

Jane Doe

vs.

Joseph Ladapo

Deposition of:

Monica Mortensen, D.O

September 28, 2023

Vol 1



Monica Mortensen, D.O
September 28, 2023

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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Monica Mortensen, D.O
September 28, 2023

Page 2

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Monica Mortensen, D.O
 September 28, 2023

1	I N D E X		Page 3
2	Volume 1		
3	TESTIMONY OF MONICA MORTENSEN, D.O.		PAGE
4	DIRECT EXAMINATION BY MS. CHRISS		4
5			
6	CERTIFICATE OF OATH		180
7	CERTIFICATE OF REPORTER		181
8			
9			
10	E X H I B I T S		
11	PLAINTIFFS'		
12	EXHIBIT	DESCRIPTION	PAGE
13	1	Expert Report of Monica Mortensen, D.O.	7
14	2	Advocate Health Care - About Us	20
15	3	Florida Department of Health's Petition To Initiate Rulemaking	106
16	4	Gender Dysphoria Roundtable - 7/8/22 Talking Points - Tallahassee, FL	120
17			
18	5	EMAIL - from Danielle Terrell 10/26/22 FDOH_000042396 - 000044086 and PowerPoint	153
19			
20	6	Florida Boards of Medicine/Osteopathic Medicine Joint Rules/Legislative Committee Rule Workshop - AGENDA 10/28/22	159
21			
22	7	EMAIL - From Gregory Coffman 9/19/22	161
23	8	Gender Analysis December 2022 Complaint	167
24	9	Meeting Minutes - 2/10/23 Florida Boards of Medicine/Osteopathic Medicine Rule Hearing	173
25			

Monica Mortensen, D.O.
September 28, 2023

Page 4

1 - - -

2 Proceedings began at 10:00 a.m.:

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

6 THE WITNESS: I do.

7 Whereupon:

8 MONICA MORTENSEN, D.O.

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

11 DIRECT EXAMINATION

12 BY MS. CHRISS:

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

19 A No.

20 Q So you understand that you are under oath
21 today?

22 A I do.

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

Monica Mortensen, D.O
September 28, 2023

Page 5

1 A Correct. Yes. I understand.

2 Q And this requires that you testify truthfully.

3 A Yes.

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

10 A Yes, it does.

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

16 A I understand.

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

20 A I understand, yes.

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

25 A I understand.

Monica Mortensen, D.O
September 28, 2023

Page 6

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

6 A I understand.

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

10 A No.

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

13 A No.

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

17 A Correct.

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

20 A Correct.

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

23 A Yes, I did.

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

Monica Mortensen, D.O
September 28, 2023

Page 7

1 A And one of your other experts as well, I think.

2 Q Dr. Shumer?

3 A Yes.

4 Q Okay. I am going to show you what we are going
5 to mark as Plaintiffs' Exhibit 1. Here's for the
6 witness, for you Mr. Perko. Do you recognize this
7 document?

8 (Plaintiffs' Exhibit Number 1 was marked for
9 identification.)

10 A Can I flip through really quick?

11 BY MS. CHRISS:

12 Q Please.

13 A I recognize the first page.

14 Q Make sure you've seen it.

15 A If I can just...

16 Yes.

17 Q And what do you recognize it to be?

18 A This is the expert report that I had written.

19 Q Did you bring any documents with you today?

20 A No, I did not.

21 Q Without telling me about conversations that you
22 had with counsel, what did you do to prepare for your
23 deposition today?

24 A For my deposition today?

25 Q Yes.

Monica Mortensen, D.O
September 28, 2023

Page 8

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

4 **Q Anything else?**

5 A No.

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

9 A Yes, I did.

10 **Q And how many times?**

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

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

16 A No, I did not.

17 **Q Was anyone else present when you met with**
18 **counsel?**

19 A No.

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

22 A Yes.

23 **Q Which were those?**

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

Monica Mortensen, D.O
September 28, 2023

Page 9

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

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

6 A No, I did not.

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

9 A No, just the expert reports.

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

13 A Just myself.

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

17 A Just the expert reports that your team
18 submitted.

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

21 A No.

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

24 A The concerns about the informed consents.

25 Q Did anyone else provide you with any

Monica Mortensen, D.O
September 28, 2023

Page 10

1 information that you considered in writing your report?

2 A No.

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

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

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

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

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

15 A Counsel did.

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

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 11

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

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

6 A That's correct.

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

9 A Not to my knowledge.

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

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

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

16 A I don't believe so.

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

20 A I do.

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

23 A I don't think so.

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

Monica Mortensen, D.O
September 28, 2023

Page 12

1 A Loyola University in Chicago.

2 Q What degree did you receive?

3 A A Bachelor's in Science.

4 Q And where did you attend medical school?

5 A Midwestern University, or Chicago college of
6 Osteopathic Medicine.

7 Q And where did you do your residency?

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

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

16 A I did three years at the University of Chicago.

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

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

25 Q So what were you doing between 2007 and 2014?

Monica Mortensen, D.O
September 28, 2023

Page 13

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

3 **Q Where are you currently working?**

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

6 **Q And how long have you been there?**

7 A Nine years.

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

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

16 **Q Do you have any other current professional
17 affiliations?**

18 A Can you clarify what you mean by that?

19 **Q Any other positions other than that at Nemours?**

20 A Like as source of income or?

21 **Q Yes.**

22 A No.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 14

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

3 Q Okay.

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

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

12 A In medical school? No.

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

15 A No.

16 Q How about gender identity?

17 A No.

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

25 A Correct.

Monica Mortensen, D.O
September 28, 2023

Page 15

1 Q So no presentations regarding gender dysphoria?

2 A Correct.

3 Q Or transgender healthcare?

4 A Correct.

5 Q We can turn to the next page, page A7 -- well,
6 I guess starting on A6, you list your clinical practice,
7 interests, and accomplishments. In their I see general
8 pediatric endocrinology, PCOS and menstrual disorders,
9 precocious puberty and pubertal disorders, adrenal
10 disorders, pediatric calcium and bone disorders, as well
11 as T1DM and T2DM. Are these the types of care that you
12 provide?

13 A Correct.

14 Q The conditions that you provide treatment for?

15 A Correct.

16 Q And gender dysphoria is not among those listed?

17 A That's correct.

18 Q What's a Densitometrist?

19 A So that is reading bone mineral density scans,
20 commonly referred to as DEXA scans.

21 Q Under research interests, on page A7, you list
22 use of technology to improve diabetes control,
23 precocious puberty, PCOS, metabolic effects of human
24 growth hormone, and bone disorders in pediatrics; is
25 that accurate?

Monica Mortensen, D.O
September 28, 2023

Page 16

1 A Yes.

2 Q Okay. So, again, gender dysphoria is not among
3 the research interests?

4 A Correct.

5 Q If we can go to your -- it says bibliography
6 for Number 15, are these your publications?

7 A That's correct.

8 Q So this isn't the bibliography associated with
9 your report, but rather your list of publications?

10 A Correct.

11 Q Okay. All five of these are related to
12 polycystic ovaries and polycystic ovary syndrome; is
13 that correct?

14 A That is correct.

15 Q None are related to the treatment of gender
16 dysphoria?

17 A Correct.

18 Q And these publications range from 2006 to 2012;
19 is that correct?

20 A Yes.

21 Q Are there any additional publications outside
22 of these?

23 A No.

24 Q And none of these are original peer-reviewed
25 research; is that correct?

Monica Mortensen, D.O
September 28, 2023

Page 17

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

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

12 A In relation to the consents that were written.

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 18

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

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

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

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

13 A Correct.

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

20 A No.

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

24 A Correct.

25 Q In paragraph 8 you state you completed an

Monica Mortensen, D.O
September 28, 2023

Page 19

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

4 A No.

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

7 A No.

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

10 A At what timeframe are you asking?

11 Q During your residency?

12 A No, I did not.

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

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

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

19 A It's quite possible, yes.

20 Q You are not certain?

21 A I'm not certain.

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

Monica Mortensen, D.O.
September 28, 2023

Page 20

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

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

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

8 BY MS. CHRISS:

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

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

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

20 A No.

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

24 A Correct.

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

Monica Mortensen, D.O
September 28, 2023

Page 21

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

3 A No. Personally, no.

4 Q What do you mean by personally?

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

7 Q But you were not involved in that treatment?

8 A Correct.

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

12 A Correct.

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

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

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

Monica Mortensen, D.O.
September 28, 2023

Page 22

1 **Q Anything else?**

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

4 **Q What about for delayed for precocious puberty?**

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

9 **Q What about for Type 1 diabetes?**

10 A Various forms of insulin and medical devices to
11 deliver insulin and continuous glucose monitors.

12 **Q What about for thyroid disorders?**

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

18 **Q Okay. And for growth problems?**

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

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

25 A Sure. We have -- I have prescribed birth

Monica Mortensen, D.O
September 28, 2023

Page 23

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

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

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

14 Q What do you mean by consensus guidelines?

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

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

21 A Probably around that time, yes.

22 Q So 2017 to 2019?

23 A Most likely, yes. I believe so.

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

Monica Mortensen, D.O
September 28, 2023

Page 24

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

3 **Q How many did you diagnose with gender**
4 **dysphoria?**

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

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

12 A Correct.

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

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

17 **Q What do you mean by correct?**

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

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

25 A They were already on medication, so I continued

Monica Mortensen, D.O
September 28, 2023

Page 25

1 their care.

2 Q Okay. And does that mean prescribing --

3 A A puberty blocker.

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

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

11 Q But you did feel comfortable prescribing the
12 puberty blockers?

13 A At the time I did.

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

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

Monica Mortensen, D.O.
September 28, 2023

Page 26

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

4 A That is correct.

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 27

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

3 A Correct.

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

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

7 Q What facility or what institutions did they
8 work at?

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

10 Q What's the basis for them --

11 A They are afraid of discrimination and
12 retaliation.

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

16 A They asked not to have their names released.

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

23 THE WITNESS: May I ask counsel a question?

24 MS. CHRISS: (Shakes head.)

25 MR. PERKO: You can answer the question.

Monica Mortensen, D.O
September 28, 2023

Page 28

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

4 BY MS. CHRISS:

5 Q Okay.

6 A Another one was Priti Patel.

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

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

12 Q Is that all?

13 A Yes.

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

16 A Correct.

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

19 A All of them did.

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

23 A Correct.

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

Monica Mortensen, D.O
September 28, 2023

Page 29

1 correctly diagnosed?

2 A Correct.

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

5 A Correct.

6 Q And you didn't prescribe hormones for any?

7 A Correct.

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

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

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

20 A Correct.

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

25 A Correct.

Monica Mortensen, D.O
September 28, 2023

Page 30

1 **Q What did you do to assist the adolescents?**

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

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

16 **Q What's the name of the psychologist you**
17 **mentioned?**

18 A Lisa Buckloh.

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 31

1 A That they reported they had the expertise, yes.

2 Q And you have no reason to believe they didn't,
3 right?

4 A Sure.

5 Q Have you monitored care, other than the two to
6 three patients you mentioned, have you monitored care
7 for any patients undergoing gender-affirming medical
8 treatment?

9 A Could you explain more what you mean by monitor
10 for care.

11 Q Yeah. Are there patients that you have
12 provided care to in any capacity who were receiving
13 puberty blocking medication or cross-sex hormones for
14 the treatment of their gender dysphoria?

15 A So you mean they're being treated by another
16 center, but I might be treating them for a different
17 endocrinology reason or providing support during that
18 care.

