Jane Doe

vs.

Joseph Ladapo

Deposition of:

Monica Mortensen, D.O

September 28, 2023

Vol 1

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

CIVIL NO.: 4:23-cv-00114-RJ-MAF

JANE DOE, et al.,

Plaintiffs,

v.

JOSEPH A. LADAPO, et al.,

Defendants.
_____/

DEPOSITION OF

MONICA MORTENSEN, D.O.

VOLUME 1 (Pages 1 - 181)

Thursday, September 28, 2023

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

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I N D E X

Volume 1

E X H I B I T S

- - -

Proceedings began at 10:00 a.m.:

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

THE WITNESS: I do.

Whereupon:

MONICA MORTENSEN, D.O.

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

DIRECT EXAMINATION

BY MS. CHRISS:

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

A No.

Q So you understand that you are under oath today?

A I do.

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

A Correct. Yes. I understand.

Q And this requires that you testify truthfully.

A Yes.

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

A Yes, it does.

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

A I understand.

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

A I understand, yes.

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

A I understand.

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

A I understand.

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

A No.

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

A No.

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

A Correct.

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

A Correct.

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

A Yes, I did.

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

A And one of your other experts as well, I think.
Q Dr. Shumer?
A Yes.
Q Okay. I am going to show you what we are going to mark as Plaintiffs' Exhibit 1. Here's for the witness, for you Mr. Perko. Do you recognize this document?
(Plaintiffs' Exhibit Number 1 was marked for identification.)
A Can I flip through really quick?
BY MS. CHRISS:
Q Please.
A I recognize the first page.
Q Make sure you've seen it.
A If I can just...
Yes.
Q And what do you recognize it to be?
A This is the expert report that I had written.
Q Did you bring any documents with you today?
A No, I did not.
Q Without telling me about conversations that you had with counsel, what did you do to prepare for your deposition today?
A For my deposition today?
Q Yes.

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

Q Anything else?

A No.

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

A Yes, I did.

Q And how many times?

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

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

A No, I did not.

Q Was anyone else present when you met with counsel?

A No.

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

A Yes.

Q Which were those?

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

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

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

A No, I did not.

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

A No, just the expert reports.

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

A Just myself.

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

A Just the expert reports that your team submitted.

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

A No.

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

A The concerns about the informed consents.

Q Did anyone else provide you with any

information that you considered in writing your report?

A No.

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

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

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

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

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

A Counsel did.

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

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

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

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

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

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

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

A That's correct.

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

A Not to my knowledge.

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

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

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

A I don't believe so.

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

A I do.

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

A I don't think so.

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

A Loyola University in Chicago.

Q What degree did you receive?

A A Bachelor's in Science.

Q And where did you attend medical school?

A Midwestern University, or Chicago college of Osteopathic Medicine.

Q And where did you do your residency?

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

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

A I did three years at the University of Chicago.

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

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

Q So what were you doing between 2007 and 2014?

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

Q Where are you currently working?

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

Q And how long have you been there?

A Nine years.

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

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

Q Do you have any other current professional affiliations?

A Can you clarify what you mean by that?

Q Any other positions other than that at Nemours?

A Like as source of income or?

Q Yes.

A No.

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

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

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

Q Okay.

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

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

A In medical school? No.

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

A No.

Q How about gender identity?

A No.

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

A Correct.

Q So no presentations regarding gender dysphoria?
A Correct.
Q Or transgender healthcare?
A Correct.
Q We can turn to the next page, page A7 -- well, I guess starting on A6, you list your clinical practice, interests, and accomplishments. In their I see general pediatric endocrinology, PCOS and menstrual disorders, precocious puberty and pubertal disorders, adrenal disorders, pediatric calcium and bone disorders, as well as T1DM and T2DM. Are these the types of care that you provide?
A Correct.
Q The conditions that you provide treatment for?
A Correct.
Q And gender dysphoria is not among those listed?
A That's correct.
Q What's a Densitometrist?
A So that is reading bone mineral density scans, commonly referred to as DEXA scans.
Q Under research interests, on page A7, you list use of technology to improve diabetes control, precocious puberty, PCOS, metabolic effects of human growth hormone, and bone disorders in pediatrics; is that accurate?

A Yes.
Q Okay. So, again, gender dysphoria is not among the research interests?
A Correct.
Q If we can go to your -- it says bibliography for Number 15, are these your publications?
A That's correct.
Q So this isn't the bibliography associated with your report, but rather your list of publications?
A Correct.
Q Okay. All five of these are related to polycystic ovaries and polycystic ovary syndrome; is that correct?
A That is correct.
Q None are related to the treatment of gender dysphoria?
A Correct.
Q And these publications range from 2006 to 2012; is that correct?
A Yes.
Q Are there any additional publications outside of these?
A No.
Q And none of these are original peer-reviewed research; is that correct?

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

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

A In relation to the consents that were written.

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

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

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

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

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

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

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

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

A Correct.

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

A No.

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

A Correct.

Q In paragraph 8 you state you completed an

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

A No.

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

A No.

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

A At what timeframe are you asking?

Q During your residency?

A No, I did not.

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

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

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

A It's quite possible, yes.

Q You are not certain?

A I'm not certain.

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

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

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

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

BY MS. CHRISS:

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

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

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

A No.

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

A Correct.

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

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

A No. Personally, no.

Q What do you mean by personally?

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

Q But you were not involved in that treatment?

A Correct.

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

A Correct.

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

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

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

Q Anything else?

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

Q What about for delayed for precocious puberty?

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

Q What about for Type 1 diabetes?

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

Q What about for thyroid disorders?

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

Q Okay. And for growth problems?

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

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

A Sure. We have -- I have prescribed birth

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

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

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

Q What do you mean by consensus guidelines?

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

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

A Probably around that time, yes.

Q So 2017 to 2019?

A Most likely, yes. I believe so.

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

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

Q How many did you diagnose with gender dysphoria?

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

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

A Correct.

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

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

Q What do you mean by correct?

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

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

A They were already on medication, so I continued

their care.

Q Okay. And does that mean prescribing --

A A puberty blocker.

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

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

Q But you did feel comfortable prescribing the puberty blockers?

A At the time I did.

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

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

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

A That is correct.

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

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

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

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

A Correct.

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

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

Q What facility or what institutions did they work at?

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

Q What's the basis for them --

A They are afraid of discrimination and retaliation.

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

A They asked not to have their names released.

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

THE WITNESS: May I ask counsel a question?

MS. CHRISS: (Shakes head.)

MR. PERKO: You can answer the question.

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

BY MS. CHRISS:

Q Okay.

A Another one was Priti Patel.

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

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

Q Is that all?

A Yes.

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

A Correct.

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

A All of them did.

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

A Correct.

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

correctly diagnosed?

A Correct.

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

A Correct.

Q And you didn't prescribe hormones for any?

A Correct.

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

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

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

A Correct.

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

A Correct.

Q What did you do to assist the adolescents?

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

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

Q What's the name of the psychologist you mentioned?

A Lisa Buckloh.

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

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

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

A That they reported they had the expertise, yes.
Q And you have no reason to believe they didn't, right?
A Sure.
Q Have you monitored care, other than the two to three patients you mentioned, have you monitored care for any patients undergoing gender-affirming medical treatment?
A Could you explain more what you mean by monitor for care.
Q Yeah. Are there patients that you have provided care to in any capacity who were receiving puberty blocking medication or cross-sex hormones for the treatment of their gender dysphoria?
A So you mean they're being treated by another center, but I might be treating them for a different endocrinology reason or providing support during that care.
Q Yes.
A Just to clarify.
Q Yes. Thank you.
A Yes, I have.
Q Okay. How many adolescents would you say you've monitored?
A I would say there was probably about three or

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

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

Q Okay. Sorry, tell me that number again?

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

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

A To my knowledge, yes.

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

A Yes.

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

A Could you clarify what you mean?

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

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

Q Is it correct that you were appointed to the

Board of Osteopathic Medicine in December of 2022?
A That's correct.
Q And the rules at issue that I mentioned weren't voted on until February of 2023, so is it fair to say you were on the board at that time?
A That is fair to say, yes.
Q They went into effect in March of 2023?
A Correct.
Q Okay. Great. Paragraph 16 of your expert report, which is on page 5, you list the additional sources documents that you reviewed in creating your expert report. This includes the two rules that I just mentioned that went into effect in March, as well as SB 254 and it's implementing emergency rules. Is that accurate that those are what you relied upon writing this report?
A Yes.
Q And are you -- you are opining on the treatment for minors, correct?
A Correct.
Q You, as in your role, you treat minors, not adult; is that correct?
A Correct.
Q And you've never provided treatment for adults?
A Correct.

