therapy for me to educate myself and then brought Susan into therapy.
Q. How old was Susan when she first saw a therapist?
A. I think she was 6.
Q. Did the therapist provide you with any materials to review?
A. Yes, she gave us information, tried to explain as much as she could of what is possible -- what is happening, how we should proceed as the parents to a transgender child.
Q. Did you do any of your own research about what Susan was experiencing?
A. I did. I initially did that before seeking therapy, but that -- it's hard to find, you know. Most things on the Internet are going to be biased. It's going to have a bias one way or another. I would rather seek guidance from a professional.
Q. Is there anything else you did to support Susan at this time?
A. Just -- let's see. When she was that age? Just let her

have clothes that she felt comfortable with, started -- she picked out her own name, and then she -- we -- I started calling her "she" and "her," using the pronouns that she preferred and using her preferred name at home, and it brought her a lot of joy.

Q. Had Susan told other family members that she identified as a girl at this time?

A. Slowly, yes, yeah. The close-knit family understood.

Q. Did you eventually take Susan to see another therapist?

A. Yes, yes.

Q. And when did that happen?

A. If we're talking, like, Rebecca or --

Q. Did you take Susan to see Dr. Linda Ouellette?

A. Yes, first it was Linda Ouellette, and then eventually -- she has another therapist at this point.

Q. Let's go back to Dr. Ouellette.

When did Susan first start seeing Dr. Ouellette?

A. When she was 6.

THE COURT: Ms. Doe, it will help us if you keep your voice up. If you will talk loudly enough that the people in the very back of the room can hear you, that will help.

THE WITNESS: Okay. Thank you. I'm sorry.

BY MS. COURSOLLE:

Q. You mentioned that Susan started using her preferred name.

About when did that happen?

A. She was around 6 years old when she started using her preferred name, and she was actually -- we realized she was telling people -- like, if she would meet them at the park, she was telling them on her own her preferred name. We didn't know that she was doing that. But it just was another sign of how important it was for her -- for people to perceive her as who she was.

Q. Was there a time when she started presenting herself as a girl outside of the home consistently?

A. Yes. Two weeks before second grade, she let me and her father know that she wanted to go to school and live her life as a girl, and she didn't want to hide it anymore. And we had to take back her school clothes and exchange them. And at that time we sent out letters -- you know, like a message -- emails to her educators to let them know that when she returned to school, she was -- this was her name, and this was -- she was going by she/her pronouns.

Q. That's a pretty big change. How did you feel about it?

A. I was scared. I mean, it was scary, but at the same time she had been very sad that whole summer thinking about and worrying about going back to school. And so I -- you know, she was happy, and she was very excited. So whatever my fear was, I knew I was doing the right thing, seeing the joy in her eyes and her being so excited about going back and being herself.

Q. Once Susan went back to school, did you notice any

differences in how she felt or behaved at home?
A. She was looking forward to going to school every day. She was very joyful going to school, putting on her clothes. She was very excited.
Q. Have you ever taken Susan to see a pediatric endocrinologist?
A. Yes.
Q. And when did you first take Susan to see an endocrinologist?
A. I believe she was around 8 or 9 years old.
Q. Why did you decide to do that?
A. It was under the suggestion of her therapist that we -- as she was getting closer -- she wasn't -- she was not in puberty yet, but to go and establish and meet with an endocrinologist and get a baseline -- medical baseline of her maturity and progression.
Q. And what happened during that first visit with the endocrinologist?
A. She just -- she just gave us education and gave us -- showed us, like -- explained more about the standards of care if we were to proceed and how we started -- how right now it was just monitoring and, you know, watching -- you know, watching and waiting and seeing how things were going to go, how she was going to grow up and proceed.
Q. Did the endocrinologist eventually prescribe medication for

Susan?
A. Eventually, yes.
Q. When did that happen?
A. It was around July in 2020. She -- my daughter was finally at a point in puberty where we were going to put a pause with the -- it was just for Lupron and putting a pause on her puberty at that time.
Q. You'll have to forgive me. My math isn't that great.
How old was Susan in July 2020?
A. I guess she was 10.
Q. And you said the medication that the endocrinologist put her on was called Lupron.
Do I have that right?
A. Yes. It was.
Q. Were there any criteria that Susan had to meet before the endocrinologist would prescribe her the Lupron?
A. Well, we received a letter. She had an evaluation from her therapist first. And then after that it had to be -- the doctor had been watching and monitoring her progression of puberty, so she had to reach a certain point in puberty and then we would pause it.
Q. What's your understanding of what the Lupron was described to treat?
A. It was just pausing her puberty, just keeping her hormones -- just blocking the hormones so that she would not go

into male puberty.
Q. Before prescribing Lupron, did the endocrinologist discuss the potential risks and benefits of the medication with you?
A. She did, yes.
Q. Do you and your husband make medical decisions for your children?
A. Yes, along with the help or support -- just the guidance of therapists and the actual medical doctors.
Q. Did you and your husband ultimately decide that Susan should begin taking the Lupron?
A. Yes. We believed it was very important to pause her puberty at 10.
Q. How did you reach that conclusion?
A. Well, she was -- she told us herself that she would be devastated if she went through boy puberty. She presents as a girl. It's been consistent since she was 3. It has not changed. That's a pretty long time. And for us it was a pause to, like, let's see if she proceeds to mature and go this path, and she has.

So for us, we -- it wasn't a question. It was just, we have to do what's best for her.
Q. Did the endocrinologist talk to you -- tell you about any potential side effects that the medication might have?
A. Lupron, it was -- the bone density is one of the things that we need to watch out for. And so we -- you know, we were

prescribed vitamin D and omega 3, and just watched her, her bone density levels. It was very important to watch that.

Q. How has Susan been doing since she's started taking Lupron?

A. She's been fine. She's been fine. She doesn't really care for shots, but she's fine with this. She looks forward to getting her Lupron shots, because she knows how important it is.

Q. You said she started in 2020. So she's been on Lupron for about three years now; is that right?

A. Yes, almost three years.

Q. If Medicaid were to stop covering Lupron, what would you do?

A. I don't know. But I would have to -- there's -- it's not a question for us; we are going to continue her care. Like I said, she said she would be devastated if she went through male puberty. And I don't want her -- that to happen for her.

Q. If Susan could no longer receive Lupron, how do you think that would affect her?

A. Well, she said that she would rather die than go through boy puberty, so I don't want that to happen.

Q. I'm sorry. That must be really hard to hear.

Has Susan's endocrinologist talked with you about starting Susan on hormone therapy?

A. Yes. At this point, with her bone growth, monitoring her bone growth and her maturity -- like her physical maturity, she is ready for gender-affirming hormones. It's what her

endocrinologist says. And she's met with her therapist, and her therapist says that she's ready, that she's informed her, and she feels that she's ready. And so we are just kind of in a holding pattern right now. We are just waiting to proceed.

Q. What is your understanding of what hormones will do for Susan?

A. It will -- it will help her have female puberty.

Right now it's on pause. And she would proceed with, like, breast growth and less hair and not develop male characteristics.

Q. Has Susan's endocrinologist discussed the risks and benefits of starting hormone therapy with you?

A. Yes.

Q. Have you and your husband decided that hormones would be the right course of action for Susan?

A. Yes.

Q. How did you reach that conclusion?

A. Well, she's been consistent. This whole time she hasn't wavered. And we know that she's living her life as a little girl, and she's seeing her friends progress. And she wants to live her life as -- you know, just go through puberty like her peers. And so for her it's just -- we believe it's the right time.

Q. How does Susan feel about potentially starting hormones?

A. She's excited, actually. She's really excited. In fact,

that's what keeps her going, is that she sees -- for her it's like this hope, this light at the end of the tunnel. And she's, like, Once I get there, it's like -- then she'll start being with her peers, like, breast growth, and I guess the other things.

Q. Does Susan know why you are here today, Ms. Doe?

A. She does.

Q. And how have you observed -- well, what does she know about why you are here today?

A. She knows that the -- well, she knows that the State was putting -- like, wanting to stop her treatment. And she knows that we are coming here to try and preserve her right to have that treatment. Two years ago this wasn't a question. We had a path we were set on, and this just came out of nowhere for us, just -- you know, we knew that the science was there, the -- you know, the data was there. We -- you know. And we just thought they are the standards of care; we were following the standards of care and everything would be fine. This has just kind of put a wrench and a lot of added stress on our life that is unnecessary, actually.

Q. I just want to clarify something that I think has been implicit in your conversations. But has Susan been officially diagnosed with gender dysphoria?

A. Yes.

Q. So the Lupron that she receives and the hormone therapy

that she would potentially receive in the future are both being prescribed to treat her gender dysphoria; is that right?

A. Yes, exactly. Yes.

Q. So based on what she just said, that Susan knows about why you are here today and this lawsuit, how does she feel about all that?

A. She's -- she's stressed because of the fact of even having to go through this. And she worries -- she worries, you know, that -- it's just she worries about not being able to access that help, that medical care. And I just -- for me, I just try to shield her from that as much as possible, the stress, so that she keeps being a happy, thriving young child, as long as I can.

Q. Where is Susan today?

A. She's at home. She's back at home with my husband.

She was too afraid to come. She saw a lot of things on the Internet, and things that were happening in the state capital, and so she did not want to come here.

Q. Is Susan entitled to Medicaid coverage?

A. She is.

Q. And I know you mentioned earlier that her brother was also adopted out of medical foster care. Is he also enrolled in Medicaid?

A. Yes. Both of my children are medical adoptions, and they are both eligible for Medicaid.

Q. And putting aside the question of the care that Susan needs

for her gender dysphoria, have both of your children been able to get their health care coverage -- the health care they need covered through Medicaid?

A. Yes. It's been continuous care this whole time.

My son is autistic, and he hasn't had any hiccups with any of his therapies. And he's had extensive therapists with ADA therapy, and it hasn't been an issue.

Q. How do you feel that Medicaid is refusing coverage for Susan's care just because she's transgender?

A. It hurts. It feels a bit discriminated against my child, because there's other -- I believe the doctor had talked about it, it's like all the therapies that she's getting, those same therapies are going to other children, it's just the diagnosis is different. Those same medicines are safe for other children. It's just because she's transgender, it's that diagnosis, for some reason she's not allowed to access the same medications.

Q. Ms. Doe, what do you want to get out of this lawsuit?

A. Just to continue her care, to get the care that she needs and she has a right to.

Q. Thank you.

MS. COURSOLLE: I have no further questions, Your Honor.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good morning.

A. Good morning.

Q. I have a few questions about Susan, and I want to get to know her medical records a little bit better.

Ms. Doe, it's my understanding -- and please correct me if I'm wrong -- that Linda Ouellette diagnosed Susan with gender dysphoria when Susan was 6.

Does that sound right?

A. I believe so, yes.

Q. And it's also my understanding that Linda Ouellette isn't a psychiatrist?

A. She's not. It was very hard to find -- during those years back then it was very hard to find a child psychologist of any kind, of any therapist that had any experience with transgender children, in my area anyway.

Q. Understood.

And you adopted Susan from foster care; right?

A. Yes.

Q. And Susan's birth mother had a history of drug abuse during her pregnancy with Susan; right?

A. Yes.

Q. There is also a history of neglect with Susan before you adopted her?

A. Yes.
Q. Ma'am, when you saw your therapist for the first time, she also said Susan had anxiety; right?
A. When she was 6, I'm not sure. But I do know that she was stressed because of the friends. Like I said, she -- like, you know, with the friends, like she was being herself and she was getting negative feedback from peers.
Q. Was she at some point diagnosed with anxiety?
A. I'm sorry?
Q. Was she at some point diagnosed with anxiety?
A. Yes. But that actually -- more the anxiety came when she was in fourth grade.
Q. Okay. So this is after the gender dysphoria diagnosis?
A. Years after.
Q. And do you know when she was diagnosed with ADHD?
A. She was 6 or 7.
Q. And I see a depression diagnosis in her medical records. Do you recall when that diagnosis was made?
A. It was -- it was about two years ago. She was sad. That that was around the time when she started -- her friends were progressing and -- physically progressing and going through puberty. And she felt like she was being left behind. She wanted to go through the female puberty like her friends.
Q. I understand.
Ma'am, you mentioned discussing with your endocrinologist

bone density issues. Do you recall that testimony?
A. Yes.
Q. Did you also discuss fertility issues with your endocrinologist?
A. Yes.
Q. And did the endocrinologist walk you through the possible permanent effects of cross-sex hormones on Susan's fertility?
A. Yes.
MR. JAZIL: No further questions, Your Honor.
THE COURT: Redirect?
MS. COURSOLLE: No, Your Honor.
THE COURT: Susan is 13; your son is 16?
THE WITNESS: Yes.
THE COURT: How old was he when you adopted him?
THE WITNESS: He was around 2 -- they were about -- he was around 2 also. He was around the same age.
THE COURT: When you adopted him did you know he was on the spectrum?
THE WITNESS: No. He didn't get diagnosed until he was 7.
THE COURT: But he had some kind of medical issue?
THE WITNESS: He had a lot of medical, yes.
THE COURT: You don't have other children?
THE WITNESS: These are the two.
THE COURT: Questions just to follow up on that?

MR. JAZIL: No, Your Honor.

MS. COURSOLLE: No, Your Honor.

THE COURT: Thank you, Ms. Doe. You may step down and return to counsel table.