19 Q Yes.

20 A Just to clarify.

21 Q Yes. Thank you.

22 A Yes, I have.

23 Q Okay. How many adolescents would you say
24 you've monitored?

25 A I would say there was probably about three or

Monica Mortensen, D.O
September 28, 2023

Page 32

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

9 The patient -- the parent could get their
10 record and share it with their endocrinologist that was
11 managing, so there was probably just a small handful of
12 those kids, but I would say that I see probably at least
13 100 kids who have stated that they are transgender that
14 I follow for either CAH or polycystic ovarian syndrome
15 or other disorders, thyroid disease, et cetera. So they
16 are being treated elsewhere for their
17 transgender-affirming care, but they are being followed
18 from me for their other medical endocrine issues.

19 **Q Okay. Sorry, tell me that number again?**

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

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

Monica Mortensen, D.O
September 28, 2023

Page 33

1 A To my knowledge, yes.

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

5 A Yes.

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

11 A Could you clarify what you mean?

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

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

25 Q Is it correct that you were appointed to the

Monica Mortensen, D.O
September 28, 2023

Page 34

1 Board of Osteopathic Medicine in December of 2022?

2 A That's correct.

3 Q And the rules at issue that I mentioned weren't
4 voted on until February of 2023, so is it fair to say
5 you were on the board at that time?

6 A That is fair to say, yes.

7 Q They went into effect in March of 2023?

8 A Correct.

9 Q Okay. Great. Paragraph 16 of your expert
10 report, which is on page 5, you list the additional
11 sources documents that you reviewed in creating your
12 expert report. This includes the two rules that I just
13 mentioned that went into effect in March, as well as SB
14 254 and it's implementing emergency rules. Is that
15 accurate that those are what you relied upon writing
16 this report?

17 A Yes.

18 Q And are you -- you are opining on the treatment
19 for minors, correct?

20 A Correct.

21 Q You, as in your role, you treat minors, not
22 adult; is that correct?

23 A Correct.

24 Q And you've never provided treatment for adults?

25 A Correct.

Monica Mortensen, D.O
September 28, 2023

Page 35

1 Q Specifically, in paragraph 16, the rule
2 promulgated by the Board of Osteopathic Medicine, Rule
3 64B15-14.014, Standards of Practice For the Treatment of
4 Gender Dysphoria in Minors. You voted in favor of that
5 rule; is that correct?

6 A That is correct.

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

10 A That is correct.

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

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

22 Q And what materials were provided to that
23 committee?

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

Monica Mortensen, D.O
September 28, 2023

Page 36

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

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

11 A Uh-huh.

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 37

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

5 A Okay.

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

9 A I would assume so.

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

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

15 BY MS. CHRISS:

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

19 A Correct.

20 Q Have you ever testified as an expert?

21 A No, I have not.

22 Q Have you ever testified in any capacity?

23 A No, I have not.

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

Monica Mortensen, D.O
September 28, 2023

Page 38

1 A That's a very open question.

2 Q **What's your understanding of gender identity?**

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

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

12 A I do.

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

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

18 Q **Can you explain a little more about what you**
19 **mean?**

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

Monica Mortensen, D.O
September 28, 2023

Page 39

1 their true gender identity is.

2 Q Are you familiar with the WPATH Standards of
3 Care?

4 A Yes.

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

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 40

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 41

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

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

13 A Correct, for other conditions.

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

16 A Could you clarify what you mean by that?

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

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

25 **Q And where are these patients receiving their**

Monica Mortensen, D.O
September 28, 2023

Page 42

1 treatment for gender dysphoria?

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

4 Q Which centers?

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 43

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

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

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

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

17 **Q Where were those four receiving treatment?**

18 A I didn't ask.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 44

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

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

10 A I haven't.

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

13 A I think that's very unclear.

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

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

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

21 A Yes.

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

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

Monica Mortensen, D.O.
September 28, 2023

Page 45

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

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

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

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

13 A Some instances yes.

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

16 A In some, yes.

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

19 A Yes.

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

23 A What do you mean by dissuade?

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

Monica Mortensen, D.O
September 28, 2023

Page 46

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

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

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

13 A I do.

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 47

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

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

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

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

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

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

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

25 Q But you have banned the treatment for minors

Monica Mortensen, D.O.
September 28, 2023

Page 48

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

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

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

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

14 Q And what is the basis for that understanding?

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

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

Monica Mortensen, D.O
September 28, 2023

Page 49

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

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

10 A I believe so.

11 **Q But you can't name which countries?**

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 50

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

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

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

21 **A Directly, no.**

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

Monica Mortensen, D.O.
September 28, 2023

Page 51

1 A Sorry, could you repeat that?

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

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

14 So looking at the risk, I think it's really up
15 to the patient, and the parents in a child's case, to
16 determine whether they feel it does. The problem is is
17 the data that supports all of the benefit is very
18 loosely based and a lot of opinion based and very low
19 grade. So what I have issue with is telling somebody
20 that their life is going to be 100 percent better and
21 they are not going to have any problems and all their
22 psychiatric issues are going to go away, when that's not
23 100 percent the case. So I feel it's fraudulent to try
24 to sell it as it's 100 percent lifesaving when it's not.
25 It works for some, but it doesn't work for others.

Monica Mortensen, D.O.
September 28, 2023

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

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

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

9 A No.

10 Q Do medical risks of hormones justify
11 restricting or limiting their use of gender dysphoria in
12 adults?

13 A Sorry, can you repeat?

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

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

19 Q So would that be a no?

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

Monica Mortensen, D.O
September 28, 2023

Page 53

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

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

10 A No, I am not aware.

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

14 THE WITNESS: Sure.

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

16 BY MS. CHRISS:

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

21 A Page 7.

22 **Q Yep. I went to page 22.**

23 A You said item 22. I was hearing you.

24 **Q Do you want to switch seats?**

25 A Sometimes, yes.

Monica Mortensen, D.O.
September 28, 2023

Page 54

1 Q I don't know about that. Okay. So paragraph
2 22 on page 7 you mentioned at one of Nemours Childrens
3 Clinics, Division of Pediatric Endocrinology and
4 Metabolism weekly educational conferences we reviewed
5 the guidelines. What are these weekly educational
6 conferences?

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 55

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

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

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

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

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

17 **Q Okay. When did these weekly conferences begin?**

18 A It was happening long before I started at
19 Nemours.

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

23 A That is correct, yes.

24 **Q Who decided to review those guidelines?**

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

Monica Mortensen, D.O
September 28, 2023

Page 56

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

3 Q Okay. And when was this?

4 A That was around the time they were released.

5 Q So around 2017?

6 A Around that time, yes.

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

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

21 Q Was Dr. Benson involved in that meeting?

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

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

Monica Mortensen, D.O
September 28, 2023

Page 57

1 **psychologist, Dr. Buckloh was she involved?**

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

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

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

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

14 A Yes.

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 58

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

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

5 A No, we did not.

6 **Q And you reviewed the WPATH Guidelines as well?**

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

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

19 A Two pediatric endocrinologists.

20 **Q And who were those?**

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

23 **Q One more time.**

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

Monica Mortensen, D.O
September 28, 2023

Page 59

1 Santiago. We call her Lou.

2 Q I am going to. Thank you.

3 A She won't mind.

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

6 A That is correct.

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

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 60

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

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

6 A Correct.

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 61

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

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

10 A In the meeting?

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

13 A No.

14 Q Why not?

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

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

24 A That's Dr. Buckloh.

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

Monica Mortensen, D.O
September 28, 2023

Page 62

1 A Her.

2 Q Her interest in this area?

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

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

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

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

23 A Yes.

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

Monica Mortensen, D.O
September 28, 2023

Page 63

1 A Yes.

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

5 A Uh-huh.

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

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

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

14 A Sure.

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

18 A No, I am not.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 64

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

11 **Q And when were these meetings?**

12 A They were back in 2017.

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

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

19 **Q Was Dr. Buckloh involved in that subgroup?**

20 A Uh-huh.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 65

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

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

11 A Sorry I wrote a long paragraph.

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

19 A Yes.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 66

1 Hasan.

2 Q But you prescribed GhRH analogues for other
3 conditions?

4 A Correct.

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

8 A Correct.

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

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

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

18 A That was our position, yes.

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

21 A The most common would be central precocious
22 puberty.

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

Monica Mortensen, D.O
September 28, 2023

Page 67

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

3 **Q Any other prescriptions you prescribed the**
4 **blockers for?**

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

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

15 A That is correct.

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

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

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

24 A Yes.

25 **Q You state, continuing in that same paragraph,**

Monica Mortensen, D.O
September 28, 2023

Page 68

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

6 A Correct.

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

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

11 Q Okay. And that was what was --

12 A That was the basis of what we were doing.

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

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

21 Q And do you know why that is?

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

Monica Mortensen, D.O
September 28, 2023

Page 69

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

3 Q So these are prepubertal minors?

4 A She she's prepubertal as well.

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

8 A No, she did not.

9 Q How many did meet the criteria?

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

12 Q And those folks were referred to you?

13 A To Dr. Hasan and Dr. Torres.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 70

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

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

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

11 Q And how many pursued puberty blockers?

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

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

18 A No, I don't.

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

22 A From the Endocrine Society.

23 Q So the same as Dr. Buckloh?

24 A Uh-huh.

25 Q You then said that the risks and benefits were

Monica Mortensen, D.O.
September 28, 2023

Page 71

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

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

6 Q **Anything else?**

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

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

14 A Yes.

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

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

19 Q **So the risks indicated --**

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

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

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

25 Q **Are they labeled by your clinic name?**

Monica Mortensen, D.O
September 28, 2023

Page 72

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

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

7 A Yes.

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 73

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

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

9 A No, we did not.

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

12 A No, we did not.

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

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

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

Monica Mortensen, D.O.
September 28, 2023

Page 74

1 A As part of the treatment team? Yes.

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

4 A That's true.

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

7 A As far as pediatric endocrinology?

8 Q Uh-huh.

9 A Yes, they have a role.

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

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

17 A Uh-huh.

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

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

22 Q Anything else?

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

Monica Mortensen, D.O.
September 28, 2023

Page 75

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

6 A Sure.

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

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

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

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

21 Q Did that include Dr. Buckloh?

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

Monica Mortensen, D.O
September 28, 2023

Page 76

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

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

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

11 MR. PERKO: Object to form.

12 THE WITNESS: I can answer?

13 MR. PERKO: Yes.

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

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

Monica Mortensen, D.O.
September 28, 2023

Page 77

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

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

Monica Mortensen, D.O
September 28, 2023

Page 78

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

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

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

12 A Correct.

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

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

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

24 A They are run by the hierarchy, but --

25 Q Right.

Monica Mortensen, D.O
September 28, 2023

Page 79

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

14 **Q But they did have a gender multidisciplinary --**

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

17 **Q Okay. So you, sort of, outlined in paragraph**
18 **22 this, correct me if I am misstating, but sort of this**
19 **multistage process of assessing, you know, youth for**
20 **treatment of gender dysphoria. Why have that, sort of,**
21 **process in place if you weren't going to prescribe the**
22 **treatment that they would need for the treatment of**
23 **gender dysphoria?**

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

Monica Mortensen, D.O
September 28, 2023

Page 80

1 until they could get into another center.