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

A That is correct.

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

A That is correct.

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

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

Q And what materials were provided to that committee?

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

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

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

A Uh-huh.

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

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

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

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

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

A Okay.

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

A I would assume so.

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

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

BY MS. CHRISS:

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

A Correct.

Q Have you ever testified as an expert?

A No, I have not.

Q Have you ever testified in any capacity?

A No, I have not.

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

A That's a very open question.

Q What's your understanding of gender identity?

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

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

A I do.

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

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

Q Can you explain a little more about what you mean?

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

their true gender identity is.

Q Are you familiar with the WPATH Standards of Care?

A Yes.

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

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

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

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

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

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

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

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

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

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

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

A Correct, for other conditions.

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

A Could you clarify what you mean by that?

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

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

Q And where are these patients receiving their

treatment for gender dysphoria?

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

Q Which centers?

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

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

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

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

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

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

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

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

Q Where were those four receiving treatment?

A I didn't ask.

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

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

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

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

A I haven't.

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

A I think that's very unclear.

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

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

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

A Yes.

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

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

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

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

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

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

A Some instances yes.

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

A In some, yes.

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

A Yes.

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

A What do you mean by dissuade?

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

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

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

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

A I do.

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

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

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

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

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

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

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

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

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

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

Q But you have banned the treatment for minors

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

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

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

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

Q And what is the basis for that understanding?

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

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

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

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

A I believe so.

Q But you can't name which countries?

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

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

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

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

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

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

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

A Directly, no.

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

A Sorry, could you repeat that?

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

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

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

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

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

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

A No.

Q Dot medical risks of hormones justify restricting or limiting their use of gender dysphoria in adults?

A Sorry, can you repeat?

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

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

Q So would that be a no?

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

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

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

A No, I am not aware.

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

THE WITNESS: Sure.

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

BY MS. CHRISS:

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

A Page 7.

Q Yep. I went to page 22.

A You said item 22. I was hearing you.

Q Do you want to switch seats?

A Sometimes, yes.

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

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

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

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

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

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

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

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

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

Q Okay. When did these weekly conferences begin?

A It was happening long before I started at Nemours.

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

A That is correct, yes.

Q Who decided to review those guidelines?

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

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

Q Okay. And when was this?

A That was around the time they were released.

Q So around 2017?

A Around that time, yes.

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

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

Q Was Dr. Benson involved in that meeting?

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

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

psychologist, Dr. Buckloh was she involved?

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

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

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

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

A Yes.

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

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

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

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

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

A No, we did not.

Q And you reviewed the WPATH Guidelines as well?

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

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

A Two pediatric endocrinologists.

Q And who were those?

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

Q One more time.

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

Santiago. We call her Lou.

Q I am going to. Thank you.

A She won't mind.

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

A That is correct.

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

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

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

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

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

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

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

A Correct.

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

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

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

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

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

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

A In the meeting?

Q In your meetings, in your evaluations of these guidelines?

A No.

Q Why not?

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

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

A That's Dr. Buckloh.

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

A Her.

Q Her interest in this area?

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

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

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

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

A Yes.

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

A Yes.

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

A Uh-huh.

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

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

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

A Sure.

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

A No, I am not.

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

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

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

Q And when were these meetings?

A They were back in 2017.

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

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

Q Was Dr. Buckloh involved in that subgroup?

A Uh-huh.

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

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

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

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

A Sorry I wrote a long paragraph.

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

A Yes.

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

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

Hasan.

Q But you prescribed GhRH analogues for other conditions?

A Correct.

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

A Correct.

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

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

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

A That was our position, yes.

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

A The most common would be central precocious puberty.

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

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

Q Any other prescriptions you prescribed the blockers for?

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

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

A That is correct.

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

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

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

A Yes.

Q You state, continuing in that same paragraph,

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

A Correct.

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

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

Q Okay. And that was what was --

A That was the basis of what we were doing.

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

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

Q And do you know why that is?

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

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

Q So these are prepubertal minors?

A She she's prepubertal as well.

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

A No, she did not.

Q How many did meet the criteria?

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

Q And those folks were referred to you?

A To Dr. Hasan and Dr. Torres.

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

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

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

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

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

Q And how many pursued puberty blockers?

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

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

A No, I don't.

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

A From the Endocrine Society.

Q So the same as Dr. Buckloh?

A Uh-huh.

Q You then said that the risks and benefits were

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

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

Q Anything else?

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

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

A Yes.

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

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

Q So the risks indicated --

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

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

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

Q Are they labeled by your clinic name?

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

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

A Yes.

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

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

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

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

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

A No, we did not.

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

A No, we did not.

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

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

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

A As part of the treatment team? Yes.

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

A That's true.

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

A As far as pediatric endocrinology?

Q Uh-huh.

A Yes, they have a role.

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

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

A Uh-huh.

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

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

Q Anything else?

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

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

A Sure.

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

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

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

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

Q Did that include Dr. Buckloh?

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

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

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

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

MR. PERKO: Object to form.

THE WITNESS: I can answer?

MR. PERKO: Yes.

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

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

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

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

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

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

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

A Correct.

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

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

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

A They are run by the hierarchy, but --

Q Right.

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

Q But they did have a gender multidisciplinary --

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

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

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

until they could get into another center.

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

MR. PERKO: Object to form.

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

BY MS. CHRISS:

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

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

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

A Yes.

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

A Mostly assessing, yes.

Q -- and not prescribing?

A Uh-huh.

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

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

Q Okay.

A So providing transgender care.

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

A Correct.

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

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

Q And by moving forward you mean what?

A Providing some care for transgender patients.

Q So puberty blocking medication?

A Correct.

Q Okay. And did you establish a multidisciplinary clinic?

A No.

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

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

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

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

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

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

A Outside of research? No.

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

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

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

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

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

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

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

Q That's just in the context of research?

A That's in the context of research.

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

A Yes.

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

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

Q Do you require written consent?

A No, I do not.

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

A Correct.

Q You stated in that same paragraph: At their

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

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

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

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

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

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

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

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

Q Do you have a copy of the Texas one?

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

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

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

Q When you said there were many unknowns, and

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

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

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

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

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

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

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

A Most are.

Q In the pediatric population?

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

we've got going on?

Q And you provide that verbally though?

A Correct.

Q Not through a written consent?

A Correct.

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

A I don't remember, no.

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

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

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

A Correct.

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

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

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

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

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

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

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

A No.

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

A No.

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

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

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

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

A No.

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

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

Q But for non-research?

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

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

A No.

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

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

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

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

Q How many families would you say were aggressive?

A Oh, a small handful.

Q And how many would you say demanded treatment?

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

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

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

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

A Correct.

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

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

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

A Oh, I couldn't tell you.

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

A Yes.

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

were prescribed the treatments for gender dysphoria?

A No, I did not.

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

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

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

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

Q You say that was one or two patients?

A Uh-huh.

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

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

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

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

A Uh-huh.

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

conditions?

A Uh-huh.

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

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

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

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

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

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

Q Okay.

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

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

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

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

A Those specific ones, yes.

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

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

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

A Not all of them, no.

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

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

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

A None, because I didn't prescribe testosterone.

Q And how many were on estrogen?

A None, because I don't prescribe estrogen.

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

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

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

Q Did any of them elect to stop the treatment?

A For the puberty blockers, no.

Q How many of them were seeing Dr. Buckloh?

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

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

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

Q Do you know who?

A No.

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

A Hasan.

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

A For the treatment of gender dysphoria.

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

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

Q So is Dr. Lou?

A Dr. Lou is fine.

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

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

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

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

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

A No.

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

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

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

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

A Could you repeat that or rephrase it?

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

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

Q So who's that individual?

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

Q Do you know meeting that was?

A It had to be the February meeting.

Q February 2023, obviously?

A Yes.

Q Okay.

A Well, obviously.

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

A Yes.

Q And have you ever done so previously?

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

Q Does Dr. Benson provide treatment for gender dysphoria?

A Not to my knowledge.

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

A Yes.

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

A Yes.

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

A Correct.

Q Do you agree with those recommendations?

A Yes.

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

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

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

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

MR. PERKO: Object to form.

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

Q Okay. What specific study are you referring to?

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

Q Dr. Mortensen, are you familiar with the letter

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

A Yes.

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

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

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

A It would not be a surprise.

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

A Yes.

MR. PERKO: Object to form.

BY MS. CHRISS:

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

A Somewhat.