It's noon. We can break, but probably put on another witness or two -- if the other witnesses are not going to take longer than this, we can break later -- if we can get another 45 minutes in, it would be great.

MR. GONZALEZ-PAGAN: Your Honor, we do have the three other plaintiffs that are ready to testify.

THE COURT: Yep.

MR. GONZALEZ-PAGAN: But I think if we can do that break, that may be best now, and we'll put them on in the afternoon.

THE COURT: You don't want to put one on first?

MR. GONZALEZ-PAGAN: We would prefer to take the lunch break, if it's alright with the Court.

THE COURT: All right. Let's do that. It's a couple of minutes after noon. Let's start back at 1:05 by that clock.

Some change? Did you decide you have somebody you want to put on?

MR. GONZALEZ-PAGAN: Your Honor, if it's alright with the Court, actually my counsel has indicated we would prefer to proceed with the second witness now.

THE COURT: Good.

MR. GONZALEZ-PAGAN: I apologize.

THE COURT: Let's go ahead.

Who is the next witness?

MS. CHRISS: Your Honor, Brit Rothstein --

(Brit Rothstein entered the courtroom.)

THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

BRIT ROTHSTEIN, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: Brit Rothstein. Last name is spelled R-o-t-h-s-t-i-e-n.

DIRECT EXAMINATION

BY MS. CHRISS:

Q. All right. Hello, Mr. Rothstein.

How old are you?

A. I am 20.

Q. Where do you live?

A. I mostly live in Orlando when I'm in school, and then I come down to South Florida during breaks.

Q. And who do you live with?

A. I am living with my boyfriend and his family right now. He's actually here with me. Then I'm starting a lease soon with him as well in Orlando.

Q. Where do you go to school?
A. In Orlando. I go to University of Central Florida.
Q. What are you studying?
A. I'm studying digital media and I'm minoring in information technology.
Q. Very nice.
What do you want to do with your degree?
A. I'm still kind of trying to figure that out. But I'm interested in, like, IT work.
Q. Okay. Did you get any financial assistance to attend college?
A. Yes. I'm on a variety of, like, scholarships and grants.
Q. So, Mr. Rothstein, tell us a little bit about yourself, your interests, et cetera.
A. I'd say I'm a pretty creative person. I like a lot of, like, artsy crafts and stuff. I like painting and drawing. I have my own Etsy shop where I, like, make handmade, like, earrings and key chains and I sell them.
Q. Where did you grow up?
A. Kind of all over South Florida, but mostly just like in Broward County.
Q. Are you employed?
A. Yes. I'm in the federal work study program. I work at the IT department at my school.
Q. Okay.

Are you enrolled in Florida's Medicaid program?
A. Yes.
Q. Prior to the rule at issue that we are here about today, did Florida Medicaid cover all of your medically necessary health care?
A. Yes.
Q. What is your gender identity?
A. Male.
Q. And what was the sex assigned to you at birth?
A. Female.
Q. When did you come to understand that you were male?
A. It's kind of hard to, like, pinpoint it exactly. But, like, ever since, like, I was about 8, I had, like, kind of -- I don't know how to, like -- the word for it. Identity issues, kind of. Not a great word, but I'm trying.
But I was able to sort it out more and put words to feelings in about sixth grade or when I was about 12.
Q. How did you come to understand that you were male?
A. I -- well, I was experiencing a lot of -- what I've learned was gender dysphoria, but I didn't know the word for it at the time, of uncomfortableness or, like -- I'm sorry. I don't know the right word for it. About gender roles that were imposed on me.
And I -- in sixth grade I was starting a female puberty, so I was starting to get chest growth and I was starting my period,

and I had a lot of discomfort and anguish surrounding it.

And so I was starting to do, like, research on my own, like online. And I came across, like, medical journals and, like, blogs of, like, transgender people or about -- like, the medical journals were about transgender issues or just being transgender. And it helped me put words to what I was feeling. And it was a long process. Like, it took me months to even, like, accept that I was trans. And then, yeah.

Q. About how old would you say you were or about when was it that you sort of were able to put words to it and understand, you know, sort of what transgender meant?

A. I think I, like, really, like, was able to, like, come to terms with it and kind of, like, call it what it was. I was a male, like, definitively, about, like, seventh grade, or when I was 13.

Q. So when you -- you mentioned the distress of having to experience puberty.

Can you explain a little bit more about how it felt to go through the changes to your body that accompanied puberty?

A. It was a lot of anxiety and depression, and my social anxiety was very bad because I felt wrong, and I felt like my peers could see -- could tell that or, like, the other people around me could tell that something was wrong with me.

I also would be -- it also -- like, the anxiety would be so bad that I would get physically ill. Like, in sixth grade, I

was in -- I went to PE class in that part, and I was in the -- I was assigned to the girls locker room, and I would get physically ill just being in there because it was just such an overwhelming feeling of: I do not belong here. I am not supposed to be here.

Q. Thank you for sharing that.

When did you officially sort of come out as transgender in that you shared with other people that you identified as male?

A. Also in seventh grade, around 13. I came out to friends first, and then I eventually came out to family.

Q. How did folks respond and react when you told them?

A. My friends were very supportive of me. They were -- like, they were happy that I was happier, kind of like figuring myself out, and my dad and sister both supported me. My mom was not supportive.

Q. Okay. I'm sorry to hear that.

Did you take any step at that point, when you initially came out, any steps related to your gender identity to try to live in congruence with it in any way?

A. Yes. After I came out to my dad, he took me to get my hair cut shorter into a more masculine haircut with shaved sides and all that, and I started wearing a chest binder, which is just a -- like compression top that, like, gives the appearance of a flat chest, and I was also wearing baggier clothes, kind of more masculine clothes.

Q. Why did you wear what you referred to as a binder?
A. Because I was going through female puberty and some of it came with chest development, and I felt a lot of distress with it because it wasn't how I felt on the inside. It didn't feel like I was supposed to be having it.
Q. At this time did you use a different name or pronouns?
A. Yes, I started going by Brit and using "he" in pronouns, and it felt a lot better being referred to in masculine terms. Like, it -- I don't know how to describe it. It just -- being referred to as a girl and then starting to be referred to as a guy, sort of all that, it felt good.
Q. Did you at any point legally change your name and gender marker to align with your gender identity?
A. Yes, I did so a couple years ago. I can't remember, like, the exact thing. But, yeah, I updated my gender marker and name.
Q. So those steps that you took that you were describing for the Court about, you know, cutting your hair, wearing baggier clothes, things of that nature, would you describe that as social transition?
A. Yes.
Q. And so after socially transitioning and beginning to live in accordance with your male gender identity, were you still experiencing the dysphoria that you discussed earlier?
A. Yes, very much so. And I would even say it was, like, a

bit worse or it was different than the dysphoria I was feeling before, because while I was taking, like, steps to try to improve it and try to live more as how I felt. I was still dealing with things like bullying from my peers because I wasn't fully passing, and also dealing with -- I still had -- I was still going through female puberty. I was still getting my period. My chest was still growing. So nothing was physically changing, and I still felt physically wrong.

Q. So we're going to talk a little bit about the medical treatment that you've received.

Have you ever sought mental health treatment for your gender dysphoria?

A. Yes. In sixth and seventh grade when I was starting to, like, put words to feelings, I was already seeing a therapist. It was Dr. Lappin. She was a family counselor for the school board, and I was seeing her for family-related issues. But I was seeing her, like, one-on-one, and then I brought it up with her.

Q. You were seeing Dr. Lappin for issues unrelated to gender identity, and then you began discussing how you were feeling with her?

A. Yes.

Q. Was she able to help you address your gender dysphoria in any way?

A. She was. She helped me kind of figure out some, like,

coping mechanisms, which I think fall under, like, social transition, because it was things of just, like, dressing more, like, aligned with my gender, so more masculine clothes, being referred to as male pronouns, things like that. But she also recommended that I try to look for a therapist who was more specialized with, like, transgender issues, because she's just a family counselor.

Q. Did you find someone who had more of that specialization in issues related to gender?

A. Yes. My dad went looking for one, and so he was able to find Dr. Grayson, and I think I started seeing her in, like, 2016, I believe --

Q. Okay.

A. -- before high school started.

Q. How long did you see Dr. Grayson just in total?

A. Throughout high school up until I left for college, so 2020.

Q. And do you know, by chance, what Dr. Grayson's qualifications are?

A. I don't remember the, like, exact, like, name of her, like, title or, like, degrees, but she has a lot of experience with transgender issues and, like, sex and gender-related things.

Q. Did Dr. Grayson diagnose you officially with gender dysphoria?

A. Yes.

Q. Did you have any other mental health diagnoses at that time when you were diagnosed with gender dysphoria?
A. Yes, I was previously diagnosed with anxiety and depression.
Q. And were you receiving treatment for those diagnoses?
A. Yes.
Q. Did either of those diagnoses impact your ability to understand your gender dysphoria?
A. No.
Q. Did they impact your ability to consent to treatment for gender dysphoria?
A. No.
Q. Did Dr. Grayson recommend that you see any other type of medical provider?
A. I spoke with her a lot about my dysphoria and my dysphoria related to my physical attributes and having to go through female puberty. So she recommended I speak to an endocrinologist about this and possible, like, further treatments about that.
Q. Do you recall approximately how old you were at that point?
A. I believe I was 15 -- or 14 or 15 --
Q. Okay.
A. -- I believe.
Q. Did you end up seeing a pediatric endocrinologist?
A. Yes. She gave me a recommendation for Dr. Hart-Unger, who

is an endocrinologist at Joe DiMaggio Children's Hospital, and so I went to see her, like, at -- by, I think, like, around the end of 2016. And I spoke to her, and I brought a letter written by Dr. Grayson that recommended -- that recommended I talk to her and that my issues -- like, yeah.

And we discussed HRT, hormone replace therapy, and, like, the options with it and talked about, like, my dysphoria and how it can help alleviate it and risks of it and, like, how we would -- like, how, like, the process of it would go, because she wanted me to do puberty blockers first and then, like, ease onto testosterone.

Q. Okay. We'll come back to the reason for that in a moment.

But were you able to be treated and receive a prescription for any treatment when you were, I believe, 14 when you saw Dr. Hart-Unger?

A. No, I wasn't able to because I -- I'm sorry. To give a little background, I was living full-time with my dad, but my mom still had custody over me. She just wasn't really in the picture because custody battles are a lot.

But to go forward with any sort of HRT or hormone blockers, I needed both parents' consent, and my mom didn't give her consent. So my parents had to go through a custody battle for two years, and the judge -- the final ruling, the judge decided -- granted my dad full custody over -- or, like, decision-making over medical transition-related things. I don't

remember the exact wording, but -- yeah, because it was in the best interest for me.

Q. Okay. So the Court granted your dad medical decision-making so that you could begin treatment --

A. Yes.

Q. -- because he thought that was in your best interest?

A. (Nods head up and down.)

Q. You said that took about two years?

A. Yes.

Q. So when were you finally able to actually get prescribed treatment from Dr. Hart-Unger?

A. I believe I was 16, like, about to turn 17, and she prescribed puberty blockers first.

Q. Okay. We'll come back to that in a moment.

But can you just, for the Court's benefit, explain what that process was like between, you know, about 14, being recommended and having the letter that you were ready to start treatment and talking to Dr. Hart-Unger about the treatment, and then having to wait those years before actually being prescribed any treatment for your gender dysphoria? What was that like?

A. It was very hard and frustrating to have to just wait on, like, everyone else deciding things. And I still was going through puberty; I still was getting my period; my chest was still growing; I was still dealing with bullying at school; I was still in therapy. I was still seeing Dr. Grayson during

this time, but it still didn't alleviate my dysphoria.
Q. So you were still socially transitioned, living in accordance with your male gender identity, and receiving therapy from Dr. Grayson throughout that time?
A. Yes.
Q. Were you still receiving treatment for your anxiety and depression during that time?
A. Yes, I was still doing counseling, but it wasn't very effective because I was still -- like, even though I socially transitioned, I was still physically in the wrong body.
Q. And so you still were experiencing gender dysphoria?
A. Yes.
Q. So you mentioned that you were first prescribed puberty blockers.
Can you explain why that was the course of treatment?
A. Yes. I have a solitary kidney. I was born with renal atrophy, which just means that my other kidney didn't develop when I was born, and because of this I developed hypertension in my, like, early childhood. I don't remember exactly when.
And due to the hypertension and solitary kidney issues, she wanted to make my transition gradual and not, like, shock my body by just introducing testosterone. But she wanted to, like, balance out my hormones and then slowly start introducing testosterone gradually until it got to a level that was, like, average for other teenage males, yeah, because one of the

effects of testosterone is higher blood pressure, and so she didn't want to, like -- yeah.

Q. So she took a cautious approach?

A. Yes.

Q. Have you always been followed for these other conditions, the renal -- I'm sorry, not renal atrophy -- solitary kidney and the high blood pressure, hypertension?

A. Yes. Like, I don't remember exactly when I was diagnosed with the hypertension, but I have been seeing a nephrologist at least since I was young. Like, I don't remember exactly what age, but, like, I'm still seeing one today. And she just makes sure -- she makes sure that my kidney function is good, that my blood pressure is being maintained. She does -- I get annual scans -- I get annual ultrasounds of my heart and kidneys, and I also get an annual, like, 24-hour blood pressure monitor on me to, like, check my blood pressure throughout a day. So it -- yeah, it's been monitored.