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

7 MR. PERKO: Object to form.

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

9 BY MS. CHRISS:

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 81

1 A Yes.

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

6 A Mostly assessing, yes.

7 Q -- and not prescribing?

8 A Uh-huh.

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

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

16 Q Okay.

17 A So providing transgender care.

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

20 A Correct.

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

Monica Mortensen, D.O
September 28, 2023

Page 82

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

5 **Q And by moving forward you mean what?**

6 A Providing some care for transgender patients.

7 **Q So puberty blocking medication?**

8 A Correct.

9 **Q Okay. And did you establish a**
10 **multidisciplinary clinic?**

11 A No.

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 83

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

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

9 A Outside of research? No.

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

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

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

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

7 **Q That's just in the context of research?**

8 A That's in the context of research.

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

11 A Yes.

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

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

20 **Q Do you require written consent?**

21 A No, I do not.

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

24 A Correct.

25 **Q You stated in that same paragraph: At their**

Monica Mortensen, D.O
September 28, 2023

Page 85

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 86

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

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

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

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

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

14 **Q Do you have a copy of the Texas one?**

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

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

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

25 **Q When you said there were many unknowns, and**

Monica Mortensen, D.O
September 28, 2023

Page 87

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

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

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

Monica Mortensen, D.O.
September 28, 2023

Page 88

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

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

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

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

16 A Most are.

17 **Q In the pediatric population?**

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

Monica Mortensen, D.O
September 28, 2023

Page 89

1 we've got going on?

2 Q And you provide that verbally though?

3 A Correct.

4 Q Not through a written consent?

5 A Correct.

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

9 A I don't remember, no.

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

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

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

20 A Correct.

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

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

Monica Mortensen, D.O.
September 28, 2023

Page 90

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

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

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

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

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

22 A No.

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

25 A No.

Monica Mortensen, D.O
September 28, 2023

Page 91

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

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

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

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

12 A No.

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

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

19 **Q** But for non-research?

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

Monica Mortensen, D.O
September 28, 2023

Page 92

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

4 A No.

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

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

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

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

22 Q How many families would you say were
23 aggressive?

24 A Oh, a small handful.

25 Q And how many would you say demanded treatment?

Monica Mortensen, D.O.
September 28, 2023

Page 93

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

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

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

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

10 A Correct.

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

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

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

18 A Oh, I couldn't tell you.

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

21 A Yes.

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

Monica Mortensen, D.O.
September 28, 2023

Page 94

1 were prescribed the treatments for gender dysphoria?

2 A No, I did not.

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

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

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

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

25 Q You say that was one or two patients?

Monica Mortensen, D.O
September 28, 2023

Page 95

1 A Uh-huh.

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

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

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

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

22 A Uh-huh.

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

Monica Mortensen, D.O.
September 28, 2023

Page 96

1 **conditions?**

2 A Uh-huh.

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

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

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 97

1 Q Okay.

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

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

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

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

15 A Those specific ones, yes.

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

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

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

25 A Not all of them, no.

Monica Mortensen, D.O
September 28, 2023

Page 98

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

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

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

11 A None, because I didn't prescribe testosterone.

12 Q And how many were on estrogen?

13 A None, because I don't prescribe estrogen.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 99

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

7 **Q Did any of them elect to stop the treatment?**

8 A For the puberty blockers, no.

9 **Q How many of them were seeing Dr. Buckloh?**

10 A I would say for the ones that I saw, at least
11 50 percent with were Dr. Buckloh.

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

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

15 **Q Do you know who?**

16 A No.

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

21 A Hasan.

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

25 A For the treatment of gender dysphoria.

Monica Mortensen, D.O
September 28, 2023

Page 100

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

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

7 Q So is Dr. Lou?

8 A Dr. Lou is fine.

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

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

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

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

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

20 A No.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 101

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

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

7 A Could you repeat that or rephrase it?

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

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

18 Q So who's that individual?

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

21 Q Do you know meeting that was?

22 A It had to be the February meeting.

23 Q February 2023, obviously?

24 A Yes.

25 Q Okay.

Monica Mortensen, D.O
September 28, 2023

Page 102

1 A Well, obviously.

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

4 A Yes.

5 Q And have you ever done so previously?

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

10 Q Does Dr. Benson provide treatment for gender
11 dysphoria?

12 A Not to my knowledge.

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

21 A Yes.

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

25 A Yes.

Monica Mortensen, D.O
September 28, 2023

Page 103

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

7 A Correct.

8 Q Do you agree with those recommendations?

9 A Yes.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 104

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

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

8 MR. PERKO: Object to form.

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

19 Q Okay. What specific study are you referring
20 to?

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

25 Q Dr. Mortensen, are you familiar with the letter

Monica Mortensen, D.O
September 28, 2023

Page 105

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

4 A Yes.

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

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

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

13 A It would not be a surprise.

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

17 A Yes.

18 MR. PERKO: Object to form.

19 BY MS. CHRISS:

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

22 A Somewhat.

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

Monica Mortensen, D.O
September 28, 2023

Page 106

1 through the rulemaking process?

2 A Correct.

3 Q Are you familiar with -- strike that.

4 Are aware that on June 2nd, 2022, Surgeon

5 General Ladapo sent a letter to the Boards of Medicine

6 sharing that guidance in the GAPMS Report from the

7 Agency for Healthcare Administration?

8 A Yes.

9 Q And requesting that you take action on that
10 matter?

11 A Yes.

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

15 A Yes.

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

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

24 A Yes.

25 BY MS. CHRISS:

Monica Mortensen, D.O
September 28, 2023

Page 107

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

10 A Yes, I read that.

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

20 A Yes.

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

23 A Well, the emergency consents.

24 Q Right. So that was after SB 254?

25 A Yes.

Monica Mortensen, D.O
September 28, 2023

Page 108

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

4 A Other than the emergency consent forms, no.

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

7 A Yes.

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

10 A Yes.

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

18 A Yes.

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

22 A I believe so.

23 MR. PERKO: Object to form.

24 A I believe so.

25 BY MS. CHRISS:

Monica Mortensen, D.O
September 28, 2023

Page 109

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

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

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

13 A I believe so.

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

18 A I believe so.

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

22 A I believe so.

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

25 MR. PERKO: Object to form.

Monica Mortensen, D.O
September 28, 2023

Page 110

1 A I'm not really sure.

2 BY MS. CHRISS:

3 Q Okay. And just looking at these informed
4 consent forms again, is it correct they require only one
5 signature at the bottom?

6 A That is correct.

7 Q And that they have one, two, three, four, five,
8 six, seven bullet points?

9 A Yes.

10 Q And to the best of your knowledge do they
11 require a witness to sign?

12 A To the best of my knowledge, no.

13 Q And do they require any initials?

14 A No, they do not.

15 Q Paragraph 6 on page 2 states: Section
16 458.3311(b) Florida Statutes, grants the Board authority
17 to establish standards of care for particular practice
18 settings, including, but not limited to, the performance
19 of complex or multiple procedures and informed consent.
20 What does complex or multiple procedures mean?

21 MR. PERKO: Object to form.

22 A It could mean a number of things.

23 BY MS. CHRISS:

24 Q What do you understand it to mean?

25 A I think if we are talking more specifically for

Monica Mortensen, D.O
September 28, 2023

Page 111

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

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

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

9 **Q Okay.**

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 112

1 A Yes.

2 Q And who was the provider that prescribed that
3 care?

4 A I do not recall off the top of my head.

5 Q At what institution did they work?

6 A I do not know, sometimes I didn't really get
7 into it with the families or the patients.

8 Q Did you ever file any sort of complaint with
9 the Board or ethical violation anything of that sort?

10 A No, but sometimes I wish I did.

11 Q But you don't remember who the prescriber was?

12 A No.

13 Q Are you aware -- we are done with that exhibit.
14 Are you aware that the Board of Medicine and Osteopathic
15 Medicine met on August 5th, 2022, to discuss this
16 petition to initiate rulemaking?

17 A Yes.

18 Q Are you aware that Surgeon General Ladapo was
19 invited to speak?

20 A Yes.

21 Q And I should ask, this is all part of the
22 rulemaking record in the public books, I assume you are
23 familiar with those?

24 A Yes.

25 Q And I presume that you got up to speed, having

Monica Mortensen, D.O
September 28, 2023

Page 113

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

3 A Oh, yes.

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

7 A Yes.

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

10 A I am unaware.

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

13 A Yes.

14 Q Is that the individual you were mentioning
15 earlier?

16 A Maybe, I don't know.

17 Q And he presented the petition to initiate
18 rulemaking?

19 A Yes.

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

23 A Yes.

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

Monica Mortensen, D.O
September 28, 2023

Page 114

1 transgender youth?

2 MR. PERKO: Object to form.

3 A Yes.

4 BY MS. CHRISS:

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

7 A Not really.

8 Q Are you familiar that he presented to the
9 Boards?

10 A Yes.

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

14 A I'm sorry, repeat that?

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

16 BY MS. CHRISS:

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

20 MR. PERKO: Object to form.

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

22 BY MS. CHRISS:

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

Monica Mortensen, D.O.
September 28, 2023

Page 115

1 MR. PERKO: Object to form.

2 A No, not aware of that.

3 BY MS. CHRISS:

4 Q You are familiar with the GAPMS report?

5 A Yes.

6 Q And Dr. Van Meter was one of the consultants

7 that created that report?

8 MR. PERKO: Object to form; relevance.

9 A Yeah, I'm not sure.

10 BY MS. CHRISS:

11 Q That report was presented to the Boards as a

12 part of what you were to rely upon in the decisionmaking

13 process in deciding whether to pursue these rules; is

14 that correct?

15 MR. PERKO: Object to form.

16 A I'm not sure what you are asking me? So I

17 didn't really answer.

18 BY MS. CHRISS:

19 Q Oh, are you -- let me break this up to separate

20 questions, apologies. So you're aware of the GAPMS

21 report that found treatment for gender dysphoria to be

22 experimental?

23 A Yes.

24 Q And that was what we discussed was the Agency's

25 findings in the petition to initiate rulemaking that we

Monica Mortensen, D.O
September 28, 2023

Page 116

1 just looked at?

2 A Yes.

3 Q Okay. And are you aware that Dr. Van Meter was
4 one of the consultants who helped with the creation of
5 the GAPMS report?

6 MR. PERKO: Object to form.

7 A I wasn't aware who was involved in that
8 process.

9 BY MS. CHRISS:

10 Q But you were aware that Dr. Van Meter presented
11 to the Board?

12 A Yes.

13 Q On these findings?

14 A Yes.

15 Q In your experience, have you seen other
16 instances where an outside person was paid to come speak
17 to the Board about an issue like this?

18 A I wouldn't know anything about that.

19 Q During your time on the Board has that
20 happened?

21 A I have no knowledge of that.

22 Q Okay. So the Board of Osteopathic Medicine
23 then met on August 12th to discuss the joint -- let me
24 back up. There was a joint committee formed with
25 certain members from the Board of Medicine and certain

Monica Mortensen, D.O
September 28, 2023

Page 117

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

3 A That is correct.

4 Q You would later be a part of that committee?

5 A That is correct.

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

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

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

15 A Yes.

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

20 A Not personally, no.

21 Q Are you aware of him?

22 A No.

23 Q The meeting minutes reflected --

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

Monica Mortensen, D.O
September 28, 2023

Page 118

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

4 MR. REDBURN: Sure it does.

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

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

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

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

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 119

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

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

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

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

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

23 MR. REDBURN: Go ahead.

24 THE WITNESS: Can I take a bathroom break?

25 MS. CHRISS: Absolutely.

Monica Mortensen, D.O
September 28, 2023

Page 120

1 MR. REDBURN: Should we break for lunch?

2 MR. PERKO: That's probably a good idea.

3 MS. CHRISS: Yeah. I think that makes sense.

4 Come back at 2:00.

5 (Break taken at 12:52 until 2:02 p.m.)

6 BY MS. CHRISS:

7 Q Dr. Mortensen, here we are again. I am going

8 to show you -- hand you what we'll mark as Exhibit 4.

9 If you don't mind taking a moment to look at this

10 document. The first page is an e-mail from Matthew

11 Benson, then the pages that follow are an open letter to

12 the Florida Board of Medicine. Oh, actually, sorry,

13 could I have these exhibits back for a moment. Sorry

14 about that.