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

through the rulemaking process?

A Correct.

Q Are you familiar with -- strike that.

Are aware that on June 2nd, 2022, Surgeon General Ladapo sent a letter to the Boards of Medicine sharing that guidance in the GAPMS Report from the Agency for Healthcare Administration?

A Yes.

Q And requesting that you take action on that matter?

A Yes.

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

A Yes.

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

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

A Yes.

BY MS. CHRISS:

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

A Yes, I read that.

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

A Yes.

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

A Well, the emergency consents.

Q Right. So that was after SB 254?

A Yes.

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

A Other than the emergency consent forms, no.

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

A Yes.

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

A Yes.

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

A Yes.

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

A I believe so.

MR. PERKO: Object to form.

A I believe so.

BY MS. CHRISS:

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

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

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

A I believe so.

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

A I believe so.

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

A I believe so.

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

MR. PERKO: Object to form.

A I'm not really sure.
BY MS. CHRISS:
Q Okay. And just looking at these informed consent forms again, is it correct they require only one signature at the bottom?
A That is correct.
Q And that they have one, two, three, four, five, six, seven bullet points?
A Yes.
Q And to the best of your knowledge do they require a witness to sign?
A To the best of my knowledge, no.
Q And do they require any initials?
A No, they do not.
Q Paragraph 6 on page 2 states: Section 458.3311(b) Florida Statutes, grants the Board authority to establish standards of care for particular practice settings, including, but not limited to, the performance of complex or multiple procedures and informed consent. What does complex or multiple procedures mean?
MR. PERKO: Object to form.
A It could mean a number of things.
BY MS. CHRISS:
Q What do you understand it to mean?
A I think if we are talking more specifically for

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

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

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

Q Okay.

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

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

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

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

A Yes.
Q And who was the provider that prescribed that care?
A I do not recall off the top of my head.
Q At what institution did they work?
A I do not know, sometimes I didn't really get into it with the families or the patients.
Q Did you ever file any sort of complaint with the Board or ethical violation anything of that sort?
A No, but sometimes I wish I did.
Q But you don't remember who the prescriber was?
A No.
Q Are you aware -- we are done with that exhibit. Are you aware that the Board of Medicine and Osteopathic Medicine met on August 5th, 2022, to discuss this petition to initiate rulemaking?
A Yes.
Q Are you aware that Surgeon General Ladapo was invited to speak?
A Yes.
Q And I should ask, this is all part of the rulemaking record in the public books, I assume you are familiar with those?
A Yes.
Q And I presume that you got up to speed, having

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

A Oh, yes.

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

A Yes.

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

A I am unaware.

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

A Yes.

Q Is that the individual you were mentioning earlier?

A Maybe, I don't know.

Q And he presented the petition to initiate rulemaking?

A Yes.

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

A Yes.

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

transgender youth?

MR. PERKO: Object to form.

A Yes.

BY MS. CHRISS:

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

A Not really.

Q Are you familiar that he presented to the Boards?

A Yes.

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

A I'm sorry, repeat that?

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

BY MS. CHRISS:

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

MR. PERKO: Object to form.

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

BY MS. CHRISS:

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

MR. PERKO: Object to form.
A No, not aware of that.
BY MS. CHRISS:
Q You are familiar with the GAPMS report?
A Yes.
Q And Dr. Van Meter was one of the consultants that created that report?
MR. PERKO: Object to form; relevance.
A Yeah, I'm not sure.
BY MS. CHRISS:
Q That report was presented to the Boards as a part of what you were to rely upon in the decisionmaking process in deciding whether to pursue these rules; is that correct?
MR. PERKO: Object to form.
A I'm not sure what you are asking me? So I didn't really answer.
BY MS. CHRISS:
Q Oh, are you -- let me break this up to separate questions, apologies. So you're aware of the GAPMS report that found treatment for gender dysphoria to be experimental?
A Yes.
Q And that was what we discussed was the Agency's findings in the petition to initiate rulemaking that we

just looked at?
A Yes.
Q Okay. And are you aware that Dr. Van Meter was one of the consultants who helped with the creation of the GAPMS report?
MR. PERKO: Object to form.
A I wasn't aware who was involved in that process.
BY MS. CHRISS:
Q But you were aware that Dr. Van Meter presented to the Board?
A Yes.
Q On these findings?
A Yes.
Q In your experience, have you seen other instances where an outside person was paid to come speak to the Board about an issue like this?
A I wouldn't know anything about that.
Q During your time on the Board has that happened?
A I have no knowledge of that.
Q Okay. So the Board of Osteopathic Medicine then met on August 12th to discuss the joint -- let me back up. There was a joint committee formed with certain members from the Board of Medicine and certain

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

A That is correct.

Q You would later be a part of that committee?

A That is correct.

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

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

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

A Yes.

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

A Not personally, no.

Q Are you aware of him?

A No.

Q The meeting minutes reflected --

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

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

MR. REDBURN: Sure it does.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. REDBURN: Go ahead.

THE WITNESS: Can I take a bathroom break?

MS. CHRISS: Absolutely.

MR. REDBURN: Should we break for lunch?
MR. PERKO: That's probably a good idea.
MS. CHRISS: Yeah. I think that makes sense. Come back at 2:00.
(Break taken at 12:52 until 2:02 p.m.)
BY MS. CHRISS:
Q Dr. Mortensen, here we are again. I am going to show you -- hand you what we'll mark as Exhibit 4. If you don't mind taking a moment to look at this document. The first page is an e-mail from Matthew Benson, then the pages that follow are an open letter to the Florida Board of Medicine. Oh, actually, sorry, could I have these exhibits back for a moment. Sorry about that.
Do you recall writing an open letter to the Board of Medicine with Dr. Benson and several other physicians?
(Plaintiffs' Exhibit Number 4 was marked for identification.)
A Yes, I do.
BY MS. CHRISS:
Q Was that on or about September 26, 2022?
A I believe I just saw that date, yes.
Q And apologies for that.
A No, it helped jog the memory.

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

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

Q And you signed onto this letter, correct?

A Correct.

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

A That is correct.

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

A That is correct.

Q Who is Larry Fox?

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

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

A Correct.

Q Dr. Mauras?

A Dr. Mauras.

Q Mauras.

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

Q Does she provide any treatment for gender dysphoria?

A No.

Q Monica Mortensen, that's you.

A That's me. That's Lou.

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

A Sure.

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

A It really doesn't, yeah.

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

A That's correct.

Q Dr. Snyder?

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

Q Does she provide treatment for gender dysphoria?

A No, she does not.

Q There's an APRN Joe Permuy?

A Uh-huh.

Q Who's he?

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

Q Does he provide treatment for gender dysphoria?

A No, he does not.

Q Same question Kaley Carroll?

A Also one of our nurse practitioners.

Q And does she provide treatment for gender dysphoria?

A No, she does not.

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

A Not to my knowledge.

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

A That's correct.

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

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

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

A That's correct.

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

A Shortly before that.

Q Okay. Who were you contacted by?

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

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

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

Q Okay. When did you apply?

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

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

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

Q And who had to provide input on that process?

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

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

A I would assume as well.

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

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

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

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

Q Did anyone other than Dr. Benson encourage you

to apply?

A No.

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

A That's my understanding.

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

A Not to my knowledge, no.

Q Like, who informed you you had been appointed?

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

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

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

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

A Yes.

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

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

Q No. No.

A -- and that's not true.

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

A Correct.

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

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

didn't want to join that committee, so.

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

A Dr. Benson.

Q Just you and Dr. Benson?

A Are pediatric endocrinologists, yes.

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

A No.

Q He didn't talk to you about that?

A No.

Q Did you provide any testimony or written comments?

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

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

A He had informed us that he was going to send a letter and he asked us to review and see if it seemed factual or if anything seemed wrong or inappropriate, then if any of us wanted to sign the letter we could.

Q So you reviewed it, I assume agreed with it,

and signed on?

A Yes.

Q Were there discussions between the authors -- or the signatories?

A Not in regards to, like, the huge content, I mean, we all knew who was signing, because our names were on there. Dr. Benson I think spent a good time with Dr. Mauras in making some of the edits to the letter.

Q When you were working on this letter did you discuss -- there's a part of the letter that discusses youth and young adults that are openly expressing regret and de-transitioning. Did you guys talk about detransitioners and that experience?

A I know that with Dr. Hasan and Dr. Torres, because that's, kind of, their area that they were going into, they mentioned that they had heard, and I believe that they might have had a patient or two, I don't know, it's all hearsay, about detransitioners. But there's been a lot of stuff in the news about detransitioners. So it's not that it's an unheard of topic.