Q. So for the benefit of those of us who might not know that word, can you explain what a nephrologist is?

A. Yes, a nephrologist is a doctor that specializes in, like, the kidney and urinary system and also blood pressure too, because it's affected by kidneys.

Q. So has your nephrologist and your endocrinologist coordinated regarding your care because of these other conditions?

A. Yes, they have. They actually work in the same office at Joe DiMaggio, the same building. They -- yeah, they work together and in -- like, when I go to an appointment of either of them, they're asking if I'm still, like, checking in with the other one. Like, whenever I see my endocrinologist, she's like, Are you, like, checking your blood pressure? Are you still seeing the other one? And I'm like, Yeah.

Also, my -- because I get blood tests about every couple months to, like, every six months or so, they will sometimes, like, piggyback off of each other's blood tests so they don't, like, have to order more tests if -- so they'll look at, like, the results from, like, the other one's blood tests to, like, check things. But they work together.

Q. Great. So before you were prescribed puberty blockers -- that was the first thing you were prescribed; right?

A. Yes.

Q. Before that did Dr. Hart-Unger do a comprehensive assessment?

A. Yes. She -- when I went back to her after we got the court case ruling, I got an updated letter from Dr. Grayson, because I was still seeing her, but we updated the letter, and it was still the same, though. It was medically necessary for me to start hormone blockers. And we had the, like, same conversation again multiple times of risks, benefits, what to be aware of, stuff like that.

Q. What were some of the risks and benefits that she made you aware of?
A. Some of the effects of which specifically?
Q. Let's start with blockers.
A. All right. Blockers -- the effects of it that we discussed were things like stopping my period and stopping chest growth from continuing, and there were also risks associated with it like hot flashes due to stopping your period, and bone density was a thing that was, like, being checked out.
Q. So at this time you were still under 18, right?
A. Yes, I was 16, 17, yeah.
Q. So did your dad go through the informed consent process with you?
A. Yes. I don't remember which one of us -- or if it was one of us or both of us signed the, like, papers, but -- I don't remember if there was one for puberty blockers, but for testosterone I know there was, like, multiple sheets of paper, and it was, like -- each symptom had its own line, and there was, like, an -- I had to, like, initial next to each one to, like, verify that I read it and understood it, yeah.
Q. And so just to be clear, Dr. Hart-Unger required the letter from Dr. Grayson prior to prescribing any treatment?
A. Yes. And she also -- like, she doesn't want just a letter and then that's it. She wants -- she wants me to continue counseling and therapy, which I still am.

Q. So you're still receiving therapy for your gender dysphoria today?
A. Yes.
Q. So you mentioned the potential risks of blockers, and then I think you mentioned the informed consent process for testosterone.
But can you explain to the Court some of the risks and benefits that were explained to you with regard to testosterone?
A. Yes. With testosterone, it has effects like a deeper voice, body fat redistribution, facial hair growth. It also has effects like stopping the puberty -- stopping the period and chest growth, but I was already having that from the blockers. And it also has other risks like increased blood pressure, increased, like, blood cholesterol, and other stuff like that. But I get regular blood tests, and everything is, like, closely monitored.
Q. Did you talk about fertility preservation at all or the potential future desire to have children?
A. Yes, we did talk about that because -- oh, I forgot to mention it. Testosterone does, like -- it can have an impact on fertility. Like, it won't make you -- it's not guaranteed to make you infertile, but it does, like, present a risk for having issues with fertility. So we did talk about that risk.
She -- Dr. Hart-Unger brought up the possibility of, like, egg freezing or egg donation -- or egg preservation in case I

wanted kids down the line, but I spoke with Dr. Grayson; I spoke with family friends, I also spoke with Dr. Hart-Unger that I had no desire to freeze my eggs, and I have no desire to have kids.
Q. And do you still feel that way today?
A. Yeah. I mean, if further down the line I want kids, I can adopt. It's -- they -- it's a great option, yeah.
Q. Did Medicaid cover your blockers?
A. Yes.
Q. And did Medicaid also cover your testosterone prescriptions?
A. Yes.
Q. How has it felt to be on testosterone? Like, what changes have you noticed?
A. I've had changes, like, facial hair growth and my voice lowering, and it has helped so much with my gender dysphoria. It's also helped my, like, confidence because it's made me feel more comfortable in my body. But it's not the, like, end-all-be-all because I still have other -- I am -- I still have gender dysphoria.
Q. Did you experience any issues or complications when you were taking -- when you began taking testosterone?
A. I believe the only, like, slight issue that showed up was an increase in my blood pressure, but I worked with my nephrologist to adjust the medications I'm on to -- because I'm on blood pressure medication to lower my blood pressure, so just

adjusting those to, like, even out, I guess, the changes from the testosterone.
Q. And so have your nephrologist and endocrinologist worked together to make sure that you're healthy and everything is as it should be?
A. Yes.
Q. Did testosterone -- having access to testosterone alleviate your chest dysphoria?
A. No. Because, like, the blockers and testosterone did alleviate it a bit as in it didn't keep growing, but it didn't help it because it was still there. I still had to go through a female puberty. So what physically happened, happened. So it did not alleviate my chest dysphoria.
Q. Did you do anything to address your chest dysphoria?
A. I was binding at the time to alleviate it.
Q. Can you just explain a little bit more about what binding is and what impacts it had on you?
A. Binding is just kind of compressing the chest to make it have a more flat appearance. And I was wearing my binder, which is just a compression top that makes it flat -- I was wearing it for -- probably almost every day for about, like, 10, 12 hours when the recommended time is up to 8 hours a day. But I was wearing it further than that because my chest dysphoria was so bad.
Q. Was it painful?

A. Yes. It -- because it's a compression top and it's around your chest, it constricts your lungs and ribs, and it can sometimes make it hard to breathe.

I also had an incident of where I had to go to the ER for rib cage bruising because I was wearing my binder for too long.

Q. I'm sorry to hear that.

Did you receive any other medical intervention to treat your gender dysphoria?

A. At what point?

Q. After -- other than the puberty blockers and therapy and testosterone, have you received any other interventions?

A. Yes. I got top surgery.

Q. And can you explain to the Court what top surgery is?

A. Top surgery, also called mastectomy or double mastectomy, is just the removal of breast tissue.

Q. Was your top surgery recommended by a medical provider?

A. Yes. Dr. Hart-Unger recommended it based off the -- me talking about my issues with my dysphoria and how my chest dysphoria was still continuing even while I was on testosterone. And she provided me a list of resources of, like, top surgeons in Florida.

Q. And did Dr. Grayson, your mental health provider, also deem that you were ready to undergo top surgery?

A. Yes, she did, and she also wrote a letter, like, recommending it, and yeah.

Q. And am I correct that you were about 19 at that point?
A. Yes.
Q. So you had been seeing Dr. Grayson for gender dysphoria specifically for about five years?
A. Yes.
Q. And had been on testosterone for about two years?
A. (Nods head up and down.)
Q. Who did you find to perform your top surgery?
A. Dr. Sara Danker in -- at UM Health in South Florida.
Q. Is UM University of Miami?
A. Yeah, University of Miami Health.
Q. What was the process that led to you obtaining top surgery?
A. Could you -- I'm sorry. It was kind of vague.
Q. No. That's okay.

What does -- just sort of walk us through the process of how you got to Dr. Danker and what led you there.

A. I was going down the list of surgeons that Dr. Hart-Unger provided me with, and it was, like, three pages. And none of the top surgeons on any of those pages took Medicaid at all, like even partially.

And my dad found Dr. Danker because at, like, some point around then she had just come back to Florida, because she was practicing in another state. And UM Health takes my insurance. So that's how we found her.

Q. When you say your insurance, you mean Medicaid?

A. Yeah, Medicaid.
Q. What was your consultation with Dr. Danker like? What happened during that?
A. It consisted of a physical evaluation, discussion about my dysphoria and my chest dysphoria. I didn't physically have the letter from Dr. Grayson at that moment, but she was -- but Dr. Danker was requiring it to, like, continue the process. But it was just, like, relaying the information that was on it, and, like, what I was feeling. And it consisted of a physical examination and a discussion of the surgery process, the pre-op, post-opt process, and yeah.
Q. Did Dr. Danker discuss with you the risks and potential complications associated with the procedure?
A. Yes. They were, I think, pretty standard risks of any surgery, like issues with, like, reactions to anesthesia, infections, or issues with the surgical site, things like that.
Q. Do you recall if you went through the informed consent process again and signed the informed consent form?
A. Yes, I did, and I signed it myself because I was 19 -- no, I think I was 20. I believe I was 20 when I actually signed it.
Q. Okay. Mr. Rothstein, did you receive prior authorization from Medicaid for this procedure?
A. Yes.
Q. How did it feel when you got that notification?
A. I was so excited, because I was emailing -- I was told over

email through -- with, like, one of the people from the surgeon's office, and I was running up and down the stairs to, like, tell my dad. And I was, like, Okay, this date -- you got to clear your calendar for this date. And I was running back up and down the stairs, and I was like a kid on Christmas. And I was excited because it felt like a lot of my transition has just been waiting, especially because I had to wait, like, so long to even get blockers or testosterone. And it was, like, the weight is, like, kind of almost over.

Q. Were you able to schedule your surgery at that point?

A. Yes. I, like, scheduled it for December 22, I believe.

Q. And that was of this past year, 2022?

A. Yes.

Q. Did you then find out that the surgery wouldn't be covered?

A. I -- yes, I was told by the surgeon's office a couple weeks before the surgery date that Medicaid, like, rescinded their approval to cover the surgery. But I was already a bit off -- like, I had lost the, like, happiness for it already because the announcement for the ban on Medicaid covering transgender health care was -- came out the day after I got the approval. And so -- and that was in, I think, August. And so from that time to right before the surgeon's office told me that it wasn't going to be covered and that I would be having to pay out of pocket, I wasn't as excited for it as I should have been, because it was very uncertain if I was even going to be able to

get it. And it was scary and frustrating of just not knowing.
Q. So, Mr. Rothstein, were you able to obtain the top surgery?
A. Yes. I had a Go Fund Me set up, and it -- I was able to receive enough money through it to cover the cost of surgery, so I was able to get it.
Q. How did it make you feel that you had to raise money to pay for something that was medically necessary for you?
A. It's frustrating also because it was, like, previously authorized. And all of my other treatments for my dysphoria and just other treatments in general for my other health issues have -- have always been covered. My sister is also on Medicaid, and she's never had an issue with Medicaid covering any of her surgeries, and she's had a lot.
Q. So how did the procedure go?
A. It went well. There weren't any complications, and yeah.
Q. Are you happy with the results?
A. I am very happy.
Q. How has it impacted your daily life?
A. It's helped a lot. Like, it makes me feel more aligned with how I feel on the inside. It -- I still have gender dysphoria, but the treatments I've had have helped a lot in managing it and treating it.
Q. I presume you don't have to wear a painful binder anymore?
A. No, I don't.
Q. You mentioned this earlier, but you still go to therapy;

right?
A. Yes, I do.
Q. And you still take your testosterone?
A. Yes.
Q. Mr. Rothstein, do you ever fear for your safety as a trans man in the state of Florida?
A. Yes. I feel like it's -- I don't know if I want to say, like, the fear has worsened now because a lot of anti-trans, like, legislature and bans have been going through all over the country and also especially here in Florida. But, I mean, I've always had a fear, like, from when I was figuring myself out because I'm scared of -- I didn't know how the world would accept me, and also now, because I do pass pretty well and I feel comfortable in my body, but there are still people that don't see it that way, and I'm still scared.
Q. How would you feel if you had to stop your treatment for gender dysphoria because of the rule at issue that we're here about today?
A. I'm sorry. Could you repeat the question?
Q. What impact do you think it would have on you to have to stop your treatment for gender dysphoria?
A. I believe my mental health would take a very big hit, and I would probably be in a worse place than I was when I didn't even know I was dealing with gender dysphoria, because I was able to take the steps to treat it. And then I just have to go back on

it. And I also don't -- I'm also not sure, like, what physical effects it would have on me to suddenly stop testosterone and then my body go back to producing estrogen.

Q. Just a couple more questions, Mr. Rothstein.

How do you think it would have impacted you if you had been able to access gender-affirming care when you first were recommended to see Dr. Hart-Unger if you hadn't had to wait those few years because of the custody issue?

A. I probably would have been in a much better mental state. My anxiety and depression probably wouldn't have been as bad, and I wouldn't have -- I likely wouldn't have had to deal with such bad social anxiety growing up.

Q. So, in your opinion, has access to treatment for gender dysphoria improved your quality of life?

A. Yes, very much so.

Q. Just one last question, Mr. Rothstein.

How has the State's decision to ban this care for you and for other transgender Medicaid beneficiaries made you feel?

A. It makes me feel horrible and discriminated against because it is discriminatory. It's not right to pick and choose which people have access to certain health aspects of health care. And there's also things like -- gender-affirming care, cisgender people get that too. It's not only transgender youth and adults. My sister took -- my sister was prescribed puberty blockers at a point -- my sister is cisgender. She was

prescribed puberty blockers to delay her period because her doctors felt like she wasn't ready at the time to be dealing with that. And there was no question about it being covered or if she should have it or not. There was no issue with that.

And it's -- it's health care that shouldn't be denied, and yeah.