15 Do you recall writing an open letter to the

16 Board of Medicine with Dr. Benson and several other

17 physicians?

18 (Plaintiffs' Exhibit Number 4 was marked for

19 identification.)

20 A Yes, I do.

21 BY MS. CHRISS:

22 Q Was that on or about September 26, 2022?

23 A I believe I just saw that date, yes.

24 Q And apologies for that.

25 A No, it helped jog the memory.

Monica Mortensen, D.O
September 28, 2023

Page 121

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

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

7 Q And you signed onto this letter, correct?

8 A Correct.

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

11 A That is correct.

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

13 A That is correct.

14 Q Who is Larry Fox?

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

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

19 A Correct.

20 Q Dr. Mauras?

21 A Dr. Mauras.

22 Q Mauras.

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

Monica Mortensen, D.O.
September 28, 2023

1 Q Does she provide any treatment for gender
2 dysphoria?

3 A No.

4 Q Monica Mortensen, that's you.

5 A That's me. That's Lou.

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

7 A Sure.

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

9 A It really doesn't, yeah.

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

14 A That's correct.

15 Q Dr. Snyder?

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

18 Q Does she provide treatment for gender
19 dysphoria?

20 A No, she does not.

21 Q There's an APRN Joe Permuy?

22 A Uh-huh.

23 Q Who's he?

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

Monica Mortensen, D.O
September 28, 2023

Page 123

1 Q Does he provide treatment for gender dysphoria?

2 A No, he does not.

3 Q Same question Kaley Carroll?

4 A Also one of our nurse practitioners.

5 Q And does she provide treatment for gender
6 dysphoria?

7 A No, she does not.

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

10 A Not to my knowledge.

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

14 A That's correct.

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 124

1 A That's correct.

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

4 A Shortly before that.

5 Q Okay. Who were you contacted by?

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

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

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

16 Q Okay. When did you apply?

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

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

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

23 Q And who had to provide input on that process?

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

Monica Mortensen, D.O.
September 28, 2023

Page 125

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

4 A I would assume as well.

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

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

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

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

25 Q Did anyone other than Dr. Benson encourage you

Monica Mortensen, D.O
September 28, 2023

Page 126

1 to apply?

2 A No.

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

5 A That's my understanding.

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

8 A Not to my knowledge, no.

9 Q Like, who informed you you had been appointed?

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 127

1 A Yes.

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

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

7 Q No. No.

8 A -- and that's not true.

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

16 A Correct.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 128

1 didn't want to join that committee, so.

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

5 A Dr. Benson.

6 Q Just you and Dr. Benson?

7 A Are pediatric endocrinologists, yes.

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

11 A No.

12 Q He didn't talk to you about that?

13 A No.

14 Q Did you provide any testimony or written
15 comments?

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 129

1 and signed on?

2 A Yes.

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

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

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

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

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

25 A Correct.

Monica Mortensen, D.O
September 28, 2023

Page 130

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

4 A No, I didn't.

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

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

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

21 A I don't recall discussing that.

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

25 A Correct.

Monica Mortensen, D.O
September 28, 2023

Page 131

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

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

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

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

15 A No.

16 BY MS. CHRISS:

17 Q Or a Joseph Burgo?

18 A No.

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

23 A Yes.

24 Q And a detransitioner Sophia Galvin?

25 A Yes.

Monica Mortensen, D.O
September 28, 2023

Page 132

1 Q And a parent named Amy Atterberry?

2 A Yes.

3 Q Okay. So those were folks that also testified
4 at the Board of Medicine meetings?

5 A Correct.

6 Q Have you had any other experiences with those
7 individuals?

8 A Like, personal experience?

9 Q Through your role on the Board or elsewhere?

10 A Oh, no. No. I think Chloe is quite an
11 advocate, so I've seen some interviews.

12 Q Yes, so if you look below of run of show where
13 you see Dr. Benson spoke after it says Amy, Billy
14 Burleigh, Erin Brewer, and Richie. Do you recall in the
15 public book that you reviewed seeing written comments
16 from these individuals?

17 A I don't recall.

18 Q Okay. And then if we could -- sorry, below
19 where it says: Experts and the evolution of
20 gender-affirming care, you see it says Dr. Benson is
21 listed as one of the experts, and discuss the knowns and
22 unknowns of medical intervention with puberty blockers
23 and cross-sex hormone treatment models in children.

24 Did Dr. Benson participate in any of the
25 meetings you discussed earlier at Nemours where the

Monica Mortensen, D.O
September 28, 2023

Page 133

1 provision of this care was discussed?

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

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

5 A I'm not sure.

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

11 A Uh-huh. Yes.

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

14 A Yes, a lot of stories were told.

15 Q All right. Thank you. Dr. Mortensen.

16 A Yes, that's me.

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

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

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

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

25 Q Okay. And what about in-person testimony at

Monica Mortensen, D.O
September 28, 2023

Page 134

1 **the hearings, how does that happen?**

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

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

16 A Yes.

17 Q What does the phrase off-label mean?

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

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

22 MR. PERKO: Object to form.

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

Monica Mortensen, D.O
September 28, 2023

Page 135

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

8 BY MS. CHRISS:

9 Q So it can be experimental?

10 A Experimental.

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

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

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

22 A I would say that's fair.

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

Monica Mortensen, D.O
September 28, 2023

Page 136

1 30 percent of encounters in children's hospitals
2 involved off-label use?

3 A That wouldn't be surprising.

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

7 A Not anymore.

8 Q When did you stop being a member?

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

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

19 MR. PERKO: Object to form.

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

22 BY MS. CHRISS:

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

Monica Mortensen, D.O
September 28, 2023

Page 137

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

4 A It's very fair to say yes.

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

8 A That is correct.

9 Q And have you prescribed aromatase inhibitors
10 for short stature?

11 A I have.

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

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

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

18 A No, I don't.

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 138

1 A Sure.

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

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

23 **Q And do you -- scratch that.**

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

Monica Mortensen, D.O
September 28, 2023

Page 139

1 A I have.

2 Q And is it FDA approved for that condition?

3 A No, it is not.

4 Q Do you prescribe metformin for patients with
5 Type 2 diabetes?

6 A I do.

7 Q Is it FDA approved for that indication?

8 A For children over the age of 10 it is.

9 Q Have you prescribed it for children under the
10 age of 10?

11 A No, I have not.

12 Q You state in your open letter that there's
13 limited data from prospective controlled trials which
14 are the gold standard by which we judge any therapeutic
15 intervention; is that correct?

16 A That is correct.

17 Q Do you only prescribe medications that have
18 data from prospective controlled trials?

19 A No.

20 Q Are you aware that medical research on children
21 is less likely to use randomized trials than is medical
22 research for adults?

23 A I am not aware, I know it's more challenging,
24 but that seems to be the studies that we do at our
25 centers.

Monica Mortensen, D.O
September 28, 2023

Page 140

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

3 A Yes.

4 Q Can you give me an example?

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

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

11 MR. PERKO: Object to form.

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

17 BY MS. CHRISS:

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

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

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

25 A Could you rephrase that?

Monica Mortensen, D.O.
September 28, 2023

Page 141

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

5 MR. PERKO: Object to form.

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

12 BY MS. CHRISS:

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

19 A I do.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 142

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

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 143

1 happening?

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

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

8 A I don't know.

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

13 A Correct.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 144

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

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

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

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

11 A No.

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

18 A (Shakes head.)

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 145

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

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

12 Q Of patients relaying to them --

13 A Relaying to them.

14 Q Something happened elsewhere?

15 A Uh-huh.

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

18 A I couldn't quantify.

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

21 A I don't recall.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 146

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

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

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

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

11 A Yes.

12 Q Okay. Similar question, you say prescribed.

13 These folks were prescribed by physicians, and
14 non-physician providers with limited experience and
15 minimal to no involvement by well-trained psychologists.
16 How did you come to know what experience the provider at
17 the Duke clinic had for the two patients you were
18 referring to?

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

25 Q But you don't know what experience and training

Monica Mortensen, D.O
September 28, 2023

Page 147

1 that endocrinologist had?

2 A No.

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

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

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

14 A I don't remember.

15 Q It says: To understand the state of the
16 evidence the Florida Department of Health commissioned
17 two researchers from McMaster University where the term
18 evidence-based medicine was coined for a systematic
19 review of the available evidence. Then there's a link
20 to [ACHA.myflorida.com/letkidsbekids](https://acha.myflorida.com/letkidsbekids). What is the
21 McMaster University report you are talking about?

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

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

Monica Mortensen, D.O
September 28, 2023

Page 148

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

3 Q Okay. And in the end of your letter you state:

4 A group of physicians, psychologists, risk management
5 experts, ethicists, and lay people on a medical board
6 should be able to assess the evidence while also
7 advising on a proper standard of care as opposed to
8 legislative and political bodies. Do you recall that?

9 A Yes.

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

12 MR. PERKO: Object to form.

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

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

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

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

Monica Mortensen, D.O
September 28, 2023

Page 149

1 received medical care in Florida?

2 A I don't know, but --

3 Q So --

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

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

8 A Not yet.

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

15 A I don't remember.

16 Q What about risk management experts?

17 A I don't recall if they were involved.

18 Q What about ethicists?

19 A I'm not sure.

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

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

Monica Mortensen, D.O
September 28, 2023

Page 150

1 but, I'm sorry --

2 Q I got what you meant. It was clear.

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

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

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

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

15 A Yes.

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

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

19 Q And --

20 A It was a lot.

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

24 A Yes.

25 Q What is the purpose of a rulemaking workshop?

Monica Mortensen, D.O
September 28, 2023

Page 151

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

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

5 A No, I am not.

6 Q Are you familiar with Dr. Patrick Hunter?

7 A Yes, I am.

8 Q And how?

9 A He's on the Board.

10 Q And what is his profession?

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

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

16 A Yes.

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

19 A No, not aware of who he invited.

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

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

25 Q Okay. Are you aware that Dr. Michael Laidlaw

Monica Mortensen, D.O
September 28, 2023

Page 152

1 was one of the subject matter experts?

2 A I believe so, yes.

3 Q Are you aware he -- actually, we'll come back

4 to that in a moment. I apologize. Who is Danielle

5 Terrell?

6 A Oh, she's one of the administrators for the

7 Osteopathic Board.

8 Q Would you agree that she's the executive

9 director?

10 A Yes, that's her actual title, thank you.

11 Q Great. Have you -- strike that.

12 What is your understanding of Ms. Terrell's

13 role?

14 A That she's one of the administrators, so she

15 takes in a lot of the paperwork and sorts through it,

16 works with the lawyers, works with us, works with a team

17 of people to help with all the business that happens

18 with the Board.

19 Q Is she a part of the public hearings and

20 workshops and things like that?

21 A I believe she was -- had to be present.

22 Q What is your understanding of -- I know you

23 touched on this earlier, but when folks show up to

24 testify or provide public comment, what's your

25 understanding of the process by which they are able to

Monica Mortensen, D.O
September 28, 2023

Page 153

1 do so?

2 A So you are meaning at the meetings?

3 Q Uh-huh.

4 A So it kind of depends on the type of meeting.

5 I believe that on the February meeting there were people

6 who submitted complaints that wanted to speak and so

7 they were granted to speak, then it was open forum with

8 the cards that we previously discussed.

9 Q So there's cards that you fill out when you get
10 there and then if they choose you you get to speak; is
11 that correct?

12 A Uh-huh.

13 Q Is it your understanding that this is random?

14 A Yes.

15 Q I'm going to show you what I'm going to
16 actually mark this time as Exhibit 5. This is an e-mail
17 exchange. Do you see the name where it says from up
18 top?

19 (Plaintiffs' Exhibit Number 5 was marked for
20 identification.)