Q But you haven't -- I think you mentioned early you hadn't had any patients report to you that they had de-transitioned or regretted --

A Correct.

Q -- treatment? Are you aware that Dr. Benson participated in a round table discussion with Surgeon General Ladapo and detransitioners?

A No, I didn't.

Q He didn't share anything about that with you?

A No. We have to be careful with the whole Board thing because of the Sunshine State Law. There's a lot of things, especially since we know that transgender is a topic for the Board, that we just kind of shut and don't discuss that. He might discuss it with other colleagues, I might discussion it with other colleagues, but I didn't know that he did that, or if he did I don't recall it.

Q I apologize. So I should have specified the timeline. So prior to you-all being appointed to the Board, so no issues with communications there, the round table that he participated in was on July 8th of 2022. So I was wondering if his experience hearing from detransitioners was at all discussed in you-all writing about that topic in this letter in September?

A I don't recall discussing that.

Q Okay. Would you -- you mentioned earlier to the best of your knowledge Dr. Benson has not provided treatment for gender dysphoria, correct?

A Correct.

Q Would you describe him as an expert in gender dysphoria?

A I -- I mean, I would say he's well-read on it. I wouldn't say he's an expert on it.

Q I'm going to show you what we'll mark, I apologize I had to take this last one back, so actual Number 4. There's two copies there. Dr. Mortensen, this is the -- what appears to be the agenda from that round table. I just want to ask if you are familiar with some of these names, if you look under intro you'll see, you know, expert Matthew Benson. Are you familiar with a Stella O'Malley?

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

A No.

BY MS. CHRISS:

Q Or a Joseph Burgo?

A No.

Q Do you recall during several of the Board of Medicine meetings that you state you reviewed the public book and the testimony of from the meeting minutes, do you recall hearing from a detransitioner Chloe Cole?

A Yes.

Q And a detransitioner Sophia Galvin?

A Yes.

Q And a parent named Amy Atterberry?
A Yes.
Q Okay. So those were folks that also testified at the Board of Medicine meetings?
A Correct.
Q Have you had any other experiences with those individuals?
A Like, personal experience?
Q Through your role on the Board or elsewhere?
A Oh, no. No. I think Chloe is quite an advocate, so I've seen some interviews.
Q Yes, so if you look below of run of show where you see Dr. Benson spoke after it says Amy, Billy Burleigh, Erin Brewer, and Richie. Do you recall in the public book that you reviewed seeing written comments from these individuals?
A I don't recall.
Q Okay. And then if we could -- sorry, below where it says: Experts and the evolution of gender-affirming care, you see it says Dr. Benson is listed as one of the experts, and discuss the knowns and unknowns of medical intervention with puberty blockers and cross-sex hormone treatment models in children.
Did Dr. Benson participate in any of the meetings you discussed earlier at Nemours where the

provision of this care was discussed?

A No, I don't think he was there at the time.

Q Do you know if prior to his joining Nemours he was providing treatment for gender dysphoria?

A I'm not sure.

Q Okay. Thank you. If you could just flip to the back briefly, the last bullet point says: Let them know their stories will be provided to the Board of Medicine and we will follow-up to make sure their stories are told. You see that?

A Uh-huh. Yes.

Q Is that consistent with your experience of these folks stories being told?

A Yes, a lot of stories were told.

Q All right. Thank you. Dr. Mortensen.

A Yes, that's me.

Q My apologies. Do you know how comments -- public comments are submitted to the Board?

A You mean for the actual meeting or do you mean via the ones that come in through the iViewer?

Q Excellent question. Let's first do the ones that come in like the one you submitted to the Boards.

A So you just -- you can e-mail the Board of Medicine.

Q Okay. And what about in-person testimony at

the hearings, how does that happen?

A So typically they would -- in the meetings I've been at they would pass around cards and people would sign up. There are certain circumstances I think where people were on the agenda, but they would have cards to put their name on and then there was just a stack and they were shuffled and they were put in front of the moderator and the moderator would just draw from the pile.

Q Okay. If we can just -- turning back to your letter for one moment. You discuss in the letter that you submitted to the Board that this is -- that your deeply concerned about the off-label use of puberty blockers and cross-sex hormones; do you remember saying that?

A Yes.

Q What does the phrase off-label mean?

A It means that it's not FDA approved for that indication.

Q Are you aware that off-label does not mean experimental?

MR. PERKO: Object to form.

A Depends on, I guess, your interpretation of it. Sometimes when it's off-label there are -- when you get an FDA approval there are people that use it off-label

but still do research studies for it, so there's literature data to support the use of it even though they hadn't applied for through indication through the FDA. There are many meds that are used off-label, but sometimes it could be considered experimental if there really isn't a lot of data to support the use of it or the long-term outcomes.

BY MS. CHRISS:

Q So it can be experimental?

A Experimental.

Q But off-label doesn't have anything to do with whether a medication is safe and effective for a particular use?

A By saying that something is FDA approved it's saying the Food and Drug Administration has reviewed and they support the data for the indication of the use and the side effects or the risks. When it's off-label it means that it hasn't been reviewed by the FDA for that indication.

Q Is it true that medications are often used off-label, particularly in pediatrics?

A I would say that's fair.

Q Are you aware of a study that looked at off-label use using a very restrictive definition of off-label for pediatrics and found that approximately

30 percent of encounters in children's hospitals involved off-label use?

A That wouldn't be surprising.

Q Are you -- I apologize, I should have touched on this during when we were going over the CV. Are you a member of the American Academy of Pediatrics?

A Not anymore.

Q When did you stop being a member?

A I don't know, probably more than five years ago. It became too expensive with all the dues that we have to do, with all the Endocrine Society, the ADA, and the Pediatric Endocrine Society, and I only have so much money, I had to chose which was going to be the best bang for my buck.

Q Understood. Are you aware that the AAP Committee on Drugs has a statement saying in no way does a lack of labeling signify therapy is unsupported by clinical experience or data in children?

MR. PERKO: Object to form.

A I mean, it's very possible that that's what they said, but I couldn't quote you on it.

BY MS. CHRISS:

Q And would you agree that among the reasons for off-label use being common in pediatrics is that often sponsors don't seek FDA approval after it's been

approved for one use because they don't expect that the future revenue will offset the cost of obtaining approval?

A It's very fair to say yes.

Q Dr. Mortensen, earlier you mentioned that you had extensive experience treating growth problems; is that correct?

A That is correct.

Q And have you prescribed aromatase inhibitors for short stature?

A I have.

Q Are you aware that medication is not FDA approved for that medication?

A I'm very aware, which is why I tell my patients that and I also document in my notes that it's off-label use and the risk and the benefits.

Q But you don't require written consent, right?

A No, I don't.

Q And you know there's no randomized control trials supporting the use of that medication?

A Dr. Mauras had a randomized control trials in using it with (indiscernible) and she's well-published, and has traveled the world showing her data.

Q Is that a study you would be able to share with us?

A Sure.

Q Thank you. Why is it important to prescribe these types of medications, like aromatase inhibitors, to youth with growth issues?

A So part of growth hormone deficiency and growth disorders is trying to achieve a functional adult height that someone would not be considered disabled or have difficulty driving a car or all those other things. So we use growth hormone for the approval or the FDA indications of whether the growth hormone deficiency, idiopathic short stature, there's, you know, SGA, there's a list of reasons it has been FDA approved for. But sometimes when a child goes through puberty at a normal age, but rather quickly, it confuses their growth plates and compromise their adult height. So the use of the medication helps prevent the premature fusion of a growth plate, because a growth plate should take several years to fuse. So they're undergoing a medical condition that's causing fast fusion of the growth plates, and this is to help slow down that fast premature fusion to allow them more time grow to grow to achieve a functional adult height.

Q And do you -- scratch that.

Do you describe -- will you prescribe Lupron for kids with short statute or growth issues?

A I have.
Q And is it FDA approved for that condition?
A No, it is not.
Q Do you prescribe metformin for patients with Type 2 diabetes?
A I do.
Q Is it FDA approved for that indication?
A For children over the age of 10 it is.
Q Have you prescribed it for children under the age of 10?
A No, I have not.
Q You state in your open letter that there's limited data from prospective controlled trials which are the gold standard by which we judge any therapeutic intervention; is that correct?
A That is correct.
Q Do you only prescribe medications that have data from prospective controlled trials?
A No.
Q Are you aware that medical research on children is less likely to use randomized trials than is medical research for adults?
A I am not aware, I know it's more challenging, but that seems to be the studies that we do at our centers.