Q. Thank you so much, Mr. Rothstein.

MS. CHRISS: I have no further questions, Your Honor.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good afternoon, Mr. Rothstein.

I just wanted to get to know your medical records a little better.

Mr. Rothstein, in looking at your records, it says that you were diagnosed with major depressive disorder; is that correct, sir?

A. Yes, that sounds right.

Q. And autism; is that correct, sir?

A. Yes.

Q. And was it Dr. Lappin who diagnosed you with those two?

A. My autism diagnosis occurred in, like, the past year or so. And Dr. Lappin diagnosed me with depression. I don't know if it was exactly, like, major depressive disorder or, like, the specific terminology for it.

Q. And it was -- so after you were done seeing Dr. Lappin, you saw Deborah Grayson?
A. There was a time where I was seeing both of them at once, a bit of an overlap. But, yeah, it was Dr. Lappin and then Dr. Grayson.
Q. And Dr. Grayson is the one who diagnosed you with gender dysphoria?
A. Yes.
Q. And in looking at the medical records, you'd agree with me that Dr. Grayson is not an MD; right?
A. I don't know.
Q. Well, does Dr. Grayson sometime provide unorthodox treatments as part of her practice?
MS. CHRISS: Objection, Your Honor; vague.
THE COURT: Overruled.
THE WITNESS: Do I have to answer that?
THE COURT: Yes. Yes. If you know, answer the question.
THE WITNESS: I don't understand what you mean by that question.
MR. JAZIL: Okay. Can we go to Plaintiffs' Exhibit 234, please -- not on -- well, not on the public screen, please.
I apologize, Your Honor.
THE COURT: That's all right.
MR. JAZIL: Page 170.

BY MR. JAZIL:

Q. So it says in her fee schedule that she provides hypnosis services for $200 for 60-minute sessions.

Do you see that, Mr. Rothstein?

A. Yes.

Q. Did Dr. Grayson, in fact, provide hypnosis services? Is that your understanding of her practice?

A. No, she never did anything like that with me. We only ever did, like, the individual therapy.

Q. Okay. Mr. Rothstein, you discussed with my friend some of the issues related to your renal failure and the one functioning kidney.

Is it my understanding that you spoke about those issues with both your endocrinologist and your nephrologist?

A. I -- it wasn't renal failure. It was renal atrophy.

Q. Okay.

A. Which it just meant that my other kidney didn't develop when I was born, so I only had one fully functioning kidney.

But both of -- my endocrinologist and nephrologist are aware of this issue, and I talked with them extensively, like, both of them, about this issue.

Q. And they discussed with you the effects that testosterone can have on your kidney as well; right?

A. I don't remember if there was a discussion on the specific effects of testosterone on the kidney, but we did discuss the

effects of testosterone on blood pressure and then blood pressure on kidney.

Q. Understood.

Mr. Rothstein, the puberty blocker you were prescribed is Lupron; right?

A. Yes.

Q. And am I correct in my understanding that before you were prescribed Lupron, your endocrinologist discussed with you the effects that Lupron can have on depression, making it worse?

A. I can't remember exactly if that was discussed, but she always -- Dr. Hart-Unger always made a very strong emphasis on how she wanted me to continue counseling, and I had letters from my doctor that I was, like, of sound mind.

Q. Understood.

Thank you, Mr. Rothstein.

MR. JAZIL: I have no further questions.

THE COURT: Redirect?

MS. CHRISS: No, Your Honor. Thank you.

THE COURT: Thank you, Mr. Rothstein. You may step down and return to counsel table.

That makes this the time for the lunch break. Let's come back at 1:50 by that clock.

(Recess taken at 12:48 PM.)

(Resumed at 1:50 PM.)

THE COURT: Good afternoon. Please be seated.

Please call your next witness.

MR. CHARLES: Good afternoon, Your Honor.

Carl Charles for the plaintiffs. And the plaintiffs call, Mr. August Dekker.

THE COURTROOM DEPUTY: Please stand and raise your right hand.

AUGUST DEKKER, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.

Please state your full name and spell your last name for the record.

THE WITNESS: August Dekker, D-e-k-k-e-r.

DIRECT EXAMINATION

BY MR. CHARLES:

Q. Good afternoon, Mr. Dekker.

How old are you?

A. I'm 28, about to be 29.

Q. When is your birthday?

A. June 23rd.

Q. And where do you currently reside?

A. Spring Hill, Florida.

Q. How long have you lived there?

A. Coming up on 19 years.

Q. Is that where you grew up?

A. I grew up in California, San Diego area.

Q. When did you move to Florida?

A. On my tenth birthday.
Q. Did you attend high school -- did you attend high school in Spring Hill, Florida?
A. Yes. I went to F.W. Springstead High School.
Q. Do you currently live with anyone in Spring Hill, Florida?
A. I live with my younger brother, Matthew.
Q. And are you currently employed?
A. No.
Q. Why not?
A. I'm legally disabled.
Q. And what is your disability?
A. I have juvenile onset rheumatoid arthritis.
Q. Do you currently take any medications for that condition?
A. Yes. I take methotrexate, m-e-t-h-o-t-r-e-x-a-t-e, celoxib, c-e-l-e-c-o-x-i-b, and Actemra.
Q. Will you spell that one, too?
A. A-c-t-e-m-r-a.
Q. Mr. Dekker, will you tell me what each of those medications does for your rheumatoid arthritis, please?
A. So my Actemra is a injection that I do every three weeks, and it helps manage the symptoms and halts the disease progression of my arthritis.

The methotrexate acts somewhat similarly; however, it's an oral pill that I take once a week.

And the celecoxib is for pain and inflammation.

Q. And how do you pay for those medications?
A. They are all covered through Medicaid.
Q. And so is Medicaid your health insurance coverage that you have?
A. Yes. I specifically have the Humana Plan.
Q. What's your understanding of why you qualify for Florida Medicaid health insurance coverage?
A. Well, I am currently receiving SSI, Supplemental Security Income, and anyone eligible for SSI automatically gets Medicaid.
Q. Do you remember how old you were when you first started receiving Florida Medicaid?
A. I believe I was around 22.
Q. Mr. Dekker, are your parents still living?
A. Yes.
Q. Do you have a relationship with either of them?
A. I have a relationship with my father.
Q. Tell me a little bit about your relationship your father.
A. It initially started off pretty rocky, mostly because we didn't really connect a lot. And especially when I came out to my parents for the first time as transgender, they didn't really understand what was happening or how I was, like, feeling, or what led me to know this about myself.

And my dad, over the course of the -- over five years since I've been out, has really made an effort to understand my identity and better support me as a trans person.

Q. I'm glad to hear that.

Mr. Dekker, just very briefly, why don't you have any contact with your mother?

A. She's emotionally abusive and does not support my transition in any way. I just find it better for my mental health to have no contact with her.

Q. Who would you say you are closest with in your family?

A. My brother, Matthew.

Q. Can you tell me a little bit about Matthew and why you describe him as your closest family member?

A. Yeah. We've basically been best friends since he was 2 years old. I'm the oldest brother, and we've always looked after each other. And he was the one person that I knew that I could go to with anything, and so he's the first person that I came out as trans to ever. And he took it in stride. He said that he wasn't necessarily surprised, but that he supported me 100 percent. And he's even, you know, at previous points defended me to our parents.

Q. Sounds like a pretty excellent brother.

A. Yeah.

Q. August, what was the sex that you were assigned at birth?

A. Female.

Q. And what is your gender identity?

A. Male.

Q. Do you have any early memories of an awareness of your male

gender identity?
A. Yes. So going back to when I was about 5 or so, I remember, you know, not really liking anything that was associated with girls. I didn't like the color pink. I hated wearing dresses and skirts. I wanted always to be in T-shirts and shorts. And I tried cutting my hair once. It came out awful because I was, like, 7, but -- and my mom fixed it and gave me a feminine haircut again, and I was very distressed about it at the time.

And when I would play in the backyard with my brothers, for instance, we would play Stargate. It's a sci-fi show that not a lot of people have watched. It's kind of goofy. And there's one character in it whose name is Samantha Carter, and she's basically the only female on the team. And my brothers would always be like, Oh, well, you play Carter. And I would be like, No, I don't want to play Carter. I want to play Daniel Jackson. He's another scientist.

But, yeah, those are some of my earliest memories with gender incongruence.

Q. Do you have any memories of experiencing distress related to the discordance between your sex assigned at birth and your gender identity when you were an adolescent?
A. Yeah. One particular thing that jumps out is when I first got my period. I think I was about 14. And by this time I had been explained to how -- the workings of a menstrual cycle and

was told that it would happen to me. But I didn't really count myself in that category. So I was like, Oh, well, I don't have to be afraid of that.

So when my period actually came, I was really confused, and I ran to my mom's room, and I was like, You have to take me to the hospital. I think I'm dying. Like, I'm bleeding. And she just was, like, kind of laughing at me. She's like, It's your period. It's supposed to happen. And I was like, Well, not to me. Like, that doesn't make any sense that I would have a period.

And in high school I continually kept having crushes on gay men, and I couldn't understand why they weren't interested in me. Because a couple of them had said that they would date me if I was, you know, a man. And I was like, Well, why are you putting me in that category? Like, I don't understand that.

Q. Did you feel like you could discuss your gender identity with your family as you were growing up?

A. Absolutely not. I would -- I wouldn't go so far as to say that my living environment was hostile, but it was certainly not conducive to me feeling safe to explore any gender feelings. My mom especially was -- is very unsupportive of the LGBTQ community at that point, and so was my church, who -- which I was heavily involved with, as my mom was the youth leader. And I just -- I didn't even want to consider the fact that I may be LGBT until I was out of the house.

Q. At what age did you come out as a transgender man?
A. Around age 22.
Q. And you talked about this a little bit, but can you tell me, how did your brothers -- you said you had more than one brother. How did your brothers react when you came out as a trans man?
A. I have three younger brothers. I initially told Matthew, and he was very supportive. And that gave me the confidence to come out to my other brothers. That was around the same time that I came out to my parents, maybe at the same time. I don't really remember. My parents reacted quite badly at the time. My brothers have always been nothing but supportive.
Q. So you came out as a transgender man at age 22.

What kind of -- what did that entail, other than telling people about your male gender identity? Was there anything that you did?
A. So when I was about 18, I decided to cut my hair short. In my mind I rationalize it as, Oh, I just like it better this way. But looking back, that was definitely dysphoria.

So immediately after I left my parents' house, I cut my hair off. And it wasn't until a couple of years after that that I started identifying with trans men more and decided to change my name and pronouns, start dressing in a more masculine way, and just live in a male identity.
Q. So you took some steps, it sounds like, socially as a part

of your coming out.

Were you still experiencing discomfort between the sex you were assigned at birth and your gender identity even after you came out?

A. Yeah. It may have actually gotten worse at a point, because I wasn't concerned with trying to push down those feelings anymore. And so I was -- it was hard for me to kind of put those feelings back into a box because they were already out. And so I -- yeah, my dysphoria was definitely not well managed with just social transition.

Q. Can you say a little bit more -- you've used the word "dysphoria." Are you referring to gender dysphoria?

A. Yes.

Q. So how would you describe how it felt to not be able to live as fully as the person you are?

A. It felt like I had this constant void in my chest. I know that sounds melodramatic, but it's true. It was like I was walking around with, like, a leaden ball in any stomach, and I couldn't find a way to get it out, and just I had to deal with it every day.

And that leaden ball in my stomach informed everything else that I did, and it just was unmanageable at a point. Like, I couldn't -- I didn't want to sleep; I didn't want to eat; I didn't want to do anything that was even remotely human because I was so disgusted with myself and, like, the way that people

perceived me.
Q. So is it fair to say that your experience of gender dysphoria impacted your day-to-day functioning in life?
A. Absolutely, yeah.
Q. Are there any examples of that that stand out in your memory?
A. Throughout high school I was pretty heavily suicidal. I had attempted suicide probably four times during high school, and, luckily, none of them worked.
But I was just at a point where I didn't yet know what was -- like, what was wrong, and so I couldn't attempt to fix it. But, like, that feeling was still there, and at the time it felt like I couldn't escape it, and so I resorted to dramatic measures for it to stop, because I didn't really know there were other options.
Q. And so thinking about the period of time after you came out socially and started to do some things with your gender presentation to walk in the world as a man, how did your gender dysphoria continue to manifest in your life?
A. So it definitely got less bad after I came out and after I started medical transition. However, I was still depressed; I was still anxious. You know, things were better, but they weren't, you know, completely all right.
Q. So did you take any steps to deal with that ongoing discomfort?

A. Yeah, I decided to -- a couple years into social transition I decided to try to pursue a medical transition, and I went through a center called Metro Inclusive Health in Tampa. I signed up for therapy there, because at the time you had to get a letter written to start hormone replacement therapy. And I was in therapy for about eight months before my letter was written, both due to my gender dysphoria and unrelated issues that I wanted to resolve before I started treatment.

Q. Okay. So you mentioned Metro Inclusive Health.

Do you remember approximately what year you first went and sought out therapy through that center?

A. I believe it was 2016.

Q. And so you mentioned that you received therapy focused on treatment for gender dysphoria.

Did you receive support related to anything besides gender dysphoria during that time at Metro Inclusive?

A. Yes, I did. I have a history of childhood sexual assault and -- as a victim, and I wanted to address that before I even started thinking about hormone therapy. It got to a point where I was confident in my ability to deal with that trauma, and probably two months after that is when I was given my letter.