21 A Yes.

22 BY MS. CHRISS:

23 Q And is that the Danielle Terrell who's the
24 executive director of the board that you sit on?

25 A Yes.

Monica Mortensen, D.O
September 28, 2023

Page 154

1 Q It states, if you will turn to page 2 for me,
2 down at the bottom where it starts: October 25th, 2022,
3 Danielle, I work with Vernadette Broyles and she asked
4 me to send you the list of testifiers for Friday.

5 Do you see that?

6 A Yes.

7 Q And Dr. Laidlaw, above that from Vernadette
8 Broyles it says: To be clear, the expert is Dr. Michael
9 Laidlaw, endocrinologist.

10 Do you see that?

11 A Yes.

12 Q If you turn to page 4 for me. For the record
13 this is Bates stamp FDOH000042405. If you see where at
14 the top it says: Danielle Terrell said thank you.
15 Below that, someone named Bettye Strickland, do you know
16 who that is?

17 A I think I'm on the wrong page.

18 Q Oh, I apologize. The fourth page. The back of
19 the second page.

20 A Are we counting --

21 MR. PERKO: The bottom it is 4205.

22 A 4205. Okay.

23 BY MS. CHRISS:

24 Q Yeah. Are you there?

25 A Front and back. Page 4 you mean the back?

Monica Mortensen, D.O
September 28, 2023

Page 155

1 Q Yes, I apologize.

2 A That's okay. The other one is one-sided. I'm
3 on the right page. Hurray.

4 Q Thank you. If you go to the middle where that
5 e-mail from Danielle Terrell on Wednesday, October 26,
6 2022, it states: Please see the list of people below
7 that will be the first to make public comment. We need
8 to ensure that cards are filled out for all
9 detransitioners and the parent.

10 Do you see that?

11 A Uh-huh.

12 Q Do you know who Vernadette Broyles is, the
13 individual who sent this em-mail to Danielle Terrell?

14 A No.

15 Q Are you familiar with the Child and Parental
16 Rights Campaign?

17 A Not really.

18 Q What do you know?

19 A They do child and parental rights. I mean, I'm
20 sure they submitted things to the Board to read, but, I
21 mean, we get, like, 6,000 pages of documents for things
22 for and against, so I don't really associate the name
23 for or against, so.

24 Q Understood.

25 A This is also well before my time.

Monica Mortensen, D.O
September 28, 2023

Page 156

1 Q Right. Right. I'm just trying to get an
2 understanding of whether it is typical for the board to
3 pre-fill out speaker cards and ensure certain people
4 will be able to speak first. Is that your experience or
5 understanding of how that process works?

6 A I'm not really sure of what the process was.
7 All I can say is the meetings I was at they were handing
8 out cards for people.

9 Q Okay. If you could turn to page 9, which at
10 the bottom states -- or the Bates number is 000044022.

11 A Yes.

12 Q Okay. In the middle you will see where
13 Danielle Terrell says on Thursday, October 27, 2022:
14 Jennifer, the list contains a total of 20 people not
15 including the SME, I believe that's meaning subject
16 matter expert.

17 A Okay.

18 Q This would total one hour of our public comment
19 time. How would you like me to respond to this?

20 Do you see that?

21 A Yes, I do.

22 Q Do you know how much time was allotted for
23 public comment?

24 A I wasn't there at the meeting, so I don't know.

25 Q Would it be reasonable if I told you the

Monica Mortensen, D.O
September 28, 2023

Page 157

1 meeting minutes reflected two hours?

2 MR. PERKO: Object to form.

3 BY MS. CHRISS:

4 Q Strike that question. You are right.

5 So looking back, briefly, at the list I

6 directed you to at first on page 3, starts on the bottom

7 of page 2 and goes on to page 3. Again,

8 detransitioners, do you recognize the names as folks who

9 testified at the Board meeting?

10 A I mean, all I recognize is Chloe Cole, but

11 she's a very prominent figure. I don't --

12 Q Have you -- I apologize.

13 A I mean, I'm terrible with names. Faces I'm
14 better with, but I'm not really sure who they are.

15 Q Have you had any interaction or any involvement
16 with Ms. Cole outside of her testifying at these
17 hearings?

18 A No. And I wasn't even at that hearing.

19 Q Okay. Okay. Thank you. Is it your
20 understanding that the public comments that folks
21 submit, there's a deadline by which they are provided?

22 A I think you mean the time that they are allowed
23 to fill out the card --

24 Q No, I'm sorry --

25 A -- or do you mean the time --

Monica Mortensen, D.O
September 28, 2023

Page 158

1 Q -- the one you send via e-mail.

2 A I'm sorry?

3 Q The ones you mentioned previously are submitted
4 by e-mail?

5 A No, I don't even know what the timeframe is,
6 because we get updated once all the times are -- so I'm
7 not 100 percent sure what timeframe before the meeting
8 people have to submit their comments. I don't know.

9 Q Okay. Turning back to this October 28th public
10 workshop where -- my understanding is it was a rule
11 development workshop; is that correct?

12 A That's your understanding. I think that's my
13 understanding too. I wasn't there.

14 Q Are you familiar with the -- again, with the
15 public book that was part of the administrative record
16 in this process?

17 A Sure.

18 Q Did you review the presentation provided by Dr.
19 Laidlaw?

20 A Yes.

21 Q I'm going to mark this as Plaintiffs'
22 Exhibit 6, and, unfortunately, I only have one copy of
23 the presentation, so I'll give that to Dr. Mortensen, if
24 that's okay.

25 MR. PERKO: Is this marked separately?

Monica Mortensen, D.O
September 28, 2023

Page 159

1 MS. CHRISS: It is supposed to be part of this,
2 but I accidentally only printed the one copy. It is
3 part of the same public book this was extracted
4 from. December 28th -- sorry, October 28th, 2022,
5 public book produced by defendants in this case.

6 (Plaintiffs' Exhibit Number 6 was marked for
7 identification.)

8 BY MS. CHRISS:

9 Q So first looking at the agenda, do you see
10 where it says: Subject matter experts?

11 A Going to this one first?

12 Q Yeah. My apologies.

13 A That's okay. First page.

14 Q Okay. Earlier I asked you if this was fair to
15 characterize this as a rule development workshop, I
16 apologize, it says rule workshop. Is that your
17 understanding of what this was?

18 A Yes.

19 Q The agenda states: Development of rule
20 language. So that's what was happening at the meeting?

21 A My understanding, yes.

22 Q Is 64B15-14.014, is that the rule that you
23 voted on as a member of the Board of Osteopathic
24 Medicine on the first page of the agenda?

25 A I believe so, I didn't memorize the numbers,

Monica Mortensen, D.O
September 28, 2023

Page 160

1 but I believe so.

2 Q Okay.

3 A There's a lot of letters and numbers.

4 Q I know.

5 A It seems like -- those look accurate.

6 Q Perfect. So you'll see there's the subject
7 matter experts we discussed previously. Discussion and
8 development of rule language. Public comments, et
9 cetera. Is this what a typical agenda looks like?

10 A Yes.

11 Q Great. If you can just go to the fourth page,
12 which is really the back of the second page. Do you see
13 the CV of Michael Biggs?

14 A I do.

15 Q Okay. Great. So if you could turn to Dr.
16 Laidlaw's presentation, which is the PowerPoint you have
17 in front of you.

18 A Okay.

19 Q Does this appear to be an accurate copy of the
20 presentation that Dr. Laidlaw submitted to the Board?

21 A It does.

22 Q And this was included in the public book for
23 this meeting?

24 A It was.

25 Q Great. We can move on.

Monica Mortensen, D.O
September 28, 2023

Page 161

1 A Please.

2 Q You are not enjoying this?

3 A I had better days.

4 MR. PERKO: So Laidlaw presentation should go
5 with the --

6 MS. CHRISS: Yes. I apologize.

7 THE WITNESS: With 6.

8 BY MS. CHRISS:

9 Q I'm going to mark this as Plaintiffs'
10 Exhibit 7. This is one last -- I think last excerpt
11 from that same public book. If you could just take a
12 quick look. Are you familiar with a Dr. Gregory
13 Coffman?

14 (Plaintiffs' Exhibit Number 7 was marked for
15 identification.)

16 A Not personally.

17 BY MS. CHRISS:

18 Q Are you aware that he was appointed to the
19 Board of Medicine?

20 A Oh, okay. Yeah. I'm not great with names. I
21 said that earlier.

22 Q That's okay. Are you aware that he was a
23 member of the Rules Committee as well?

24 A The Rules Committee? I'm really trying to
25 remember what his face looks like right now.

Monica Mortensen, D.O
September 28, 2023

Page 162

1 Q I won't tell him.

2 A Now that you are telling me he's a member of
3 the Board, how embarrassing. I didn't memorize their
4 names.

5 Q That's okay.

6 A I must have talked to him. Okay.

7 Q Dr. Coffman was appointed at the same time as
8 Dr. Benson to the Board of Medicine. Just, if you are
9 not familiar with him, no trouble, this is just a
10 statement that he submitted to the Boards prior to being
11 appointed to the Board of Medicine. But we can move on.

12 So, Dr. Mortensen, earlier we discussed a
13 little bit about the vote, sort of, decision to remove
14 the IRB-approved clinical trial exception to this rule,
15 but what is your understanding of the basis for the
16 original inclusion of that exception in the rule?

17 A I wasn't there for the first part, which was
18 the Rules Committee. And my understanding there was a
19 split between whether research should be included or
20 excluded. My understanding is we didn't hold authority
21 over it anyway. My feeling is is that it didn't really
22 matter if it was or it wasn't that. I feel like there's
23 enough people doing research in the world that we really
24 didn't need it, it wasn't a deal-breaker for me.

25 Q Are you aware that the Board of Medicine voted

Monica Mortensen, D.O
September 28, 2023

Page 163

1 on November 4th, 2022, to remove that IRB-approved
2 clinical exception, but the Board of Osteopathic
3 Medicine that you would come to sit on did not --

4 A Correct.

5 Q -- and voted not to remove that?

6 A Correct.

7 Q And what is your understanding of why they
8 voted to keep that in?

9 A I don't know, because I wasn't a member of the
10 Board at that time, that information wasn't made privy
11 to me.

12 Q So between November -- between you being
13 appointed in December, and you taking a vote on the
14 removal of that section in February, there were no --
15 were there any discussions between board members as
16 to --

17 A There wasn't with this board member with any of
18 the other board members. If other board members had a
19 discussions I'm not privy to that.

20 Q Are you aware that during the November 4th,
21 2022, meeting, which I have the meeting minutes for, if
22 it would be helpful, but I just will ask if you are
23 aware first, that Drs. Vila -- am I saying that right?

24 A Vila sounds familiar, yes.

25 Q Okay. Dr. Vila and Dr. Hunter provided their

Monica Mortensen, D.O
September 28, 2023

Page 164

1 explanation of why they thought the IRB-approved
2 clinical exception should be removed?

3 A I vaguely recall that conversation -- during
4 the presentation, yes.

5 Q Okay. And do you recall them talking about
6 hearing extensive testimony from detransitioners and
7 that being a part of their decisionmaking?

8 A I don't remember that exactly, but it's very
9 possible.

10 Q Okay. And at that meeting the Board of
11 Osteopathic Medicine you unanimously voted to reject the
12 removal of that exception, right?