Q Do you believe there are times when it would be unethical to conduct randomized trials?

A Yes.

Q Can you give me an example?

A Sometimes when it's a life-threatening situation, so there have been times, like, cancer agents or things like that, that they have to get an approval for.

Q Would it be unethical to expose -- knowingly expose a participant to an inferior intervention?

MR. PERKO: Object to form.

A I think that's one of the pitfalls of research is when you do have placebo arms that is part of the risk that happens with research. So you could be giving a med that one is a placebo and one is the med and you don't know which one you are giving.

BY MS. CHRISS:

Q If you understood that the benefits of the treatment were demonstrated as alleviating the condition at issue, would you find it unethical to withhold that treatment from members of the control group?

A I'm not sure what you are asking?

Q Is it ethical to withhold treatment that you know is effective in alleviating the condition at issue?

A Could you rephrase that?

Q In your opinion, would it be ethical to withhold medical care for a person with a condition that the medical care has been shown to improve that condition?

MR. PERKO: Object to form.

A So I think -- are you asking me, like, in a research setting? Or, I mean, that's kind of the problem that happens with research is, what you do is you file for an exemption saying that we believe the benefit outweighs the risk, and that's what we are going to do, so.

BY MS. CHRISS:

Q Okay. So in your letter you state: Rapid proliferation of a myriad of clinics and programs where many of these children are prescribed these therapies on demand with little to no in depth assessment of the psychological needs of these youngsters. Do you recall that?

A I do.

Q What are the myriad of clinics you-all are referring to?

A I mean, there's been clinics outside of Florida as well. I mean, I can't list them verbatim, but I just remember that we were -- from my experience of -- there are actually some pediatricians that are doing this and

there are people across state lines that are doing it, it just seems like anybody -- anybody who wants to can provided this medicine.

Q So you state there's a myriad of clinics where they are prescribing these therapies on demand with little to no in-depth assessment. Analysis did you-all do to come to that conclusion? That there's little or no in-depth assessment?

A I think that's the basis of our experience that we've witnessed in the clinic, as I stated earlier, I had many people that would tell me they went and they saw a therapist and they got a letter saying, yes, this is what I have, and they got one hour. Just one hour and you have the diagnosis and they want to start medications today.

And the guidelines actually propose that you do more in-depth, you have more conversation. Even the Dutch waiting a long time before they started medications. So that's why we are saying this rapid pace it seems. I had patients who have gone and on their first visit I think were prescribed testosterone. I know that happened at Duke, because I had two patients who went to Duke for that.

Q So other than two patients at Duke, what other patients do you have personal knowledge of that

happening?

A That's only the personal knowledge. The rest is what I've heard from friends and colleagues.

Q Okay. So -- okay. Are you aware of whether Dr. Benson did any analysis of the clinics, or had any personal experience with patients having that experience in order to come to this conclusion?

A I don't know.

Q When a patient is assessed for gender dysphoria outside of your clinic, or even, I guess, in your clinic, I presume you don't sit in with the psychologist?

A Correct.

Q How are you able to decide how in-depth of an assessment was done for that patient?

A A lot of times it's the notes that they forward or the letter that they submit. So sometimes it's saying, you know, I've worked with this patient for two years, this has been the history, this is why they meet the criteria, so on and so forth. If I know it's a reputable source and it's confirmed by the conversation I'm having, it's a far more comfortable situation then receiving a letter that's just very generic and blank and saying, I assessed the patient, this is what they have, then asking the patient how many -- you know, how

many sessions did you have? What did you discover under the sessions? What do you know about it? Finding they were very limited evaluations.

Q How many of the letters that were sent to you were those, sort of, blank this is the patient, this is what they have?

A I can -- remember, I only have a small handful, so it was only about two.

Q And you don't remember who the therapist was that wrote that letter?

A No.

Q Okay. You state in the open letter: We commend the largest longitudinal intervention trial funded by the NIH in 2015 in US transgender youth, et cetera, et cetera. Are you familiar with that statement made? You talk about how it's critically important to do these clinical trials, right?

A (Shakes head.)

Q Do you believe that clinical trials should be occurring in Florida to study the impacts on transgender youth?

A I think there's enough people in the world and the United States doing it that we really don't have to do it here.

Q You say -- I think you've addressed it, just

want to make sure. You say: We have witnessed children being prescribed cross-sex hormones after a single brief visit to clinics. When you say witnessed, what do you mean there?

A As I said earlier, I witnessed it from two patients from Duke that they left to go there and on their first visit they were taught how to give testosterone and they had the injections on that first visit. Then Dr. Mouras and some other colleagues had shared their experience of similar situations happening at other places.

Q Of patients relaying to them --

A Relaying to them.

Q Something happened elsewhere?

A Uh-huh.

Q And how many patients would you say they experienced that with?

A I couldn't quantify.

Q Do you know what -- other than Duke, what clinics this occurred at?

A I don't recall.

Q You didn't reach out to anyone at Duke to share your concerns?

A No, instead at that time I think UF came into play and other centers in Florida came into play, so

people weren't really going to go up to Duke. We took them off our list of referring places.

Q Is -- so UF is not among the clinics that you are referring to that, are in your-all's opinion, providing this care incorrectly?

A Again, I haven't had a lot recently, but I don't -- I, myself, don't recall my patients. I believe I heard from someone else they did, there was issue, but I, myself, personally, no.

Q Okay. And you-all still refer patients there?

A Yes.

Q Okay. Similar question, you say prescribed. These folks were prescribed by physicians, and non-physician providers with limited experience and minimal to no involvement by well-trained psychologists. How did you come to know what experience the provider at the Duke clinic had for the two patients you were referring to?

A Well, when I asked the patient they weren't even seen by a psychologist or anyone up there, they were only seen by the endocrinologist. And they used the exact same generic letter that I had, and just presented it to them, took it as factual, and started medication.

Q But you don't know what experience and training

that endocrinologist had?

A No.

Q Or how many patients they had treated for gender dysphoria?

A No. As I said earlier, it's a relatively new field, so when you are defining an expert, two years, three years, five years, I mean. Ten or plus more years of direct patient care would be an expert. So seeing that this is a relative new field, there's not a lot of experts in the United States.

Q You state in your open letter: The Florida Department of Health commissioned two researchers from McMaster University. What are you referring to there?

A I don't remember.

Q It says: To understand the state of the evidence the Florida Department of Health commissioned two researchers from McMaster University where the term evidence-based medicine was coined for a systematic review of the available evidence. Then there's a link to ACHA.myflorida.com/letkidsbekids. What is the McMaster University report you are talking about?

A I don't remember all the details, I have to refresh myself on that.

Q Are you familiar with what let kids be kids is referring to?

A Vaguely, but I don't remember all of the details.

Q Okay. And in the end of your letter you state: A group of physicians, psychologists, risk management experts, ethicists, and lay people on a medical board should be able to assess the evidence while also advising on a proper standard of care as opposed to legislative and political bodies. Do you recall that?

A Yes.

Q So you agree that legislative and political bodies shouldn't be making these decisions?

MR. PERKO: Object to form.

A I think that it would be great if physicians could monitor physicians, but, unfortunately, sometimes it goes beyond that and government regulation needs to come into play. The opioid epidemic is the biggest example of that over the years.

Q When it comes to the treatment of gender dysphoria are you aware of any complaints that were filed against providers from misprescribing or misdiagnosing?

A You just had a list of people that testified saying that they did have complaints.

Q Those individuals, or is it your understanding that any of those individuals are Florida residents or

received medical care in Florida?

A I don't know, but --

Q So --

A -- I'd like to make sure they received healthcare here.

Q Are you aware of any complaints filed against providers for providing this care inappropriately?

A Not yet.

Q And when you say -- you said: A group of physicians, psychologists, risk management experts, ethicists, and lay people on a medical board should make these decisions. What psychologists were involved in the Board of Medicine and Osteopathic Medicine's rulemaking to ban gender dysphoria care for minors?

A I don't remember.

Q What about risk management experts?

A I don't recall if they were involved.

Q What about ethicists?

A I'm not sure.

Q Okay. As I mentioned earlier, there was an -- I don't know if I mentioned it earlier. Are you aware there was a public workshop on the Board of Medicine and Osteopathic Medicine's rules that were promulgated in this case that we discussed earlier?

A Sorry, I should vocalized and not make a face,

but, I'm sorry --

Q I got what you meant. It was clear.

A But for the record, I have to say, I'm sorry, what?