Q. So you mentioned PTSD. Do you have a PTSD diagnosis?

A. Yes, I was diagnosed at Metro Inclusive.

Q. So beside gender dysphoria and your arthritis and PTSD -- well, actually, sorry. Let me back up.

Who diagnosed you with PTSD?
A. Ashley Hancock.
Q. And did Ms. Hancock have specific therapies that she engaged in with you or strategies to help you feel, as you described, able to manage that diagnosis?
A. Specifically with my PTSD, we talked about my triggers and how to avoid them and also how to cope with them if I ran into them in, you know, daily life. Luckily, my triggers are fairly uncommon, and I don't really run into them that often.
Q. Mr. Dekker, will you do me a favor and just speak a little bit more loudly?
A. Yeah. Sorry.
Q. No problem.
So would you say that the treatment that you received was helpful?
A. Yes. It allowed me to deal with my trauma in a way that felt like a resolution.
Q. And did your PTSD diagnosis interact with your gender dysphoria at all?
A. I don't think so, no.
Q. Did your therapist tell you that the treatment for PTSD would impact any therapy that was happening for gender dysphoria?
A. No.
Q. And do you have any other diagnoses that you're aware of?

A. I have -- well, I was diagnosed with major depressive disorder and generalized anxiety disorder.
Q. And when abouts did you receive those diagnoses?
A. 2018.
Q. And do you recall who provided you with those diagnoses?
A. It happened during the time that I was inpatient at a behavioral health center. I don't know who exactly diagnosed me.
Q. And why were you receiving inpatient care?
A. I was having suicidal ideation related to a relationship at the time.
Q. And during those inpatient stays, were you receiving medical treatment for gender dysphoria?
A. No, I was not.
Q. How has your depression diagnosis interacted with gender dysphoria, if at all?
A. I would say my dysphoria informs my depression and not the other way around. My -- the way I experience depression and anxiety now, consistently on hormones, is that it's entirely situational, and there's none of that underlying malaise that was there when I was not able to transition. Of course, you know, everyone gets sad or anxious sometimes, but I'm no longer at that level where it's a majority of my life. It's only in cases where, you know, something bad has happened or, you know, something very impactful has happened.

Q. And what about anxiety? How do you -- how would you describe how that has interacted with gender dysphoria, if at all?
A. I would say my gender dysphoria and anxiety were correlated in the idea that -- my anxiety is mostly related to how people perceive me and my gender. So if I'm experiencing anxiety, it's likely because I'm afraid that I'm being perceived as a woman in public, for instance, or, you know, by a friend. And that has grown a lot more manageable the longer I have been in transition, and it's basically nothing now.
Q. Do you take any medications to manage the symptoms of either depression or anxiety?
A. I take mirtazapine, m-i-r-t-a-z-a-p-i-n-e, and that's prescribed to me as a sleep aid. But it does have antidepressant properties. And I take hydroxyzine, h-y-d-r-o-x-y-z-i-n-e, as needed for anxiety.
Q. Okay. So let's back up a little bit.
You initiated care at Metro Inclusive Health in 2016, and you said you were in therapy with Ashley Hancock for a number of months.
At what point did she diagnosis you with gender dysphoria?
A. It was about eight months from our first appointment.
Q. And did you all discuss and did she recommend that medical treatments would be appropriate to treat your gender dysphoria?
A. Yes. She wrote me a letter recommending that I start

testosterone therapy.
Q. Okay. So you got a letter from your mental health care provider.
What was the next step in the process?
A. The next step was getting cleared by the MD team at Metro Inclusive, the medical doctors. That involved blood tests, a physical exam, probably some other stuff I'm forgetting. And then when I was cleared, then I was able to get my testosterone prescription, and the first injection was actually done at the clinic so they could show me how it was done and, you know, what to avoid during an injection.
Q. You said you got some lab work done.
Do you remember what the lab work showed?
A. I don't remember exactly what it showed, but they totally cleared me to start HRT.
Q. And before you started testosterone -- sorry. Let me back up a little bit.
How old were you in 2016?
A. I was 22, I think.
Q. Before you started testosterone, were you advised about the risks and benefits of that treatment?
A. Yes.
Q. And can you -- do you recall that conversation and what was discussed?
A. Yes. So the risks -- some of the risks included a decrease

in fertility, male pattern baldness, possible cardiac issues, higher blood pressure, possible decrease in organ function, specifically with kidney and liver. And that's all I can remember right now.

Q. And what about the benefits?

A. The benefits included, for me at least, the normal things that you would associate with male puberty: Increased facial and body hair, deepening voice, body fat redistribution, increase in muscle mass. Just general man things, I guess.

Q. When you started testosterone, were you told anything about how that medication might interact with your medications for your arthritis or -- your arthritis broadly?

A. I wasn't told at the time because I wasn't on the medications that I'm currently on. I was only taking celecoxib at that time, which had no interactions with testosterone.

Q. Okay. So no medical professional advised you that there was a problem with you starting testosterone while having rheumatoid arthritis?

A. No.

Q. So if I'm doing math sort of correctly, it seems like you first started testosterone in 2017; is that right?

A. Yes.

Q. And did you notice any impact on your symptoms of gender dysphoria?

A. Almost immediately, actually. I felt more confident pretty

much the week after I got my first injection. I don't know what's in my genes, but I started getting a little hint of a mustache, like, a month in. I was super excited about that. And as, you know, the months went on, you know, I was making videos of my voice changing and posting them for my friends to see. And it was just, like, a process that changed the entire way that I interacted with the world.

Q. Did you find that once you started testosterone some of that day-to-day distress diminished?

A. Yeah, for sure. I definitely felt a reduction in my depression and in -- sorry -- anxiety, and, you know, life just felt easier. It felt more manageable.

Q. And -- I'm sorry. Just a second.

Did you experience any negative side effects of taking testosterone?

A. I sweat a lot. That's kind of annoying sometimes. But otherwise, no.

Q. And did you observe any issues between testosterone and the celecoxib I think you said you were taking?

A. Yes. And, no, I did not notice any interactions.

Q. So from 2017 forward, did you continue taking testosterone to treat your gender dysphoria?

A. I continued taking testosterone for about eight or nine months, and then I was coerced by the partner I was currently with to stop my testosterone therapy.

Q. When you stopped taking testosterone for the treatment of your symptoms of gender dysphoria, what happened to those symptoms?
A. They returned with a vengeance. I was depressed to the point of not wanting to get out of bed. I had to physically, like, almost hit myself to try to get myself to take a shower, because I didn't want to keep looking at my body. And I stopped hanging out with friends. I didn't want to even go out to the store to get groceries. I was that, you know, unhappy with my body at that point that I didn't want anyone to see it. I didn't want anyone to perceive me as a woman and -- because, like, seeing people perceive me that way would have done even more damage to my already fragile mental state at that time.
Q. You said you stopped taking testosterone because a -- the partner you were with at the time coerced you.

Can you say a little bit more about why you decided to take that break?
A. So it was a long-term abusive relationship. We were married at the time. And basically she told me, I don't like you being on testosterone anymore. If you continue to take it, I'm going to leave.

And I was extremely codependent with her up to that point because I am disabled and I could not work. I could not earn money for myself. I had no way to survive other than her, because she had also isolated me from my family. And so when

she gave me that ultimatum, I didn't believe there was a choice for me if I wanted to continue to survive.

Q. Did you know that your symptoms of gender dysphoria would probably come back if you did that?

A. Yes.

Q. At what point -- I'm sorry.

Did you ever start testosterone again?

A. Yes, I restarted testosterone in June 2019, after my separation with my wife.

Q. And have you been taking testosterone consistently since June of 2019?

A. Yes.

Q. And what happened to your gender dysphoria symptoms after you restarted testosterone in June of 2019?

A. Almost immediately they became much more manageable again. I was happier. I was more secure in myself. I was confident. I wanted to go outside and meet people. I wanted them to know who I was and how -- wanted them to see how I presented myself, because I felt proud of myself and who I was.

Q. And have you observed any issues between your testosterone therapy and your medications to treat your arthritis since you've been back on testosterone?

A. No. I guess maybe there is one -- anecdotally, I wouldn't say this for everyone who is taking testosterone, but just for me, personally, I have noticed, as a positive, that while on

testosterone some of the symptoms of my arthritis are diminished. I think that's because testosterone helps with some connective tissue disorders, and my rheumatoid arthritis is somewhat related to connective tissues since that's what your joints are. And so the stronger my connective tissue is, the less symptoms that I have for my arthritis, and yada, yada.

Q. Do you see a doctor specifically for your rheumatoid arthritis, Mr. Dekker?

A. Yes. I've been seeing the same rheumatologist since 2021.

Q. Does he do any monitoring of your disease progression?

A. Yes, I get multiple labs done every eight weeks.

Q. What do those labs include?

A. I get a CBC with differential done. I have a test for my organ function, my kidney, liver, my red blood cell count, my platelet count, white blood cells, and my blood pressure is tested every time I go to the office. Basically everything under the sun that they can test for, I've probably had it done.

Q. You said that happens every eight weeks?

A. Yes.

Q. And has he noted any issues in that lab work about your disease progression and the treatment of your gender dysphoria with testosterone?

A. No. Whenever something comes up in my labs, he personally calls me. The last time was because my white blood cell count was a little low, and we just decided to switch up the length of

time between my injections. And the time before that was my vitamin D level was critical. So he gave me some prescription-strength vitamin D for that. But nothing has come up about my testosterone or my gender dysphoria.

Q. When you say your injections, are you referring to the injectable medication you take for your arthritis?

A. Yes, Actemra.

Q. Actemra. Okay.

Mr. Dekker, how do you pay for your testosterone prescription?

A. It's been covered by Medicaid.

Q. As a part of your experience of gender dysphoria, did you ever experience dysphoria related to your chest?

A. Absolutely. I think most of my dysphoria was centered around my chest, especially after I started testosterone, because the happier I was with, like, my face and other aspects of my body, my chest really stood out to me as the one thing that caused me the most distress. And I have been dreaming about top surgery since I was initially coming out as a trans man.

Q. Did you ever wear what's referred to as a chest binder?

A. Yes. When I first came out as a trans man, I bought one. It was a very poor material one off of Amazon. I quickly, thereafter, got a better quality one.

And -- however, with my arthritis, it was difficult for me

to bind for the length of time that I wanted to, and so personally I only felt safe to wear my binder about one or two days a week. So I would have to kind of structure my errands around that and try to get everything done in one day if I wanted to go outside and feel comfortable, and that was kind of a pain. And I never wore my binder for more than the recommended eight hours because I didn't want to do damage to my bones, because they are already fragile, but I wanted to. And I thought about it a lot. And at points I was very frustrated with my body that it was not allowing me to -- to wear the binder as much as I wanted.

Q. So you mentioned this a little bit, but did your chest dysphoria go away with the testosterone treatment?

A. No. If anything, it maybe got a little worse because it was, like, what I was focusing on the most, because my other concerns have kind of been taken care of through testosterone therapy.

Q. So in conversations with your medical providers, was it ever indicated that it was appropriate for you to receive top surgery as treatment for your gender dysphoria?

A. Yes. So I talked about it a lot with my therapist. And probably up to a year before I actually started to schedule surgery, I was talking about it with her, making sure that I was ready, making sure that this was the right option for me, and, you know, just talking about what would come after as well,

because surgery is a hard thing to go through, especially for someone with a complicated medical history. And we wanted to mitigate every possible harm that could be done or complication that I could have.

Q. So you said you talked with your therapist for about a year before top surgery.

What steps did you have to take once -- after your conversations it was indicated that that was an appropriate treatment for you, what came next?

A. So I started researching the requirements of Medicaid to get top surgery covered through Medicaid. That involved getting a referral from my primary care doctor, a letter of recommendation from a mental health provider, and I believe my surgeon's office also required one year on hormones to schedule a consultation. I had to get all of this before I could even schedule a consultation.

Q. Okay. So you mentioned letters.

Can you talk to me a little bit about that?

A. Yes. So I got my first letter of recommendation from my psychiatrist that I have been seeing since 2019, Troy Pulas. And I additionally got a second letter just to make working with Medicaid a little bit easier, maybe, you know, get an approval in, you know, maybe a little bit quicker time. And that second provider was someone I had not seen before because they wanted an independent evaluation from someone who I was not in care

with.
Q. So you were only -- as you understood it, you were only required by Florida Medicaid to get one letter?
A. Yes.
Q. So once you had, as you said, sort of compiled these requirements, what did you do next?
A. I scheduled the consultation, and there's -- it was a two-hour drive. But I go to that hospital anyway. My rheumatologist is at the same hospital, so I'm familiar with the hospital and the network of doctors there.

So at my consultation we spoke about what my goals were for the surgery, the risks and benefits of the surgery, what we could do to minimize any complications I might have with healing, because I am on immunosuppressants. Actually, in the office my surgeon emailed my rheumatologist and asked him what the best course of action would be for my current medication. And he replied pretty quickly with a plan and links to studies about -- why stopping one would be beneficial and the other one isn't needed. And I think she took a couple of pictures of my chest. And that was about it for the consultation.
Q. Let me back up a little bit.