13 A Correct.

14 Q Are you familiar with Dr. Patrick Hunter's
15 affiliations with any other groups?

16 A The only that I know is what's been bought up
17 at the meetings.

18 Q Has -- did that include his membership with a
19 group called Genspect?

20 A Possible.

21 Q Okay. What about SEGM, The Society for
22 Evidence-Based Gender Medicine?

23 A I believe so.

24 Q And are you familiar with SEGM or Genspect?

25 A Not really.

Monica Mortensen, D.O
September 28, 2023

Page 165

1 Q Are you aware that they are, sort of,
2 self-described anti-transgender organizations?

3 MR. PERKO: Object to form.

4 A I believe it if you say so. I didn't really
5 look them up.

6 BY MS. CHRISS:

7 Q Okay. When you were appointed to the Board on
8 December 6, 2022, did Dr. -- did you take someone's
9 place?

10 A I would assume so. Usually they don't create
11 new board positions, they are usually replacing somebody
12 that's no longer on the board. That's my assumption.

13 Q Was it your understanding that Drs. Schwemmer,
14 Gadea, and Mendez were removed from the Board when you
15 and several others joined?

16 A I really didn't know who the previous board
17 members were.

18 Q Okay. No problem?

19 A It's like when a physician leaves a practice,
20 bygones, I don't know who they were.

21 Q I won't tell.

22 A I don't care. I got to focus on what I got to
23 focus on.

24 Q Okay. And when the Boards published their
25 joint notices of public hearing on the proposed rules on

Monica Mortensen, D.O
September 28, 2023

Page 166

1 January 9th is it your understanding that the Board of
2 Medicine rule, and the Board of Osteopathic Medicine
3 rule, differed slightly, in that the Board of
4 Osteopathic Medicine rule still included the exception?

5 A Yes, it's my understanding.

6 Q Were you present at the February 10th, 2023,
7 hearing?

8 A I sure was.

9 Q And you participated in this hearing?

10 A I did.

11 Q What is the purpose of a public hearing?

12 A It's to give the public an opportunity to speak
13 on the topic, whether it be from a professional
14 standpoint or a personal standpoint.

15 Q And you are aware, I think you mentioned
16 earlier, that there were requests presented to the Board
17 for the hearing, petitions for the hearing?

18 A Yes, that's my understanding.

19 Q And are you aware that four out of six of the
20 requests for the hearing were from folks urging the
21 Boards not to adopt the rules?

22 A I didn't pay attention as to how many were for
23 or against, and I didn't create the agenda.

24 Q Right. You reviewed the reading materials --

25 A But I reviewed the statements --

Monica Mortensen, D.O
September 28, 2023

Page 167

1 Q -- prior too?

2 A Yes, I did. Like 10,000 pages, yeah.

3 Q Do you recall reviewing -- I'm going to mark
4 this as Exhibit 8. Did you review this petition --
5 sorry, petition for a rule hearing by a group called
6 Gender Analysis?

7 (Plaintiffs' Exhibit Number 8 was marked for
8 identification.)

9 A I reviewed it, yes.

10 BY MS. CHRISS:

11 Q So you are familiar with the allegations
12 therein?

13 A Yes.

14 Q Did the Boards considered this in their
15 decisionmaking?

16 A I don't know what they used in their
17 decisionmaking, I can only speak to what I used in mine.

18 Q Okay. Did you consider it?

19 A I reviewed all of it, and what everything tells
20 me here is that nobody knows what's good and what's
21 wrong and what's bad and how this is and how to do it
22 and how to treat it. So what I gather from hearing the
23 stories and reading this, and reading the medical
24 literature, is that no one knows what causes
25 transgender, no one knows is it medical? Is it

Monica Mortensen, D.O
September 28, 2023

Page 168

1 psychological?

2 No one knows what's the best route of
3 treatment, and everyone's hoping to find the best
4 answer. And that the medical people are very divided
5 over what they believe, and even the community is
6 divided over what it needs. So from everything that I
7 read in the pros and the cons, it tells me that I've got
8 some people who feel very strongly on the one end, very
9 strongly on the other, and they both have some good
10 arguments, and some of them have some not so great
11 arguments.

12 But the reality is we don't know what we don't
13 know and we don't really know what the best path of
14 treatment is and this is a relatively new field and it
15 has -- going to have some repercussions down the road.
16 And even though science tries to move forward and try
17 the best path for the best routes of treatment, we don't
18 even really know what is the best path of treatment.

19 **Q So the answer is, yes, you reviewed that**
20 **document --**

21 A Yes.

22 **Q -- in your decisionmaking?**

23 A Yes.

24 **Q Okay. Are you aware that every major medical**
25 **association in our country supports the provision of**

Monica Mortensen, D.O
September 28, 2023

Page 169

1 **gender-firming care for transgender individuals for whom**
2 **it is medically necessary?**

3 MR. PERKO: Object to form.

4 A I am aware that those board members who submit
5 that is, but not every member who sits on all of those
6 societies agree with the statements that are submitted.
7 So your statement is accurate, but I think that it's
8 leading saying that every member of all those societies
9 back those statements. That is not factual.

10 Q **If I did state that, that was not the intent of**
11 **my question --**

12 A Just being clear.

13 Q **-- I stated every major medical organization**
14 **support these treatments?**

15 A I believe so.

16 Q **Okay. And have you spoken to any of the**
17 **members of the -- I think you said the board members of**
18 **these organizations who have expressed to you they**
19 **disagree?**

20 A Oh, I know a lot of people on the Pediatric
21 Endocrine Society, I know a lot of people on the
22 Endocrine Society, I know people who are still members
23 of the AP who do not agree with the statements. I know
24 people who are starting to withdraw from those groups.
25 I know a lot of people are afraid to speak up, but

Monica Mortensen, D.O
September 28, 2023

Page 170

1 there's a lot of people who feel that the Endocrine
2 Society made this statement so the American Academy of
3 Pediatrics backs it. They are not experts. They are
4 relying on the experts to state that statement. So are
5 they really trained and experienced on it? No. But
6 that's just like when the American Heart Disease says
7 that you need an hour of exercise, the AAP is going to
8 back the experts.

9 So all of these people backed the experts, but
10 the experts are not correct on everything. There's a
11 lot the experts don't know.

12 Q Do you follow the Endocrine Society Guidelines,
13 generally, in other provision of other types of care?

14 A Generally, yes.

15 Q And when you were providing treatment for
16 gender dysphoria you stated previously in the deposition
17 that you followed the Endocrine Society Guidelines?

18 A Yes, I wanted to believe that it could help. I
19 wanted to believe it.

20 Q Are you aware of any medical organization that
21 opposes the treatment of gender dysphoria?

22 A No, I'm not aware.

23 Q So just returning for a moment to the
24 November 4th hearing that we spoke about. There were
25 two individuals who provided information on their

Monica Mortensen, D.O
September 28, 2023

Page 171

1 petitions for the hearing; is that correct?

2 A For the?

3 Q Who requested the hearing.

4 A For the hearing for February?

5 Q Yes.

6 A Or November?

7 Q Did I say November? I apologize.

8 A I thought you did, that's why I got confused.

9 Q So sorry. I tried to memorize all these dates.

10 A Same. It's hard.

11 Q February 10th, 2023, there were two individuals
12 that spoke about their petitions, correct?

13 A To my knowledge, yes.

14 Q And one of those was Mr. Wilson from the
15 Florida Department of Health?

16 A Yes, I believe so.

17 Q And he encouraged the Board of Osteopathic
18 Medicine to remove the research exemption?

19 A Correct.

20 Q Did you -- do you recall during that meeting,
21 or that hearing, hearing from multiple doctors that
22 provide treatment for gender dysphoria in the state of
23 Florida?

24 A Yes, I do recall hearing.

25 Q Including Dr. Michael Howler and Dr. Paul

Monica Mortensen, D.O
September 28, 2023

Page 172

1 Arons?

2 A Uh-huh.

3 Q And do you recall them testifying about their
4 personal clinical experience in treating many minors who
5 experience gender dysphoria?

6 A Yes.

7 Q And do you recall their testimony about the
8 positive benefits that their patients received through
9 this treatment?

10 A Yes.

11 Q Did the Board of Osteopathic Medicine take the
12 public comments into consideration before voting?

13 A I don't know what all -- I can only speak as
14 myself, because we didn't talk. I heard everything that
15 they said, and I listened. Some of it was very
16 heartbreaking and emotional and moving, so I listened
17 wholeheartedly with an open mind to hear everything they
18 had to say.

19 Q And did it impact your opinion at all?

20 A It did, but it didn't change my opinion that
21 there's so many unknowns that it's not very safe for
22 someone under the age of 18.

23 Q Is it accurate that the -- actually, I should
24 just show you. One moment. Mark this as Plaintiffs' 9.
25 So under Board of Osteopathic Medicine on the first page

Monica Mortensen, D.O
September 28, 2023

Page 173

1 you see your name, members present?

2 (Plaintiffs' Exhibit Number 9 was marked for
3 identification.)

4 A Yes.

5 BY MS. CHRISS:

6 Q Okay. If you would just turn to the very back
7 where it says: Dr. DiPietro -- am I saying that
8 correctly?

9 A Yes.

10 Q Called the Board of Osteopathic Medicine
11 meeting to order at 4:21 p.m. Dr. DiPietro asked the
12 Board of Osteopathic Medicine members if there was any
13 motion to change or modify the rule as it currently
14 stands. Dr. Ducatel made a motion to remove the current
15 research exception in order to mirror of Board of
16 Medicine rule. There was no discussion between members.
17 The motion to remove the current research exception was
18 seconded and approved unanimously and the meeting --
19 summarizing -- the meeting was adjourned at 4:23 p.m. A
20 motion to adjourn the meeting was approved unanimously
21 at 4:23 p.m.

22 A Correct.

23 Q So I'm not great at math, but it seems like it
24 was two minutes between the calling to order and the
25 adjournment. Why are -- I guess I should ask, to the

Monica Mortensen, D.O
September 28, 2023

Page 174

1 best of your knowledge, you can only speak for yourself,
2 why was there no discussion of the information that the
3 Board had learned during the meeting?

4 A It was offered, but I, myself, had been sitting
5 there for the whole time and had read all the things and
6 went through everything else, so I had time to see what
7 I had, and I knew where I was going to go with it. I
8 suppose everyone else felt the same.

9 Q So just -- the previous vote, November 4th,
10 unanimously everybody voted to reject the removal of the
11 exemption, then February, no one -- no discussion, but
12 in February they unanimously voted to remove?

13 A I wasn't there for November, so I'll take your
14 word on it.

15 Q Just make sure I got this correct --

16 A But for this meeting the motion was to remove
17 the research exemption. It was discussed, people talked
18 about it, it was offered did anybody else want further
19 discussion on it? I already knew where I was going to
20 go on it based on everything I was hearing, I assume
21 everybody else did, and we agreed on it.

22 Q So I believe you stated previously the reason
23 that you didn't think IRB-approved clinical trials were
24 necessary, despite stating in your open letter that that
25 was so important to conduct such trials to gather

Monica Mortensen, D.O
September 28, 2023

Page 175

1 evidence, you didn't think that was something that

2 should be happening in the state of Florida?

3 A Agreed. I think that, and I believe that even

4 WPATH and Endocrine Society say more research is needed,

5 more research is needed, but I don't think we need to do

6 it in Florida. I think there's plenty of other

7 institutions in this nation and the world that already

8 started research, so I don't think it needs to be

9 duplicated.

10 Q So you voted to remove the opportunity and

11 ability of any provider in the state of Florida to

12 conduct that research?

13 A In children, yes.

14 Q You mentioned a moment ago there was testimony

15 that was heartbreaking. Can you just elaborate on what

16 testimony you found heartbreaking?