Q Yep, I bet that's what she's already written. What is a public workshop, in terms of the rulemaking process?

A My understanding is that it is an open forum of people, either scheduled to speak or allowed to speak, in regards to certain topics.

Q Okay. Are you aware there was a public workshop for the development of the Board of Medicine and Osteopathic Medicine's rules creating a standard of care for gender dysphoria treatment in minors?

A Yes.

Q And have you reviewed the public book that was associated with that, that workshop?

A I went through some of it, yes. Most.

Q And --

A It was a lot.

Q It was a lot. And you are aware that the Boards invited expert -- subject matter experts to speak at that meeting?

A Yes.

Q What is the purpose of a rulemaking workshop?

A I would believe it's to make rules in regards to certain issues for the public safety and health.

Q Are you aware of how the subject matter experts were selected?

A No, I am not.

Q Are you familiar with Dr. Patrick Hunter?

A Yes, I am.

Q And how?

A He's on the Board.

Q And what is his profession?

A I believe he's a pediatrician, and I think he has a background in ethics, but I'm not 100 percent sure.

Q Was he a member of the joint committee that you sat on?

A Yes.

Q Are you aware that he invited Dr. Michael Biggs to be a subject matter expert?

A No, not aware of who he invited.

Q Are you aware that he invited Dr. Kaltiala to be a subject matter expert?

A No. Again, this was before my time, so I don't know who invited or who was in charge of inviting or who chose who got to speak.

Q Okay. Are you aware that Dr. Michael Laidlaw

was one of the subject matter experts?

A I believe so, yes.

Q Are you aware he -- actually, we'll come back to that in a moment. I apologize. Who is Danielle Terrell?

A Oh, she's one of the administrators for the Osteopathic Board.

Q Would you agree that she's the executive director?

A Yes, that's her actual title, thank you.

Q Great. Have you -- strike that.

What is your understanding of Ms. Terrell's role?

A That she's one of the administrators, so she takes in a lot of the paperwork and sorts through it, works with the lawyers, works with us, works with a team of people to help with all the business that happens with the Board.

Q Is she a part of the public hearings and workshops and things like that?

A I believe she was -- had to be present.

Q What is your understanding of -- I know you touched on this earlier, but when folks show up to testify or provide public comment, what's your understanding of the process by which they are able to

do so?

A So you are meaning at the meetings?

Q Uh-huh.

A So it kind of depends on the type of meeting. I believe that on the February meeting there were people who submitted complaints that wanted to speak and so they were granted to speak, then it was open forum with the cards that we previously discussed.

Q So there's cards that you fill out when you get there and then if they choose you you get to speak; is that correct?

A Uh-huh.

Q Is it your understanding that this is random?

A Yes.

Q I'm going to show you what I'm going to actually mark this time as Exhibit 5. This is an e-mail exchange. Do you see the name where it says from up top?

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

A Yes.

BY MS. CHRISS:

Q And is that the Danielle Terrell who's the executive director of the board that you sit on?

A Yes.

Q It states, if you will turn to page 2 for me, down at the bottom where it starts: October 25th, 2022, Danielle, I work with Vernadette Broyles and she asked me to send you the list of testifiers for Friday.

Do you see that?

A Yes.

Q And Dr. Laidlaw, above that from Vernadette Broyles it says: To be clear, the expert is Dr. Michael Laidlaw, endocrinologist.

Do you see that?

A Yes.

Q If you turn to page 4 for me. For the record this is Bates stamp FDOH000042405. If you see where at the top it says: Danielle Terrell said thank you. Below that, someone named Bettye Strickland, do you know who that is?

A I think I'm on the wrong page.

Q Oh, I apologize. The fourth page. The back of the second page.

A Are we counting --

MR. PERKO: The bottom it is 4205.

A 4205. Okay.

BY MS. CHRISS:

Q Yeah. Are you there?

A Front and back. Page 4 you mean the back?

Q Yes, I apologize.

A That's okay. The other one is one-sided. I'm on the right page. Hurray.

Q Thank you. If you go to the middle where that e-mail from Danielle Terrell on Wednesday, October 26, 2022, it states: Please see the list of people below that will be the first to make public comment. We need to ensure that cards are filled out for all detransitioners and the parent.

Do you see that?

A Uh-huh.

Q Do you know who Vernadette Broyles is, the individual who sent this em-mail to Danielle Terrell?

A No.

Q Are you familiar with the Child and Parental Rights Campaign?

A Not really.

Q What do you know?

A They do child and parental rights. I mean, I'm sure they submitted things to the Board to read, but, I mean, we get, like, 6,000 pages of documents for things for and against, so I don't really associate the name for or against, so.

Q Understood.

A This is also well before my time.

Q Right. Right. I'm just trying to get an understanding of whether it is typical for the board to pre-fill out speaker cards and ensure certain people will be able to speak first. Is that your experience or understanding of how that process works?

A I'm not really sure of what the process was. All I can say is the meetings I was at they were handing out cards for people.

Q Okay. If you could turn to page 9, which at the bottom states -- or the Bates number is 000044022.

A Yes.

Q Okay. In the middle you will see where Danielle Terrell says on Thursday, October 27, 2022: Jennifer, the list contains a total of 20 people not including the SME, I believe that's meaning subject matter expert.

A Okay.

Q This would total one hour of our public comment time. How would you like me to respond to this?

Do you see that?

A Yes, I do.

Q Do you know how much time was allotted for public comment?

A I wasn't there at the meeting, so I don't know.

Q Would it be reasonable if I told you the

meeting minutes reflected two hours?

MR. PERKO: Object to form.

BY MS. CHRISS:

Q Strike that question. You are right.

So looking back, briefly, at the list I directed you to at first on page 3, starts on the bottom of page 2 and goes on to page 3. Again, detransitioners, do you recognize the names as folks who testified at the Board meeting?

A I mean, all I recognize is Chloe Cole, but she's a very prominent figure. I don't --

Q Have you -- I apologize.

A I mean, I'm terrible with names. Faces I'm better with, but I'm not really sure who they are.

Q Have you had any interaction or any involvement with Ms. Cole outside of her testifying at these hearings?

A No. And I wasn't even at that hearing.

Q Okay. Okay. Thank you. Is it your understanding that the public comments that folks submit, there's a deadline by which they are provided?

A I think you mean the time that they are allowed to fill out the card --

Q No, I'm sorry --

A -- or do you mean the time --

Q -- the one you send via e-mail.
A I'm sorry?
Q The ones you mentioned previously are submitted by e-mail?
A No, I don't even know what the timeframe is, because we get updated once all the times are -- so I'm not 100 percent sure what timeframe before the meeting people have to submit their comments. I don't know.
Q Okay. Turning back to this October 28th public workshop where -- my understanding is it was a rule development workshop; is that correct?
A That's your understanding. I think that's my understanding too. I wasn't there.
Q Are you familiar with the -- again, with the public book that was part of the administrative record in this process?
A Sure.
Q Did you review the presentation provided by Dr. Laidlaw?
A Yes.
Q I'm going to mark this as Plaintiffs' Exhibit 6, and, unfortunately, I only have one copy of the presentation, so I'll give that to Dr. Mortensen, if that's okay.
MR. PERKO: Is this marked separately?

MS. CHRISS: It is supposed to be part of this, but I accidentally only printed the one copy. It is part of the same public book this was extracted from. December 28th -- sorry, October 28th, 2022, public book produced by defendants in this case.

(Plaintiffs' Exhibit Number 6 was marked for identification.)

BY MS. CHRISS:

Q So first looking at the agenda, do you see where it says: Subject matter experts?

A Going to this one first?

Q Yeah. My apologies.

A That's okay. First page.

Q Okay. Earlier I asked you if this was fair to characterize this as a rule development workshop, I apologize, it says rule workshop. Is that your understanding of what this was?

A Yes.

Q The agenda states: Development of rule language. So that's what was happening at the meeting?

A My understanding, yes.

Q Is 64B15-14.014, is that the rule that you voted on as a member of the Board of Osteopathic Medicine on the first page of the agenda?

A I believe so, I didn't memorize the numbers,

but I believe so.

Q Okay.

A There's a lot of letters and numbers.

Q I know.

A It seems like -- those look accurate.

Q Perfect. So you'll see there's the subject matter experts we discussed previously. Discussion and development of rule language. Public comments, et cetera. Is this what a typical agenda looks like?

A Yes.

Q Great. If you can just go to the fourth page, which is really the back of the second page. Do you see the CV of Michael Biggs?

A I do.