You said the hospital was two hours away. What hospital did you go to for your consult?
A. The University of Florida, Shands.
Q. And what was the name of the surgeon that you had a

consultation with?
A. Sarah Virk.
Q. You said that you spoke with Dr. Virk about risks and potential complications. Did you also talk about benefits?
A. Yes.
Q. Can you tell me what you remember about that conversation: The risks, the potential complications, and the benefits of top surgery?
A. So benefits would be a huge reduction in my gender dysphoria and just improving my quality of life. You know, the risks come with any surgery. It's, you know, infection, bleeding, hematomas, edema, which is swelling, fluid buildup -- any number of things that can happen with any surgery. And my specific complications that she was trying to mitigate were issues with healing. And I was given what is called a negative pressure dressing, or a wound vacuum, to mitigate the healing issues that may have occurred due to me being on immunosuppressants.
Q. Okay. So is that what you referred to earlier as the plan that she came up with with your rheumatologist?
A. Yes. I was also advised to pause my Actemra for two weeks before and two weeks after surgery because that is my main immunosuppressant.
Q. When -- did you have top surgery?
A. Yes.

Q. When did you have that surgery?
A. April 19, 2022.
Q. And did you experience any complications?
A. Not really. I mean, there were a couple very small spots along my incisions that reopened, but I was able to just cover them with some Neosporin and a Band-Aid, and they healed up about a week after that.
Q. How was the surgery paid for?
A. As far as I know, it was covered through Medicaid.
Q. Can you describe for me, Mr. Dekker, your feelings after the procedure?
A. I felt like the world had been lifted off of my shoulders. Like, it felt like this was the way things were supposed to be all the time. It felt natural, and I didn't -- I'm wearing a white shirt today. And before top surgery, my closet was entirely black because I was trying to hide any evidence of my chest. Just the simple fact that I can wear a white or, like, a beige-colored shirt now has done wonders for me, mental health-wise. It's also expanded my wardrobe quite a bit.

And just the confidence I have now in my body, in my chest, being able to take my shirt off when I go swimming, to the beach, being able to roughhouse with my brother without worrying about my chest getting in the way -- like, these are things that I should have been able do when I was growing up. And I'm so glad that I get to do it now because it's been life changing.

It's probably the best thing that I've ever done for myself.
Q. That sounds really positive. Thank you for sharing that.
Mr. Dekker, what would it have meant for you to not have obtained testosterone therapy and top surgery?
A. I would be completely -- I wouldn't be a person. I would be a statistic. I would be dead from suicide, probably, and if not suicide, then substance abuse or any number of things where that -- that people do to destroy themselves, because I didn't like myself when I was -- when I thought I was a girl.
And now I have so much love for myself. Like, it's crazy how much that I want to live now and how much that I want to see the world change and make this -- like, make it a better place. And if you told high school me that, like, I would be where I am now, they wouldn't believe you. Like, I never -- growing up I didn't expect to live past 20. And now I'm almost 30, and that's the best gift that I've ever given myself is the will to live through gender-affirming care.
Q. Thank you, Mr. Dekker.
So can you please tell me, why are you participating in this lawsuit?
A. I want to ensure that I still have access to this care. It's important to me to continue my testosterone therapy. I want to grow old and bearded and fat and happy, and I want to do that, you know, as a man in the company of men that I love. And I can see a future for myself now, and that started with

gender-affirming care.

Additionally, I'm thinking about every trans person here in Florida on Medicaid and trying to be who they need right now, because I know I'm strong enough to do this, but other people might not have that strength right now considering how much we are being attacked right now. And I want to do everything I can to make it so that they don't have to fight, because I can fight. I can fight for them, and I can fight to help them gain access or continue accessing care that they need.

MR. CHARLES: No further questions, Your Honor.

THE COURT: Cross-examine.

CROSS-EXAMINATION

BY MR. JAZIL:

Q. Good afternoon, Mr. Dekker.

I wanted to follow up on a few of the questions from my friend about your medical history.

You were talking to my friend and you testified that before you started using testosterone you discussed the associated risks and the benefits with your physicians.

Did I understand that right?

A. Yes.

Q. And my understanding is that that discussion took about 20 minutes or so?

A. 20, 25 minutes, yes.

Q. Now, Mr. Dekker, you discussed with my friends the letters

you got before you sought your top surgery.

Do you recall that testimony, sir?

A. Yes.

Q. The second letter that you mentioned, you said that you got that letter from someone you hadn't seen before.

Did I understand that right?

A. Yes.

Q. Was that someone named Abbie Rolf?

A. Yes.

Q. I'd like to --

MR. JAZIL: And this is not for the public screen. I'd like to pull up Plaintiffs' Exhibit 237A.

BY MR. JAZIL:

Q. Mr. Dekker, would you mind taking a look at that letter? And let me know if you'd like us to scroll down. It's two pages.

Sir, is that the letter you received, the second letter?

A. Yes.

Q. And it says here on the top: *My name is Abbie Rolf, MA, Registered Mental Health Counselor Intern.*

Do you see that, sir?

A. Yes.

Q. It goes on to say, last sentence of the first paragraph: *I have personally completed 10 hours of training specifically related to assessment and letter-writing for gender-affirming*

medical interventions and provide training to others on the same.

Do you see that, sir?

A. Yes.

Q. The last paragraph on the first page, it says that: *It is my professional opinion that in this way, he meets the diagnostic criteria as defined in the Diagnostic and Statistical Manual Fifth Edition.*

Do you see that, sir?

A. Yes.

MR. JAZIL: Mr. Dekker, thank you for your time. I have no further questions.

THE COURT: Redirect?

MR. CHARLES: Just briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. CHARLES:

Q. Mr. Dekker, do you still have that letter on your screen?

A. No.

Q. Okay. We'll just pull that up, Plaintiffs' Exhibit 237A.

MR. CHARLES: Not on the public screen. Thank you.

BY MR. CHARLES:

Q. Okay. Mr. Dekker, do you see the beginning of that letter there?

A. Yes.

Q. It says: *My name is Abbie Rolf, MA, Registered Mental*

Health Counselor Intern.

A. Yeah.

Q. Do you see that?

And it says: *I am practicing under the supervision of Dr. Christina McGrath Fair, LMC (MH14339) and Nick Marzo, MS LPC, LMHC, CPCS, CST, NCC, CCMHC.*

Do you see that?

A. Yeah.

Q. Okay.

Did I read that correctly?

A. Yeah.

Q. Okay.

Is it your understanding at the time that Ms. Rolf wrote this letter that she was practicing under the supervision of Dr. Christina McGrath Fair and Nick Marzo?

A. I honestly was not aware at the time. I think Abbie Rolf made some mention that she was working with some other practitioners; however, I didn't remember their names.

Q. And if you'll look down -- hold on.

Okay. Do you see on the bottom left-hand side, Mr. Dekker, Abbie Rolf's signature there?

A. Yes.

Q. And do you see the other blacked-out box where --

A. Yes.

Q. -- there is another signature block?

Sorry. Do you see that, Mr. Dekker?
A. Yeah.
Q. And you see it says: *Licensed Mental Health Counselor?*
A. Yes.
Q. And the license number there?
A. Yes.
MR. CHARLES: Nothing further, Your Honor.
THE COURT: Thank you, Mr. Dekker. You may step down.
(Mr. Dekker exited the courtroom.)
THE COURT: Please call your next witness.
MS. DeBRIERE: Yes, Your Honor. Plaintiffs call Jade Ladue.
(Ms. Ladue entered the courtroom.)
THE COURTROOM DEPUTY: Please remain standing and raise your right hand.

JADE LADUE, PLAINTIFFS WITNESS, DULY SWORN

THE COURTROOM DEPUTY: Please be seated.
THE WITNESS: Thank you.
THE COURTROOM DEPUTY: Please state your full name and spell your last name for the record.
THE WITNESS: Jade Ladue, L-a-d-u-e.

DIRECT EXAMINATION

BY MS. DeBRIERE:
Q. Good afternoon, Ms. Ladue.
A. Good afternoon.

Q. Where do you live?
A. I live in Sarasota County, Florida.
Q. Have you always lived in Florida?
A. Nope. Lived in Massachusetts and just moved down here about three years ago.
Q. And who do you live with?
A. I live with my husband and our five children.
Q. And what do you do for a living?
A. I work as a teller at a bank.
Q. How about your husband, what does he do?
A. He's disabled.
Q. Can you tell me a little bit more about that?
A. He has a venous malformation in his leg, which is an active aneurysm that keeps him from moving it. You know, he can't bend it, so if he bumps it or hits it hard enough, then it can be life-threatening for him.
Q. How long has he had that condition?
A. Since birth.
Q. And does he receive any benefits as a result of that condition?
A. Yes, he does. He gets SSI Disability.
Q. And where is your husband today?
A. He's here.
Q. You mentioned you also live with your children. How old are they?

A. We have 6, 13, 14, 16, 16.
Q. And are you the biological mom of all of the children?
A. No. So we are a blended family. Both -- my husband has two daughters with a previous marriage; I have my two sons, and then we have one son together.
Q. Is your son a plaintiff in this lawsuit?
A. Yes, he is.
Q. And what is your son's initials?
A. K.F.
Q. Where is K.F. right now?
A. K.F. is back home with his other siblings and my mother-in-law.
Q. Does your mother-in-law typically live with you?
A. No. She actually flew down to visit with them and help us out while we are here.
Q. Is K.F. enrolled in Medicaid?
A. Yes, he is.
Q. Are your other children enrolled in Medicaid?
A. Yes, they all are.
Q. Do you know why your children are eligible for Medicaid?
A. Yes. We are considered on the lower end income-wise, so we do qualify for it. Also, my job does not allow me insurance, so I wouldn't even be able to put them on if I wanted to.
Q. Does your husband have insurance through his disability benefit?

A. Yes, he has Medicaid.
Q. Is he able to add the children to that benefit?
A. No, he is not.
Q. Does K.F. receive his Medicaid through managed care?
A. Yes. It's through Humana.
Q. Ms. Ladue, can you describe K.F. for us?
A. He's amazing. He's your typical 13-year-old boy. He's very active with his friends. He's very active in sports, family, our church. He's a big part of the youth program there at our church, and really just loves being around his friends and family. It's really important to him.
Q. Can you just describe -- I don't know -- a typical day in your household?
A. So we wake up. We are up usually pretty early. We like to get up early and have our coffee, before we get the kids up, to have a little quiet time and just kind of reflect on the day. We'll get them up, get them ready for school. I get ready for work. Some of them take the bus; my husband takes some of them to school, and off to work I go. And usually after school consists of a lot of sports between all of them, or some kind of activity. Home for dinner, bed, and do it all over again the next day.
Q. That sounds familiar.
How would you describe K.F.'s relationship with Joshua?
A. It's great. Joshua has been in K.F.'s life since he was 3

years old, so that's his father. He calls him Dad. That's, you know, the person he looks up to.

Q. And, I'm sorry. Who is Joshua?

A. Joshua is my husband. Sorry.

Q. My fault.

How about K.F.'s relationship with his siblings. Can you describe that a bit?

A. Yeah. They get along really well. I guess they have their typical sibling moments where they butt heads, but for the most part they get along great. They're all pretty close in age, the four older ones. We have that little age gap with our younger guy. But they really do get along great; they do.

Q. Switching gears.

What was K.F.'s assigned sex at birth?

A. Female.

Q. Is K.F. transgender?

A. Yes, he is.

Q. What is K.F.'s gender identity?

A. Male.

Q. And when did you first learn about his gender identity?

A. He came out to us when he was 7 years old. So it's been quite a few years that we've been on this journey.

And he actually came out to my parents on -- my parents would take all the kids every summer on, like, a long weekend camping trip. We look back at it now, he's tried to tell us

many times, and I think we brushed it off. But came out to my mother originally at the pool on the camping trip.

Q. When you say that K.F. tried to tell you, what do you mean by that?

A. So for the couple years before -- and he'll tell you up until this point he's known since he was 4 years old that he was supposed to be a boy.

When he came out, he told my parents. And when they got back, we had a nice long conversation about it and, you know, told him that we'd love and support him no matter what, and that we just want him to be healthy and happy. And I think it caused a lot of anxiety and issues. And some of the things he would tell us was, you know, we'd go school clothes shopping and he'd want to shop in the boy's section, and I'm like, No, shop over here in the girl's section. And he would run around with no shirt on in the house and wear his big brother's *Star Wars* pajamas, and say, Look, I'm the boy.

And I think those are all just kind of little things that we look back now, and we're like, it makes sense. I think he was kind of trying to tell us at that point.

Q. Why do you think he came out to his grandparents first?

A. He's always had an amazing relationship with them, especially my mother, his grandmother. We lived with them for a little bit when he was really young, and just had that really close bond with my mom and dad. And I think -- I think he just

had that comfort level and knew that no matter what, Grandma wasn't going to be, like, No, no, no, you are not a boy; you are a girl. And I think that's why.

Q. And what was your -- what were the grandparents' reaction to K.F.'s disclosure?

A. At first -- so, it actually started with they were at the pool at the campground, and there was a little boy that was wearing this American flag bathing suit that he really liked, and he's like, Grandma, I want that bathing suit. And my mom was like, Well, they make girl ones, and we can look and see if maybe we can get you one. And he's like, No, I want that one. And he was very persistent about it. And he's like, You guys keep wanting me to be a girl, but I'm a boy.

And my mom is, like, What do you mean, and kind of was starting to pick his brain a little bit about it and ask questions. And brought him over to the side and just talked to him about what was going on. And he was very adamant that for years he's a boy and that we keep trying to make him a girl.