17 A It's very -- as a physician, and maybe as a

18 person, as a human being, to hear someone suffering,

19 it's very hard to hear. I mean, I also see it in my

20 clinic that's it's heartbreaking. You know, I think

21 hearing some of the stories of what families were going

22 through and the struggles that they are having, it's

23 hard not to, you know, be moved by somebody experiencing

24 a struggle. I mean, we see at in our clinic too with

25 kids who have cancer, and long-term diabetes, I mean,

Monica Mortensen, D.O
September 28, 2023

Page 176

1 anyone who has a medical disorder, which I'm not saying
2 it's a mental disorder, I'm saying a medical disorder,
3 they are going to have struggles and it's hard to see
4 people struggling.

5 And as a physician we want to help, which is
6 one of the reasons why we wanted to believe the
7 guidelines and were willing to entertain the guidelines,
8 even though they were loose, is if it could provide some
9 help and support. And we couldn't make ourselves a
10 center, but if we could help a little bit of support
11 until they could get into the place they really needed
12 to be, then we were okay with it at first.

13 But when we really started to experience the
14 negative side and see where things were going, it just
15 didn't seem reasonable or feasible anymore. It seems
16 like this has exploded and that there's really not any
17 real regulation on anything. That these treatments are
18 being caused and given to kids at younger and younger
19 ages and stages.

20 **Q Did you credit the testimony of the doctors**
21 **that spoke directly to you about the tremendous positive**
22 **benefits these treatments have had on their patients?**

23 **MR. PERKO: Object to form.**

24 **A I heard what they said. I also know they are**
25 **living in a bubble and they believe what they want to**

Monica Mortensen, D.O
September 28, 2023

Page 177

1 believe too. So -- there are also people who said that
2 it proved benefit for them. But why does it have to be
3 under 18? If they are choosing to spend the whole rest
4 of their life, and that's what they want to do, why
5 can't they wait until they are 18? What's a couple more
6 years until that frontal lobe fully forms, that they can
7 make truly informed decisions about what they want to do
8 with their life and who they want to and where they want
9 to go and if they want to have children.

10 Most 14-year-olds aren't really thinking about
11 fertility. Even if our cancer kids, when you are saying
12 there's a likelihood will all this chemotherapy you are
13 not going to have children, you know, should we harvest
14 eggs, you're having a conversation, and they don't
15 understand. So to me to put a pause on it until they
16 are 18 seems reasonable, since there's not enough data
17 to support all of this and what's going to happen down
18 the road. Seems reasonable to put a pause until they
19 are 18.

20 Q Do you believe that no minor patients benefit
21 from this treatment?

22 A I think that it's very hard to say. There
23 probably is a small group, but you are throwing out the
24 baby with the bath water. I mean, you have so many,
25 there might be a small that has some benefit, but there

Monica Mortensen, D.O
September 28, 2023

Page 178

1 might be a bigger amount that have a negative benefit,

2 so what do you do?

3 Q And you are basing this off the 10 individuals

4 that you've personally provided treatment for, witnessed

5 their treatment, and the two that you mentioned received

6 what you deem inappropriate care from Duke?

7 A And the reading and the data and the testimony

8 and talking with my friends and some of my other friends

9 at the other centers that I previously mentioned.

10 Q Do you believe that the doctors who provided

11 the testimony about the benefit their patients are

12 receiving, that they are wrong about their patients

13 benefitting from this?

14 A I think they want to believe that there is

15 benefit and that there is no harm in it, but they don't

16 actually know what the long-term harm is. The challenge

17 we also have is when you are looking at the data you

18 have to separate out from the trans-female to the

19 trans-male, because testosterone is euphoric, it's one

20 of the reasons why it's a controlled substance.

21 So when taking a look at psychological impact

22 on health, if I'm giving you a medication that's going

23 to boost your hemoglobin and give you more energy and

24 increase your muscle mass, psychologically you are going

25 to have some improvement. So is it that they are just

Monica Mortensen, D.O.
September 28, 2023

Page 179

1 taking testosterone and that's better than taking
2 Wellbutrin or an antidepressant or an anti-anxiety?
3 Nobody knows.

4 But that's why it's so hard to interpret the
5 data, is because you have a lot of confounding
6 principles. And I think a lot of people don't
7 understand that maybe the trans-males were happier than
8 the trans-females because we were getting a euphoric
9 medication. And that was only a two-year study from the
10 NIH, it didn't tell you what was going to happen five
11 years, 10 years down the road.

12 MS. CHRISS: If we could take a brief break
13 then come back on the record.

14 (Break taken at 3:22 p.m. until 3:33 p.m.)

15 (The deposition of MONICA MORTENSEN, D.O.
16 continues in Volume 2.)

17 * * * * *

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Monica Mortensen, D.O
September 28, 2023

Page 180

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
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21
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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

Monica Mortensen, D.O
September 28, 2023

1 REPORTER'S CERTIFICATE

2

3 STATE OF FLORIDA)

4 COUNTY OF DUVAL)

5

6 I, Kelly G. Broomfield, Stenographic Reporter,
7 certify that I was authorized to and did
8 stenographically report the deposition of MONICA
9 MORTENSEN, D.O.; that a review of the transcript was
10 requested; and that the transcript, Volume 1, pages
11 1-181, is a true and complete record of my stenographic
12 notes.

13 I further certify that I am not a relative,
14 employee, attorney, or counsel of any of the parties,
15 nor am I a relative or employee of any of the parties'
16 attorney or counsel connected with the action, nor am I
17 financially interested in the action.

18

19 DATED this 8th day of October, 2023.

20



21

22 Kelly G. Broomfield, FPR
23 Stenographic Reporter
24 LEXITAS

25

26

27

Monica Mortensen, D.O
September 28, 2023

1

	158:7		156:13 159:4
<hr/>		<hr/>	
\$	10:00	2	163:1,21
<hr/>	4:2	<hr/>	165:8
\$450	10th	2	2023
11:5	47:16 109:10	17:7 19:23	34:4,7 47:17
<hr/>	119:17 166:6	20:4 33:2	101:23 109:10
-	171:11	47:19 54:25	119:17 127:15
<hr/>		77:15 110:15	166:6 171:11
-ologies	11:15	118:24 139:5	180:8,12
54:14	53:15	154:1 157:7	
<hr/>	11:22	179:16	2025
0	53:15		180:17
<hr/>	12	20	
000044022	106:19	87:24 102:22	20th
156:10		156:14	106:19
<hr/>	12:52	2006	22
1	120:5	16:18	53:19,20,22,
<hr/>	12th	2007	23 54:2 61:20
1	116:23 117:8	12:18,25	79:18 107:12
7:5,8 9:11		20:25	
11:18 17:7	13	2012	23
21:14,19 22:9	29:8 107:3	16:18	81:9
33:3 53:19	14-year-olds	2014	24
54:25 84:2	177:10	12:19,25	92:5 108:15
118:25	15	20:25	254
10	16:6	2015	33:10,15,18
21:13,15 23:7	16	26:11 144:14	34:14 35:9
24:2,13,15	34:9 35:1	2017	102:15 107:24
80:12 87:24	72:12 104:3	23:12,19,22	109:15 118:7
95:19 98:5	164930	56:5 64:12	119:5
139:8,10	180:18	75:4 80:15,23	25th
178:3 179:11	17	86:10	154:2
10,000	26:11 35:11	2019	26
167:2	72:12	23:22 93:6	120:22 155:5
100	18	2022	27
20:15 25:22	103:3 104:3	20:15 34:1	156:13
32:13,20	172:22 177:3,	102:22 106:4,	28
36:17 49:12	5,16,19	12,19 107:8	180:8
51:20,23,24		112:15 120:22	28th
52:2 55:25		123:25 130:17	158:9 159:4
88:22 101:2		154:2 155:6	2:00
111:7 151:12			120:4

Monica Mortensen, D.O
September 28, 2023

2

2:02 120:5			accept 40:20,21,24
2nd 106:4 107:8	<hr/> 5 <hr/>	<hr/> 9 <hr/>	accepted 40:23 43:14 107:7
<hr/> 3 <hr/>	5 34:10 107:1 153:16,19	9 92:6 156:9 172:24 173:2	access 33:6 35:24 36:16 61:5 119:1
3 17:1 21:13 106:17,18,22 157:6,7	50 99:11,12	90 68:25	accidentally 159:2
30 84:16 136:1 180:17	5th 112:15 117:6	9th 166:1	accommodate 6:3
300 105:1	<hr/> 6 <hr/>	<hr/> A <hr/>	accomplishments 15:7
3:22 179:14	6 17:6 108:5 110:15 158:22 159:6 161:7 165:8	a.m. 4:2	accordance 29:3 46:1
3:33 179:14	6,000 155:21	A1 11:19	accurate 6:8,12 15:25 19:13,17 20:3 33:3 34:15 86:23 105:12 117:12 160:5, 19 169:7 172:23
<hr/> 4 <hr/>	64B15-14.014 35:3 159:22	A6 14:19 15:6	ACHA 113:4
4 107:1 120:8, 18 131:7,13 154:12,25	<hr/> 7 <hr/>	A7 15:5,21	Acha.myflorida.com/letkidsbekids. 147:20
4205 154:21,22	7 18:14 53:21 54:2 108:5,11 161:10,14	AAP 136:15 170:7	achieve 138:6,22
458.3311(b) 110:16	70 68:25	ability 70:3 175:11	ACLU 85:18
4:21 173:11	<hr/> 8 <hr/>	abnormalities 76:17	action 43:19 106:9
4:23 173:19,21	8 18:25 68:1 81:9 167:4,7	Absolutely 119:25	actions 102:24
4th 163:1,20 170:24 174:9	8th 106:12 130:17 180:11	abuse 39:14 40:1 85:12 111:21	
		abused 39:17	
		Academy 136:6 170:2	
		accelerated 22:16	

Monica Mortensen, D.O
September 28, 2023

3

actively 32:21 98:19	95:10	adults 21:6,16 34:24	139:8,10
actual 25:24 40:18 131:6 133:19 152:10	admit 94:21	40:19 45:4,15 52:12,16,18 53:9 108:13 129:12 139:22	172:22 Agency 105:15 106:7 107:2,4,7 114:12,24
ADA 136:11	adolescence 24:20 121:6	advanced 12:22	Agency's 115:24
addition 63:6,15	adolescent 78:18 89:16	advancing 45:6	agenda 131:8 134:5 159:9,19,24 160:9 166:23
additional 16:21 34:10	adolescents 21:16,22 23:8,18,24	advice 81:21 82:25 91:21,25	agents 76:16 140:6
address 42:13 43:4 99:6	24:11 28:18, 21 29:22 30:1 31:23 32:1 39:24 44:12, 16 46:10 51:5 55:1 80:3,13 81:3 83:8 87:4,17 89:11,13 92:7 99:20,23 103:3,6	advised 109:5 111:19	ages 176:19
addressed 144:25	adopt 108:2 109:2, 11,24 166:21	advising 28:21 60:22 148:7	aggressive 92:8,10,14,23
adjourn 173:20	adopted 107:21 109:21 111:6	advisory 106:19 107:4	agree 39:5 44:11,22 103:8,10 136:23 148:10 152:8 169:6, 23
adjourned 173:19	adopting 33:16	advocate 19:5,13,14 20:9 132:11	agreed 57:5 68:1 78:13 83:20 98:24 128:25 174:21 175:3
adjournment 173:25	adoption 127:10	affect 33:15	AHCA 105:15
adjunct 14:1,6	adrenal 15:9 22:23 23:2,3	affiliations 13:17 164:15	ahead 119:23
administration 105:15 106:7 107:5 114:13, 24 118:19 135:15	adult 34:22 40:12 67:9 85:12 89:15 107:12 138:6,15,22	affirm 4:3 38:9	Alioto 63:7
administrative 158:15		affirmative 121:5	allegations 167:11
administrators 79:6 83:1 85:24 89:22 91:24 152:6, 14		affirmed 39:20	alleviate 45:11
admissions		afraid 27:11 169:25	
		age 32:22 60:11 67:7 138:14	