Q Okay. Great. So if you could turn to Dr. Laidlaw's presentation, which is the PowerPoint you have in front of you.

A Okay.

Q Does this appear to be an accurate copy of the presentation that Dr. Laidlaw submitted to the Board?

A It does.

Q And this was included in the public book for this meeting?

A It was.

Q Great. We can move on.

A Please.

Q You are not enjoying this?

A I had better days.

MR. PERKO: So Laidlaw presentation should go with the --

MS. CHRISS: Yes. I apologize.

THE WITNESS: With 6.

BY MS. CHRISS:

Q I'm going to mark this as Plaintiffs' Exhibit 7. This is one last -- I think last excerpt from that same public book. If you could just take a quick look. Are you familiar with a Dr. Gregory Coffman?

(Plaintiffs' Exhibit Number 7 was marked for identification.)

A Not personally.

BY MS. CHRISS:

Q Are you aware that he was appointed to the Board of Medicine?

A Oh, okay. Yeah. I'm not great with names. I said that earlier.

Q That's okay. Are you aware that he was a member of the Rules Committee as well?

A The Rules Committee? I'm really trying to remember what his face looks like right now.

Q I won't tell him.

A Now that you are telling me he's a member of the Board, how embarrassing. I didn't memorize their names.

Q That's okay.

A I must have talked to him. Okay.

Q Dr. Coffman was appointed at the same time as Dr. Benson to the Board of Medicine. Just, if you are not familiar with him, no trouble, this is just a statement that he submitted to the Boards prior to being appointed to the Board of Medicine. But we can move on.

So, Dr. Mortensen, earlier we discussed a little bit about the vote, sort of, decision to remove the IRB-approved clinical trial exception to this rule, but what is your understanding of the basis for the original inclusion of that exception in the rule?

A I wasn't there for the first part, which was the Rules Committee. And my understanding there was a split between whether research should be included or excluded. My understanding is we didn't hold authority over it anyway. My feeling is is that it didn't really matter if it was or it wasn't that. I feel like there's enough people doing research in the world that we really didn't need it, it wasn't a deal-breaker for me.

Q Are you aware that the Board of Medicine voted

on November 4th, 2022, to remove that IRB-approved clinical exception, but the Board of Osteopathic Medicine that you would come to sit on did not --

A Correct.

Q -- and voted not to remove that?

A Correct.

Q And what is your understanding of why they voted to keep that in?

A I don't know, because I wasn't a member of the Board at that time, that information wasn't made privy to me.

Q So between November -- between you being appointed in December, and you taking a vote on the removal of that section in February, there were no -- were there any discussions between board members as to --

A There wasn't with this board member with any of the other board members. If other board members had a discussions I'm not privy to that.

Q Are you aware that during the November 4th, 2022, meeting, which I have the meeting minutes for, if it would be helpful, but I just will ask if you are aware first, that Drs. Vila -- am I saying that right?

A Vila sounds familiar, yes.

Q Okay. Dr. Vila and Dr. Hunter provided their

explanation of why they thought the IRB-approved clinical exception should be removed?

A I vaguely recall that conversation -- during the presentation, yes.

Q Okay. And do you recall them talking about hearing extensive testimony from detransitioners and that being a part of their decisionmaking?

A I don't remember that exactly, but it's very possible.

Q Okay. And at that meeting the Board of Osteopathic Medicine you unanimously voted to reject the removal of that exception, right?

A Correct.

Q Are you familiar with Dr. Patrick Hunter's affiliations with any other groups?

A The only that I know is what's been bought up at the meetings.

Q Has -- did that include his membership with a group called Genspect?

A Possible.

Q Okay. What about SEGM, The Society for Evidence-Based Gender Medicine?

A I believe so.

Q And are you familiar with SEGM or Genspect?

A Not really.

Q Are you aware that they are, sort of, self-described anti-transgender organizations?

MR. PERKO: Object to form.

A I believe it if you say so. I didn't really look them up.

BY MS. CHRISS:

Q Okay. When you were appointed to the Board on December 6, 2022, did Dr. -- did you take someone's place?

A I would assume so. Usually they don't create new board positions, they are usually replacing somebody that's no longer on the board. That's my assumption.

Q Was it your understanding that Drs. Schwemmer, Gadea, and Mendez were removed from the Board when you and several others joined?

A I really didn't know who the previous board members were.

Q Okay. No problem?

A It's like when a physician leaves a practice, bygones, I don't know who they were.

Q I won't tell.

A I don't care. I got to focus on what I got to focus on.

Q Okay. And when the Boards published their joint notices of public hearing on the proposed rules on

January 9th is it your understanding that the Board of Medicine rule, and the Board of Osteopathic Medicine rule, differed slightly, in that the Board of Osteopathic Medicine rule still included the exception?

A Yes, it's my understanding.

Q Were you present at the February 10th, 2023, hearing?

A I sure was.

Q And you participated in this hearing?

A I did.

Q What is the purpose of a public hearing?

A It's to give the public an opportunity to speak on the topic, whether it be from a professional standpoint or a personal standpoint.

Q And you are aware, I think you mentioned earlier, that there were requests presented to the Board for the hearing, petitions for the hearing?

A Yes, that's my understanding.

Q And are you aware that four out of six of the requests for the hearing were from folks urging the Boards not to adopt the rules?

A I didn't pay attention as to how many were for or against, and I didn't create the agenda.

Q Right. You reviewed the reading materials --

A But I reviewed the statements --

Q -- prior too?

A Yes, I did. Like 10,000 pages, yeah.

Q Do you recall reviewing -- I'm going to mark this as Exhibit 8. Did you review this petition -- sorry, petition for a rule hearing by a group called Gender Analysis?

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

A I reviewed it, yes.

BY MS. CHRISS:

Q So you are familiar with the allegations therein?

A Yes.

Q Did the Boards considered this in their decisionmaking?

A I don't know what they used in their decisionmaking, I can only speak to what I used in mine.

Q Okay. Did you consider it?

A I reviewed all of it, and what everything tells me here is that nobody knows what's good and what's wrong and what's bad and how this is and how to do it and how to treat it. So what I gather from hearing the stories and reading this, and reading the medical literature, is that no one knows what causes transgender, no one knows is it medical? Is it

psychological?

No one knows what's the best route of treatment, and everyone's hoping to find the best answer. And that the medical people are very divided over what they believe, and even the community is divided over what it needs. So from everything that I read in the pros and the cons, it tells me that I've got some people who feel very strongly on the one end, very strongly on the other, and they both have some good arguments, and some of them have some not so great arguments.

But the reality is we don't know what we don't know and we don't really know what the best path of treatment is and this is a relatively new field and it has -- going to have some repercussions down the road. And even though science tries to move forward and try the best path for the best routes of treatment, we don't even really know what is the best path of treatment.

Q So the answer is, yes, you reviewed that document --

A Yes.

Q -- in your decisionmaking?

A Yes.

Q Okay. Are you aware that every major medical association in our country supports the provision of

gender-firming care for transgender individuals for whom it is medically necessary?

MR. PERKO: Object to form.

A I am aware that those board members who submit that is, but not every member who sits on all of those societies agree with the statements that are submitted. So your statement is accurate, but I think that it's leading saying that every member of all those societies back those statements. That is not factual.

Q If I did state that, that was not the intent of my question --

A Just being clear.

Q -- I stated every major medical organization support these treatments?

A I believe so.

Q Okay. And have you spoken to any of the members of the -- I think you said the board members of these organizations who have expressed to you they disagree?

A Oh, I know a lot of people on the Pediatric Endocrine Society, I know a lot of people on the Endocrine Society, I know people who are still members of the AP who do not agree with the statements. I know people who are starting to withdraw from those groups. I know a lot of people are afraid to speak up, but

there's a lot of people who feel that the Endocrine Society made this statement so the American Academy of Pediatrics backs it. They are not experts. They are relying on the experts to state that statement. So are they really trained and experienced on it? No. But that's just like when the American Heart Disease says that you need an hour of exercise, the AAP is going to back the experts.

So all of these people backed the experts, but the experts are not correct on everything. There's a lot the experts don't know.

Q Do you follow the Endocrine Society Guidelines, generally, in other provision of other types of care?

A Generally, yes.

Q And when you were providing treatment for gender dysphoria you stated previously in the deposition that you followed the Endocrine Society Guidelines?

A Yes, I wanted to believe that it could help. I wanted to believe it.

Q Are you aware of any medical organization that opposes the treatment of gender dysphoria?

A No, I'm not aware.

Q So just returning for a moment to the November 4th hearing that we spoke about. There were two individuals who provided information on their

petitions for the hearing; is that correct?