Q. And so when did you learn about this incident that happened while K.F. was camping with his grandparents?

A. So I did get a call, and she pretty much said, my mother, his grandmother did say that, you know, We need to have a conversation about something that happened. And, of course, I thought something maybe bad happened.

And, you know, once we picked him up and then we, you know,

had a good probably 45-minute conversation about everything they talked about and what happened. And, you know, then after that, I mean, they were okay with it. And I think they were a little shocked, a little taken back by it. But, once again, they are amazing and are supportive no matter what. So they just want to see their kids and grandkids, you know, happy, I think is the most important part.

But then when we got home, we had a long conversation with just myself, my husband, and K.F., and really just kind of asked, you know, What's going on? Grandma tells us that you had this conversation about how you have known for years that you are a boy and we keep making you a girl. What's going on? And he pretty much said everything that he told my mom, just that, you know, I'm supposed to be a boy, and I'm not a girl, and you guys keep wanting me to dress like a girl and act like a girl and I'm not.

We asked him how long he's been feeling that. He said, Years. He said, Four. He's like, I'm going to grow up and I'm, Going be a dad. I'm going to have facial hair and muscles, and just kind of went into all of these -- like he had this whole plan that we knew nothing about at the time. But, you know, we told him we were a little, you know, shocked, I think, by it. But now that we look at it, like I said, it makes sense, all these pieces have come together over the years.

And we told him the same thing. We were, like, you know,

we'll support you. I'm like, I'm going to get online. I'm going to do some research, and I'm going to, you know, see what we can do and kind of go from there. But I'm, like, We love you and no matter who you are, as long as you are happy and healthy, that's what's important to us. So that's kind of where we left it at that.

Q. At the time that K.F. had disclosed this to you, did he have any access to social media?

A. No. Nope. No phones, no tablets, nothing. Actually, the only thing he had was a little LeapFrog video game thing with ABCs, and kind of -- I call them little kid games, but nothing -- no social media whatsoever.

Q. Remind us how old he was at the time?

A. 7.

Q. And prior to coming out, did K.F. have any awareness of a transgender identity, what that meant?

A. No. Actually about a week later, after doing some research and -- you know, I did, you know, sit down and talk to him and, you know, let him know there is something called transgender. He had no idea. Completely clueless to what it was and what it meant. And I was like, you know, There's a group of people, kids, adults that, you know, are born in one sex but identify as the opposite sex. And he was -- it was mind blowing to him. He was like, Oh, my goodness, there are other people out there like me. He was just very -- I think a sense of comfort knowing that

he wasn't alone. So, yeah, he was actually really excited about it.

Q. So you'd mentioned that after he came out to you, you went online and did some research.

And then what happened next?

A. So literally right when our conversation was done, I'm Googling -- you know, I've heard of transgender people. I wasn't really familiar with them. I wasn't sure if kids this young can identify as transgender. I knew older people did.

So doing research, I did realize that there was a lot of young -- even younger than 7., and found a therapist that was local to us, called her office. Ilene her name is. And we pretty much got right in there. I think it was within a week we had an appointment.

And, you know, like what any parent would do, you want to get your child help; you want to make sure that they're getting the treatment that they need and just to make sure there wasn't anything else going on that maybe we didn't know about.

Q. So at the time what state did you live in?

A. Massachusetts.

Q. Thank you.

Can you describe that first appointment with the therapist that K.F. had?

A. It was great. We were there for quite awhile. She was really nice. She actually works with adolescents and teens,

transgender or gender dysphoria. And she was very knowledgeable.

She, you know, just gave us a lot of reassurance that, A, you are doing the right thing by reaching out and trying to meet with a counselor, therapist. She gave us some resources such as PFLAG, which is a, you know, support group, which we did find one local to us, and also mentioned that there was a couple of hospitals in Boston that also had gender programs that we could maybe try to get on the list for there.

Q. Backing up just for a second, Ms. Ladue, prior to age 7 did K.F. have any mental health issues that concerned you?

A. Yeah, we had a lot. We had for years what at the time we were kind of calling night terrors and upset stomachs. When his anxiety gets really high, he would always get upset stomachs. He has a fear of throwing up, so it would trigger a whole new ballgame there.

And we met with neurologists. We had EEGs done, sleep studies done, gastroenterologists. We had him on, you know, an upset -- antacid kind of medicine for a little bit, which did help a little bit but not anything -- once he actually came out, I think it was, like, a big weight off his shoulders that, All right. They know who I am and who I'm meant to be. And I think that was kind of, you know, the turning point for his anxiety. It really did help, so --

Q. So -- I'm sorry to interrupt that.

So going back to this first appointment, did you talk about any of those issues with the therapist?

A. Yes. Yep, we did talk about them because the night terrors were the big thing. Every night he was up having what they thought might have been some kind of sleepwalking seizures or -- you know, they weren't sure what it was. That's why we did the EEG and sleep studies.

But, you know, we did talk to her about that, and, you know, she did let us know that a lot of kids who aren't out yet to their family and friends do suffer a lot of anxiety and depression, and it could be a part of it. But she's, like, You know, that's not for me to necessarily say. You've got to kind of see how things go and meet with psychologists and -- but she's like, I see it all the time in the young adolescents and teens, that she works with.

Q. Did K.F. have any questions for the therapist -- for Ilene?

A. Yeah, he did have a couple. I guess his first thing was that, you know, he's excited that there was other people like that, because she did explain that she works with kids that are kind of going through the same thing that he's going through, and he was very excited about that and really wanted to kind of get into a group with other kids that were like him. That was really important, which we had a lot of trouble finding groups at that age. A lot of it was 13 and up, like, teens and stuff. So he was pretty bummed about that. But, you know, when he was

going to get facial hair, like all those kind of, you know, questions and, you know, What's next and when do I get to see the doctors? Stuff like that.

Q. So after that first meeting, how often did K.F. go to therapy?

A. Weekly. We did see weekly until we got into Boston GeMS Hospital, which is their gender program, and then we kind of started seeing her occasionally and still kept in touch, you know, for a while via text message. She just wanted to see how he was doing and just some updates once he got, you know, plugged in with generals.

Q. What was the space -- how much time between when he first had the meeting with the therapist and getting into the GeMS program?

A. It was only a couple months. They had a cancellation. We were on almost a year waitlist, and they called me, and they were like, We have an appointment next week. I'm like, I'll take it.

Q. During that time between the first therapist meeting and going to GeMS, he met with the therapist weekly?

A. Yes, yep.

Q. What did the therapist conclude about K.F.?

A. She did say K.F. did have some gender dysphoria, and that, you know, although he is young, he's definitely presenting transgender and, you know, with that gender dysphoria and the

fact that he was very convinced that this is who he was and that he was a boy and -- but, you know, she was like, Time will tell. He's young, so, you know, you've just got to kind of see, you know, how it goes over the next couple of years and go from there.

Q. Other than GeMS, did the therapist make any other kind of recommendations about K.F.'s treatment?

A. Not really any recommendation other than, like, meeting with -- PFLAG is a parent support group, because it was important for me to reach out to other families that were kind of going through the same thing I was and -- which PFLAG was amazing.

And she did say that she wanted us to meet with the doctor and psychologist; that maybe there is some kind of medication that they can give him to help him out with his anxiety and depression. So that's definitely something we followed up on when we were at GeMS.

Q. What grade was K.F. in at the time that he met with the therapist?

A. It was actually the summer going into second grade.

Q. Okay. Did the therapist have any recommendations about that following school year?

A. Yeah. She actually -- she actually recommended setting up a meeting with the school and -- just to let them know kind of what was going on, because K.F. did go there for kindergarten

and first grade and presented more female, and he was very adamant that he wanted to use "he" and "him" pronouns. That was a huge thing for him.

So she actually went with me, and we went to the school and met with the principal, the assistant principal, the school nurse, and the school psychologist, and just kind of let them know a few weeks before school started, like, you know, this is, you know, K.F. and that, you know, he's now presenting male. You know, he's dressing more male; he has got a shorter haircut and really wants to use the he/him pronouns and for people to use male pronouns when addressing him. And the school was great.

She actually goes around Massachusetts and advocates at schools, so she was very knowledgeable and was able to give us some insight, which luckily his school was great. We didn't really have many issues at all. You know, they said he can use the gender neutral bathrooms or the teacher bathrooms that are, you know, both sexes, and once he's comfortable using the boy's room, that's okay. He can use the boy's room. So it was a really smooth transition for us, I think.

Q. And just to be certain what about what you said.

So when he was in first grade, he was identifying female still?

A. Yes.

Q. But in the second grade he started identifying --

A. As a male.
Q. -- with the gender he aligns with; is that right?
A. Yeah.
Q. How did that school year go? How did that second grade year go?
A. It was probably one of the best years he's had. He loved it. And I think kids, when they're that young, they are so -- that doesn't matter. It doesn't matter if you're wearing different clothes or have a short haircut. That's just -- they are, like, Hey, K.F., let's go. Let's go play. You know, they're so, I think, naive at that age that that doesn't bother them. I think, you know, middle and high school gets a little more tricky with stuff like that, but his friends are really supportive. He had an amazing teacher that was supportive, and K.F. had a great year that year.
Q. Did K.F. have a different name at birth?
A. Yes.
Q. When did K.F. start using his preferred name?
A. Well, K.F. had a nickname that we kind of all in the family called him anyway, and that kind of stuck. You know, the siblings, my husband and I, even friends would call him that. So we just kind of kept with it and just kept it, and it kind of worked.
Q. Well, I mean, so your child is going through a lot; right? They're changing the way they dress; he's cutting his hair; he

changes his name.

So what reaction are you and your husband having to all of this?

A. I mean, we -- we support it. We -- and from day one, we've told him, you know, he's the same person. He's totally the same person he was before, other than he has short hair and he dresses more manly. He's got the same personality; he's bubbly; he's outgoing; he has got a lot of friends. Like, it's just -- you know, the hair grows back. You can change your clothes. That -- it's just -- yeah, it was okay.

You know, I think the hardest part for us was, you know, the pictures, you know, because at one point he did ask us to take down the girl pictures and that he didn't want those up there anymore, and we did. You know, we got some new family pictures and, you know, some new pictures that we put up around the house, and that just made him really happy.

Q. So you had mentioned the Boston Children's Hospital GeMS program.

Can you tell us a bit about that?

A. Yeah, it's -- I forget exactly what it stands for, but it's a gender program. They have doctors and psychologists there or nurse practitioners that work under doctors and psychologists, and it's really great.

Our initial -- first appointment was what they called the two-hour psych evaluation, where we went in there and met with

their psychologist, Colleen, who was amazing. She pretty much brought us all in, talked to us, you know, talked to my husband and I separate, then talked to K.F. separate, then, you know, brought us in again and worked a lot with -- I think they call it play therapy with coloring and, you know, just trying to see what's going on and, you know, see if there is any other underlying issues that might have been going on.

And, you know, what kind of concluded from that was -- you know, Colleen has worked with transgender kids even younger than K.F. and, you know, he definitely was very adamant and persistent that this is who he is, and that, you know, he's going to grow up and be a dad; and, you know, he never was a girl so -- but where he was so young, she even said, you know, this is something we've just got to see how the next couple of years go and, you know, just follow up with us and the doctor here and just kind of take it slow and just, you know, hope that everything goes smoothly.

Q. And, again -- I'm sorry for this -- remind me K.F.'s age when you first started at GeMS.

A. He was 7. I think he, like, just turned 8 or was about to just turn 8, yeah.

Q. Okay. And what was K.F.'s reaction to this first appointment?

A. He was actually really excited. You know, he always was very afraid of doctors and needles and all that stuff, but I

have to say for someone who gets blood work pretty much every six to eight months, he goes in there and is like, Let's do this. This is going to help get to where I need to be. And just the confidence knowing that there was going to be a good outcome with it I think made him feel more positive that -- and made us -- reassured us that we were doing the right thing, because, you know, we'd have to drag him into the doctor's office before, and now it's like, Let's go. So I think it was really helpful.

Q. And who did K.F. primarily seen at GeMS?

A. Colleen, the psychologist, and then Sarah Pilcher, which is the nurse practitioner there.

Q. And how long did K.F. receive therapy at GeMS?

A. Let's see. '17 -- so probably like four or five years, until we moved to Florida. '17, '18, '19, '20 -- yeah, very well five years. I had to think about that. Sorry.

Q. Did you receive any other kind of treatment at GeMS?

A. We did have -- in August of 2020, he did have his first hormone blocker put in.

Q. And how old was he in August of 2020?

A. Almost -- right before his 11th birthday.

Q. So tell me about what led up to that. What kinds of discussions did you have with what providers at GeMS?

A. So we were on a regular basis, every couple of months, meeting with the psychologist and the nurse practitioner, Sarah,

there. You know, we did a little -- in the beginning, it was mainly just meeting with them, checking for, like, breast development. In our family, female puberty starts pretty young, and, you know, I did tell them that. And he was very afraid of that, of getting his period, getting boobs. So when he started turning 10, we would start doing blood work.

We also did -- I think it's called a DEXA scan and his hand X-rayed to see where his growth plates were at, and then once he got to that Tanner Stage 2 is when they said that he is now ready for the hormone blocker.

Q. Okay. I think you mentioned he received an implant; is that --

A. Yes, a Supprelin implant.

Q. Do you know why they recommended a Supprelin implant for the blocker?

A. The Supprelin implant was going to be a little bit easier for him versus coming in every couple of months for a shot. That way we can kind of put it in, get a few years out of it, and not have to drive into Boston. We were a little ways from the hospital, so, you know, we didn't want to have to go there more than needed, I guess you could say.

Q. And, Ms. Ladue, I'm sorry for this, but I just want to go back to when K.F. initially met with Colleen when he was 7, almost 8.

Did Colleen provide any kind of diagnosis to K.F -- for

K.F.?

A. Yeah. She did say that he did have some gender dysphoria. He was very afraid of turning into a girl, as he used to say, and that was a big thing. She's worked with a lot of kids very young and, you know, said that he was definitely presenting more transgender and gender dysphoria, so -- but where he was so young, it was just a matter of kind of following up, because there was no major interventions or medications at that age. It wasn't until years later that we had to worry about that.

And then when time came, they actually provided a whole seminar on the different kinds of blockers that they had. They, you know, told us about the different ones. There was the psychologist doctors and nurse practitioners at this seminar. So they let us know the good, the not so good, you know, the risks, the side effects, the -- you know, the rare side effects. It was a really thorough thing that my husband and I went to, which was very helpful for us too.

Q. Do you remember any of the side effects or risks that they talked about at that seminar?

A. Yeah. Some of the side effects and risks long-term could be osteoporosis, you know, bone developing, growth developing you know, infections, you know, body rejecting it, you know, and then, you know, some of the rare side effects that could lead to a lot worse.

Q. Did anybody have a conversation with K.F. about the

potential for side effects with the Supprelin implant?
A. Yes. Actually, the doctor and Sarah Pilcher, the nurse practitioner, and Colleen, the psychologist, both did have a conversation, a couple of them actually, before it was decided.
Q. And did K.F. have any questions or concerns for either the doctors or you?
A. Yeah. I think, you know, K.F.'s big thing, was it going to hurt, you know, and, Am I going to feel anything? And, you know, sometimes they do it in office, but they did give him -- I forget if it's like a local, pretty much put him to sleep local, so -- and he was in and out of there in probably 10, 15 minutes and woke up and didn't feel anything.
Q. After receiving the initial Supprelin implant, did K.F. show any side effects?
A. Nope, no side effects. The only thing that -- until this day is you can't touch it, because it feels likes a spaghetti noodle in his arm and he gets all freaked out. But other than that, there is no side effects. He's actually -- his anxiety is a lot less. He's such a happy kid, and I think that just kind of reassures us that we're making the right decision; that this is who he is and what he needs so that, as he says, he doesn't become a girl.
Q. What is your understanding of what the Supprelin implant does?
A. Pretty much just blocks the female hormone and -- so he

doesn't develop female puberty.
Q. And how long does a Supprelin implant last?
A. Usually anywhere between a couple to a few years. It just depends. And like I said, we follow up every, like, six to eight months with blood work just to make sure that his hormones are still being suppressed.
Q. This implant that occurred at GeMS in Massachusetts, how did you pay for that implant?
A. It was actually Mass Health, which is like Florida Medicaid, covered it.
Q. When you decided to move to Florida, did you do anything to plan for K.F.'s continued care here?
A. Yes, we did a lot of research. We actually wanted to move down years before, but, you know, with K.F. coming out, we really wanted to stick with the doctors and with everything that we had there.
So when we decided -- you know, started talking about moving down here, I did a lot of research of all the hospitals, a lot of online support groups that I'm a part of, just to try to make sure that we could find the right one, which we did at John Hopkins All Children's Hospital in St. Pete, which is where we found Kevin Louis, who is currently K.F.'s doctor.
Q. How much time passed between when K.F. received his initial Supprelin implant and moving to Florida?
A. We had that implant done just a few months before moving

down here.
Q. And what -- just so I can keep it straight in my head, what month was that?
A. I want to say it was August of -- or July -- it's either July or August of 2020 we had it done, the implant, and then we moved down here at the end of September, beginning of October.
Q. You just mentioned Kevin Louis at John Hopkins All Children's Hospital. Do you know what kind of credentials Mr. Louis has?
A. Yeah, he has a doctorate in NP, nurse practitioner.
Q. Describe the care at John Hopkins that you received.
A. They were great. They have -- well, I should say they did have a gender program up until this past fall when they closed it down just due to all the legislations and bills that have been going on.

He works under an endocrinology department. They've been great. Their whole team is amazing. You know, they specialize in working with transgender and gender dysphoria kids.

So pretty much our first -- initial appointment was just in there kind of getting to know each other, you know, have all of our records from Boston Children's sent down, and just kind of getting to know them, and then we followed up six months later. And, you know, he was great, very informative, very helpful and -- yeah.
Q. Yeah. Has K.F. had another implant since moving to

Florida?
A. Yes, he did just have his second one put in in April of last year.
Q. Kind of similar to what you described to us for GeMS, leading up to that second implant can you tell me what you talked about with the providers, what steps you had to undertake?
A. Yeah. So we had some blood work. They thought it was a little different that, you know, he only had it for about a year and a half, but it looked like his hormone levels were elevating a little bit, which made them nervous, meaning that the blocker wasn't working as good as they'd like it to. So that's when we started submitting everything for insurance to get Humana Medicare to pay for it. And we did blood work -- same thing. They did the hand X-ray too just to make sure that -- it was, you know, a couple year difference from his last one that he had.
Q. And, Ms. Ladue, I heard you just say "Humana Medicare."
Was it Humana Medicare that covered K.F.'s implant?
A. Medicaid. I always get them fixed up. I apologize.
Q. That's fine. A lot of people do.
After the second implant, were there any concerns that you had about it or that K.F. had about it?
A. No. The doctor was -- we were a little concerned because the initial implant that he had was actually disintegrated in

his arm, which they said does happen, not often. So that does mean that he may need to have more than what -- you know, more often versus, you know, some people get years out of it. And we only had about two years.

Q. You know, I'd like to know -- so throughout this whole process, you've been discussing the risks associated with the treatment that K.F. is receiving, in particular the Supprelan implant.

Why did you decide to have K.F. receive the implant? Why did you consent to it?

A. Because the benefits really outweighed the risks. This was someone who suffered a lot of anxiety, a lot of sleep issues. It was to the point where I was getting a call at work three days a week saying he can't be in school because his anxiety is through the roof.

And I think, yeah, you look at long-term effects of maybe some osteoporosis or some of the effects that they do talk about, but I think it was really important for not only his mental health, but to reassure him that I'm not going to let him go through female puberty if we can help it.

Q. Now that Medicaid has stopped covering his Supprelin, how are you going to be able to pay for it?

A. I don't even know. As a lot of people know, Supprelin implants are very, very expensive, and financially we just wouldn't be able to afford that.

So now that we are just over a year -- it was about this time, you know, about a year and a half in, that we realized his other one wasn't working well, and we actually just had his last appointment with Kevin Lewis last week. They are no longer going to be able to see any transgender kids anymore.

Q. Is K.F. ready to start hormones?

A. Yes. He was actually supposed to start them this month, and, unfortunately, with their gender clinic closing down, they are no longer able to see him. They won't prescribe it. And you know, he felt horrible. You know, I think the whole -- Kevin Lewis and everyone that works with him are just as mad and outraged about everything that's going on. But there is no point of him starting it to potentially not get it next month. So, you know, we got to wait to see what happens and just pray for a good outcome.

Q. And if K.F. can access hormones in Florida, how will you pay for them?

A. Hopefully through insurance.

Q. If you didn't have Medicaid coverage for K.F., would you be able to pay for the hormone?

A. No. We'd be forced to leave the state.

Q. You earlier testified that your other children are Medicaid enrolled.

Are they able to receive all the health care their providers have recommended for them?

A. Of course, yes, they are.

Yep, they can receive everything no problems. You know -- and it's very unfortunate that just because someone has gender dysphoria or transgender that they can't receive the medication that's necessary for them.

Q. Does K.F. know why you and your husband came to Tallahassee this week?

A. Yes. Yes, he does.

Q. How does he know?

A. Before we even agreed to do any of this, we sat down with all the kids and talked to them and let them know that, you know, if we try to fight this, we can hopefully make a change and, you know, get the help and the care that he needs. And he was actually like, Let's do this. Like, he wanted to be here today, but we really -- I didn't feel comfortable with him, you know, being a part of it all, so he is back home. But, yeah, they are all very aware of why we're here and what we're doing.

Q. So do his siblings know about what's going on here too?

A. Yep. Yes.

Q. And how do they feel about it?

A. They are fine. They are, like, you know, Go you. Yeah, they're really excited that we're, you know, trying to fight this. And, you know, I think it's important because -- not only for K.F., it's also for transgender people. I mean, everyone deserves to have the medication -- the lifesaving medicine that

is necessary for them.

You know, as you just heard all this talk -- like, all the stuff that you go through and all the heartbreak and the body dysphoria and -- you know, I've been very fortunate that K.F. came out at a younger age, that, you know, we are able to get him these blockers so that he doesn't have to go through that. And it's so important.

Q. If K.F. couldn't access this care, what do you think would happen to K.F.?

A. I don't even know. I think he would be very upset. I can tell you right now if he had to go through female puberty, he would be devastated. And I just pray that I never have to witness or see that.

Q. Ms. Ladue, one final question.

What do you hope -- as K.F.'s mom, what do you hope for his future?

A. I just want him to be happy, and -- sorry.

I think they deserve to be who they are. And, you know, no one that is not in our situation should be able to dictate what medical care and what medicine is good for them. That is between us, the parents, the person, and the doctors, and I think it's so important that people remember that, you know.

And, unfortunately, a lot of it comes down to politics, and it's just -- I just want to him to be happy and healthy, and that's all I care -- I don't care who he dates. I don't care

who he is, because he's the same person. He just looks a little different.

So I think everyone -- everyone needs to realize that, because this is not a choice for them. This is who they are, and I think that's just something people need to know.

Q. Ms. Ladue, thank you so much for your time today.

A. Thank you.

Q. I'm going to sit down, and Mr. Jazil will stand up.

A. All right. Thank you.

THE COURT: Cross-examine.

MR. JAZIL: No questions, Your Honor. Thank you.

THE COURT: Thank you, Ms. Ladue. You may step down.

(Ms. Ladue exited the courtroom.)

THE COURT: It's probably time for the afternoon break. Tell me where we are.

MR. GONZALEZ-PAGAN: Your Honor, with apologies to the Court, we are actually a little bit in a holding pattern. The only witnesses we have left are the ones that are -- that we mentioned earlier today that we have reset for Wednesday of next week.

THE COURT: If it was a jury trial, I'd say, So you rest? But that's fine.

So you're through today?

MR. GONZALEZ-PAGAN: We're through, and then we will be presenting our next three witnesses on Wednesday that we have

rescheduled. And then my friend's side can present their case.

THE COURT: That work?

MR. JAZIL: Yes, Your Honor.

THE COURT: Yeah. It works better. The people on the other side are the ones in town, so they can go back and work on something else. I understand Mr. Jazil has another case or two.

So Wednesday morning, 9:00 o'clock.

And then you've got -- so give me a heads-up what that means in terms of the whole case. I think I've got sentencings the week after that. And then they, of course, take back seat to trials, so they can easily get moved if they have to. But I try to give people as much advance notice as I can.

MR. JAZIL: Your Honor, I have four expert witnesses and two fact witnesses. One of the fact witnesses will be rather short. The other fact witness I expect to take the better part of the day.

So --

THE COURT: The experts, you were saying maybe half a day?

MR. JAZIL: Yes, sir.

THE COURT: That's probably on the high side.

MR. JAZIL: Half a day each. I'll try to streamline as much as possible, Your Honor.

MR. GONZALEZ-PAGAN: We thought they would be a half a day each ourselves.

THE COURT: It sounds like it's possible we'll finish next week and possible we won't.

MR. JAZIL: Yes, Your Honor.

THE COURT: That's probably as good an estimate as anybody can make at this point.

Very good. Have a pleasant weekend, I guess. For those of you, if you are traveling, travel safe, and we'll see you back here Wednesday morning.

(Proceedings recessed at 3:33 PM on Thursday, May 11, 2023.)

* * * * * * * *

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

/s/ Megan A. Hague 5/11/2023

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

I N D E X

PLAINTIFFS' WITNESSES	PAGE
DR. KELLAN BAKER	
Cross-Examination By Mr. Beato	511
Redirect Examination By Ms. Dunn	516
DR. JOHANNA OLSON-KENNEDY	
Direct Examination By Mr. Gonzalez-Pagan	520
Cross-Examination By Mr. Jazil	574
Redirect Examination By Mr. Gonzalez-Pagan	591
Further Examination By Mr. Gonzalez-Pagan	598
JANE DOE	
Direct Examination By Ms. Coursolle	601
Cross-Examination By Mr. Jazil	616

PLAINTIFFS' WITNESSES (cont'd.)	PAGE
BRIT ROTHSTEIN	
Direct Examination By Ms. Chriss	620
Cross-Examination By Mr. Jazil	645
AUGUST DEKKER	
Direct Examination By Mr. Charles	649
Cross-Examination By Mr. Jazil	675
Redirect Examination By Mr. Charles	677
JADE LADUE	
Direct Examination By Ms. DeBriere	679

E X H I B I T S

PLAINTIFFS' EXHIBITS	OFFERED	RECEIVED
361	528	528