A For the?

Q Who requested the hearing.

A For the hearing for February?

Q Yes.

A Or November?

Q Did I say November? I apologize.

A I thought you did, that's why I got confused.

Q So sorry. I tried to memorize all these dates.

A Same. It's hard.

Q February 10th, 2023, there were two individuals that spoke about their petitions, correct?

A To my knowledge, yes.

Q And one of those was Mr. Wilson from the Florida Department of Health?

A Yes, I believe so.

Q And he encouraged the Board of Osteopathic Medicine to remove the research exemption?

A Correct.

Q Did you -- do you recall during that meeting, or that hearing, hearing from multiple doctors that provide treatment for gender dysphoria in the state of Florida?

A Yes, I do recall hearing.

Q Including Dr. Michael Howler and Dr. Paul

Arons?

A Uh-huh.

Q And do you recall them testifying about their personal clinical experience in treating many minors who experience gender dysphoria?

A Yes.

Q And do you recall their testimony about the positive benefits that their patients received through this treatment?

A Yes.

Q Did the Board of Osteopathic Medicine take the public comments into consideration before voting?

A I don't know what all -- I can only speak as myself, because we didn't talk. I heard everything that they said, and I listened. Some of it was very heartbreaking and emotional and moving, so I listened wholeheartedly with an open mind to hear everything they had to say.

Q And did it impact your opinion at all?

A It did, but it didn't change my opinion that there's so many unknowns that it's not very safe for someone under the age of 18.

Q Is it accurate that the -- actually, I should just show you. One moment. Mark this as Plaintiffs' 9. So under Board of Osteopathic Medicine on the first page

you see your name, members present?

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

A Yes.

BY MS. CHRISS:

Q Okay. If you would just turn to the very back where it says: Dr. DiPietro -- am I saying that correctly?

A Yes.

Q Called the Board of Osteopathic Medicine meeting to order at 4:21 p.m. Dr. DiPietro asked the Board of Osteopathic Medicine members if there was any motion to change or modify the rule as it currently stands. Dr. Ducatel made a motion to remove the current research exception in order to mirror of Board of Medicine rule. There was no discussion between members. The motion to remove the current research exception was seconded and approved unanimously and the meeting -- summarizing -- the meeting was adjourned at 4:23 p.m. A motion to adjourn the meeting was approved unanimously at 4:23 p.m.

A Correct.

Q So I'm not great at math, but it seems like it was two minutes between the calling to order and the adjournment. Why are -- I guess I should ask, to the

best of your knowledge, you can only speak for yourself, why was there no discussion of the information that the Board had learned during the meeting?

A It was offered, but I, myself, had been sitting there for the whole time and had read all the things and went through everything else, so I had time to see what I had, and I knew where I was going to go with it. I suppose everyone else felt the same.

Q So just -- the previous vote, November 4th, unanimously everybody voted to reject the removal of the exemption, then February, no one -- no discussion, but in February they unanimously voted to remove?

A I wasn't there for November, so I'll take your word on it.

Q Just make sure I got this correct --

A But for this meeting the motion was to remove the research exemption. It was discussed, people talked about it, it was offered did anybody else want further discussion on it? I already knew where I was going to go on it based on everything I was hearing, I assume everybody else did, and we agreed on it.

Q So I believe you stated previously the reason that you didn't think IRB-approved clinical trials were necessary, despite stating in your open letter that that was so important to conduct such trials to gather

evidence, you didn't think that was something that should be happening in the state of Florida?

A Agreed. I think that, and I believe that even WPATH and Endocrine Society say more research is needed, more research is needed, but I don't think we need to do it in Florida. I think there's plenty of other institutions in this nation and the world that already started research, so I don't think it needs to be duplicated.

Q So you voted to remove the opportunity and ability of any provider in the state of Florida to conduct that research?

A In children, yes.

Q You mentioned a moment ago there was testimony that was heartbreaking. Can you just elaborate on what testimony you found heartbreaking?

A It's very -- as a physician, and maybe as a person, as a human being, to hear someone suffering, it's very hard to hear. I mean, I also see it in my clinic that's it's heartbreaking. You know, I think hearing some of the stories of what families were going through and the struggles that they are having, it's hard not to, you know, be moved by somebody experiencing a struggle. I mean, we see at in our clinic too with kids who have cancer, and long-term diabetes, I mean,

anyone who has a medical disorder, which I'm not saying it's a mental disorder, I'm saying a medical disorder, they are going to have struggles and it's hard to see people struggling.

And as a physician we want to help, which is one of the reasons why we wanted to believe the guidelines and were willing to entertain the guidelines, even though they were loose, is if it could provide some help and support. And we couldn't make ourselves a center, but if we could help a little bit of support until they could get into the place they really needed to be, then we were okay with it at first.

But when we really started to experience the negative side and see where things were going, it just didn't seem reasonable or feasible anymore. It seems like this has exploded and that there's really not any real regulation on anything. That these treatments are being caused and given to kids at younger and younger ages and stages.

Q Did you credit the testimony of the doctors that spoke directly to you about the tremendous positive benefits these treatments have had on their patients?

MR. PERKO: Object to form.

A I heard what they said. I also know they are living in a bubble and they believe what they want to

believe too. So -- there are also people who said that it proved benefit for them. But why does it have to be under 18? If they are choosing to spend the whole rest of their life, and that's what they want to do, why can't they wait until they are 18? What's a couple more years until that frontal lobe fully forms, that they can make truly informed decisions about what they want to do with their life and who they want to and where they want to go and if they want to have children.

Most 14-year-olds aren't really thinking about fertility. Even if our cancer kids, when you are saying there's a likelihood will all this chemotherapy you are not going to have children, you know, should we harvest eggs, you're having a conversation, and they don't understand. So to me to put a pause on it until they are 18 seems reasonable, since there's not enough data to support all of this and what's going to happen down the road. Seems reasonable to put a pause until they are 18.

Q Do you believe that no minor patients benefit from this treatment?

A I think that it's very hard to say. There probably is a small group, but you are throwing out the baby with the bath water. I mean, you have so many, there might be a small that has some benefit, but there

might be a bigger amount that have a negative benefit, so what do you do?

Q And you are basing this off the 10 individuals that you've personally provided treatment for, witnessed their treatment, and the two that you mentioned received what you deem inappropriate care from Duke?

A And the reading and the data and the testimony and talking with my friends and some of my other friends at the other centers that I previously mentioned.

Q Do you believe that the doctors who provided the testimony about the benefit their patients are receiving, that they are wrong about their patients benefitting from this?

A I think they want to believe that there is benefit and that there is no harm in it, but they don't actually know what the long-term harm is. The challenge we also have is when you are looking at the data you have to separate out from the trans-female to the trans-male, because testosterone is euphoric, it's one of the reasons why it's a controlled substance.

So when taking a look at psychological impact on health, if I'm giving you a medication that's going to boost your hemoglobin and give you more energy and increase your muscle mass, psychologically you are going to have some improvement. So is it that they are just

taking testosterone and that's better than taking Wellbutrin or an antidepressant or an antianxiety? Nobody knows.

But that's why it's so hard to interpret the data, is because you have a lot of confounding principles. And I think a lot of people don't understand that may be the trans-males were happier than the trans-females because we were getting a euphoric medication. And that was only a two-year study from the NIH, it didn't tell you what was going to happen five years, 10 years down the road.

MS. CHRISS: If we could take a brief break then come back on the record.

(Break taken at 3:22 p.m. until 3:33 p.m.)

(The deposition of MONICA MORTENSEN, D.O. continues in Volume 2.)

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CERTIFICATE OF OATH.

STATE OF FLORIDA)
COUNTY OF DUVAL)

I, Kelly G. Broomfield, the undersigned authority, certify that MONICA MORTENSEN, D.O., personally appeared before me on September 28, 2023, and was duly sworn.

WITNESS my hand and official seal this 8th day of October, 2023.

Kelly G. Broomfield, Stenographic Reporter
Notary Public - State of Florida
My Commission expires: September 30, 2025
My Commission No. HH 164930

REPORTER'S CERTIFICATE

STATE OF FLORIDA)
COUNTY OF DUVAL)

I, Kelly G. Broomfield, Stenographic Reporter, certify that I was authorized to and did stenographically report the deposition of MONICA MORTENSEN, D.O.; that a review of the transcript was requested; and that the transcript, Volume 1, pages 1-181, is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 8th day of October, 2023.

Kelly G. Broomfield, FPR
Stenographic Reporter
LEXITAS

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