Monica Mortensen, D.O
September 28, 2023

4

alleviated 96:17	anti- transgender 165:2	apples 61:6	139:2,7 173:18,20
alleviating 96:20 140:19, 24	antianxiety 179:2	application 124:22 126:7	approximately 135:25
Allopathic 124:10	antidepressant 179:2	applied 124:10,15 135:3	approximation 10:20
allotted 156:22	Antonio 28:9	applies 125:3	April 102:22 106:19
allowed 47:20 94:4,8 104:6 150:9 157:22	anxiety 77:14 95:5,9 96:3,5,23 98:3,10,15 104:15	apply 124:11,16,25 126:1	APRN 122:21
American 54:23 136:6 170:2,6	anymore 50:20 60:2,4 86:10 136:7 176:15	applying 70:21	APRNS 74:2
amount 68:16 77:2 178:1	anytime 89:14 91:22	appointed 33:25 113:1 123:12,24 124:20 125:3, 6 126:9,12 127:12 130:15 161:18 162:7, 11 163:13 165:7	area 26:13 30:14 44:1 58:9 61:18,23 62:2,8 65:3 129:16
Amy 132:1,13	AP 169:23	appointment 124:3 126:3	areas 29:13 62:25
analogue 65:13	apologies 115:20 120:24 133:17 159:12	appropriately 45:18	arguments 168:10,11
analogues 65:21 66:2,7, 20,24	apologize 65:10 80:21 81:13 107:3 125:1 127:9 130:14 131:6 136:4 152:4 154:18 155:1 157:12 159:16 161:6 171:7	approval 40:25 91:3,14 134:25 136:25 137:3 138:9 140:7	Arizona 28:10
analysis 58:4 142:6 143:5 167:6	appeared 180:8	approved 47:20 48:12 83:12 84:1,2, 3 88:11 91:23 108:14 134:18 135:14 137:1, 13 138:12	arms 140:13
anastrozole 22:3	appears 131:8		Arnold 78:19 79:10, 11
and/or 44:4			aromatase 137:9 138:3
anecdotally 41:17			Arons 172:1
Anthony 63:7			article 63:6,16
			articles 36:5 49:3 57:19

Monica Mortensen, D.O
September 28, 2023

5

assault 40:9	128:25 165:10 174:20	August 10:23 112:15 116:23 117:6, 8	162:25 163:20,23 165:1 166:15, 19 168:24 169:4 170:20, 22
assaulted 39:17	assumed 76:4	auspices 100:15 101:12	
assess 67:13 68:13 69:23 96:9 97:21 148:6	assumption 165:12	author 104:23 105:8	<hr/> B <hr/>
assessed 26:5 44:19 70:4 93:8 143:9,24	attach 107:9	authored 63:7	baby 177:24
assessing 26:7 79:19 80:4 81:5,6	attached 107:2 108:16	authority 47:14 110:16 162:20 180:7	bachelor 18:18
assessment 81:5 96:7 141:16 142:6, 8 143:15	Attachment 11:18	authors 129:3	Bachelor's 12:3
assigned 38:9,11 46:1	attempt 96:13	automatically 72:19	back 20:16 21:14 23:11 33:3 48:22 52:20 57:4,9 62:14, 19 64:12 67:2 68:9 75:19 85:5 86:10 90:8 116:24 120:4,13 131:6 133:7 134:10 152:3 154:18,25 157:5 158:9 160:12 169:9 170:8 173:6 179:13
assist 29:21 30:1 32:7 64:6 75:24	attempts 96:12	aware 52:1,7,22 53:8,10 55:5 56:18 62:16, 21 63:3 72:17,20,24 104:4 106:4 107:21 111:3 112:13,14,18 114:11,17,23 115:2,20 116:3,7,10 117:21 128:8 130:1 134:20 135:23 136:15 137:12,14 139:20,23 143:4 148:19 149:6,21 150:11,21 151:3,17,19, 20,25 152:3 161:18,22	backed 170:9
assistance 73:20	attend 12:4 54:12,14 57:11 114:25		background 4:17 11:25 125:15,22 151:12
assistant 13:14 35:18	attendance 57:10 64:15		backlog 26:18
assistants 127:25	attended 57:7		
associate 13:11 155:22	attention 166:22		
association 54:24 168:25	Atterberry 132:1		
assume 5:14 36:17 37:9 112:22 125:2,4,23	attest 111:25		
	attorney 91:13		
	attorneys 91:3		
	audibly 5:17		

Monica Mortensen, D.O
September 28, 2023

6

backs 170:3	basis 27:10 39:10	13,17 53:5	big 56:10 77:17
bad 167:21	40:1 42:20	65:17 141:10	79:24 85:5
ball 64:6	44:20 46:14	177:2,20,25	90:5 125:20
ban 49:19 102:15 118:12 149:14	48:14,24	benefits 67:12,13,21	bigger 56:12 178:1
bang 136:14	68:12 76:8	70:25 71:1,	biggest 148:16
banned 47:5,6,25 48:8 49:7,8, 13 109:9 127:11	85:2 86:21	12,13 72:8,17	Biggs 151:17 160:13
banning 50:24 51:4 114:19 118:7 119:18 128:9	103:16 119:1, 8,9,12 142:9	73:7,10 83:19	bilateral 85:16
bans 33:6 119:1,8, 10,12	162:15	84:22 90:15	Billy 132:13
bar 46:10	Bates 154:13 156:10	137:16 140:18	biological 77:7,8,18
based 41:23 49:23 51:18 54:18 55:3 57:13 60:20 90:2,3 98:22 103:13, 25 105:15 107:4 119:19 174:20	bath 177:24	172:8 176:22	birth 22:25 38:11 46:1 76:16,21
basically 23:4 97:19	bathroom 119:24	benefitting 178:13	bit 11:25 17:5 60:21 162:13 176:10
basing 178:3	began 4:2 80:15 97:16	Benson 56:21 102:10 120:11,16 121:9 123:8 124:10 125:25 126:7,10 127:3 128:5, 6,8,18 129:7 130:1,23 131:11 132:13,20,24 143:5 162:8	blank 143:23 144:5
	begin 55:17	Benton 117:18	block 48:18
	beginning 80:14 89:19 118:16	bet 150:5	blocker 22:16 25:3 60:12 64:8 67:8 70:10 72:25 73:5 76:25
	behalf 17:7 77:6	beta 22:16	blockers 17:24 22:5 25:5,12 44:11,15 50:23 51:3 65:14 67:4
	behavioral 95:10	Bettye 154:15	
	beings 20:2	Bi-county 19:1	
	believed 66:14	bibliography 10:3 16:5,8 49:4 57:22 104:21	
	believing 39:10 42:20		
	beneficial 73:25 74:5		
	benefit 43:5 44:18 45:2 51:7,12,		

Monica Mortensen, D.O
September 28, 2023

7

70:11 71:8,16	150:12 151:9	Bones	157:5
72:18 75:11	152:7,18	105:21,23	bring
84:9,12 91:7	153:24 155:20	book	7:19 43:6,10
98:3 99:8	156:2 157:9	72:4 131:21	62:14
103:4 104:1	159:23 160:20	132:15 150:16	Broomfield
106:20 122:12	161:19 162:3,	158:15 159:3,	180:6,16
132:22 134:14	8,11,25	5 160:22	brought
blocking	163:2,10,15,	161:11	56:2
28:24 31:13	17,18 164:10	books	Broyles
71:2 76:25	165:7,11,12,	36:10,21	154:3,8
82:7	14,16 166:1,	37:2,8 112:22	155:12
blood	2,3,16 169:4,	boost	Bruggeman
32:6 76:15	17 171:17	178:23	6:25
board	172:11,25	born	bubble
6:19 33:13,	173:10,12,15	38:8	176:25
16,18,20,23	174:3	bottom	buck
34:1,5 35:2,	boards	11:19 110:5	136:14
7,13,14 36:1,	12:24 33:8	154:2,21	Buck^low
13,18 47:10,	35:17 47:18	156:10 157:6	98:22
13,15,18	100:21	bought	Buckloh
71:17,24	102:14,18	164:16	30:18 57:1
91:16 101:1	105:24 106:5,	bounds	61:24,25 63:6
108:15 109:1,	13 107:21	42:11	64:19 68:5
2 110:16	108:2,9	brain	69:25 70:23
111:5,8	109:16,23	87:15,18	75:21,22
112:9,14	111:10	break	99:9,11
113:5 114:25	113:11,20,24	6:1,2,5	bullet
116:11,17,19,	114:5,9	53:12,15	110:8 133:7
22,25 117:1,	115:11 119:4	104:11 115:19	Burgo
6,8 118:6,11	123:11 126:15	119:24 120:1,	131:17
120:12,16	127:10 133:22	5 179:12,14	Burleigh
121:12	150:22 162:10	breast	132:14
123:12,24	165:24 166:21	40:14 45:8	business
124:3,9,11,12	167:14	76:19 77:1	50:6 152:17
125:3,6,8,12	bodies	125:18	By^county
127:20 130:6,	148:8,11	Brewer	12:10
9,16 131:19	body	132:14	bygones
132:4,9	35:7 39:19	briefly	165:20
133:8,18,23	40:13 77:13	28:10 133:7	
134:12 148:5	bone		
149:11,13,22	15:10,19,24		

Monica Mortensen, D.O
September 28, 2023

8

C	cards	22 10:14,25	76:6 85:1
	134:3,5	11:8,11,13,15	94:14 97:23
CAH	153:8,9 155:8	32:25 33:4	139:25 145:25
32:14	156:3,8	51:15,23 54:7	178:9
calcium	care	67:10 90:2,3	central
15:10	15:11 21:6	149:24 159:5	18:9 66:21,24
calculate	25:1 26:15	case-by-case	cerebral
67:1	28:22 29:22	44:20 46:14,	85:6
call	30:8 31:5,6,	20 49:14	CERTIFICATE
54:16 59:1	10,12,18	cases	180:1
94:10 105:20	32:3,17 39:3	54:17	certified
called	47:4,21 48:1,	categorically	125:20
63:2 164:19	9 55:2,3	47:5	certify
167:5 173:10	60:14 63:12	categories	180:7
calling	65:2 67:10	41:10	cetera
173:24	78:13 81:10,	category	26:16 32:15
Campaign	12,17,18 82:6	39:25	81:23 144:15
155:16	85:11 94:20	caused	160:9
cancer	105:15 108:6	176:18	challenge
62:6 76:15,19	109:9 110:17	causing	178:16
77:1,2,3,4	111:1,3 112:3	138:19	challenging
125:18 140:6	114:19 119:18	ceased	54:17 82:14,
175:25 177:11	121:5 125:17	69:7	16 139:23
cancers	128:10 132:20	center	change
76:24 77:3	133:1 141:2,3	13:15 17:24	40:16 55:15
candidates	146:5 147:8	18:2 21:5	172:20 173:13
125:2	148:7 149:1,	25:7,9,10,19,	changed
capacity	7,14 150:14	23 26:1,21	13:10 38:5,14
31:12 37:22	165:22 169:1	31:16 60:10,	103:21 104:17
41:11,15	170:13 178:6	13 64:1,7	changing
107:12	career	72:15 73:6	40:14
car	65:23	76:7 78:14,20	channels
87:16 138:8	careful	80:1 83:6	100:18
card	130:6	123:23 125:13	characterize
157:23	Caregivers	176:10	159:15
cardiovascular	62:17	centers	charge
77:17	Carroll	25:20,21	151:23
	123:3	26:2,19 30:23	chart
	case	32:1 42:2,4	
	4:16 6:15,18,		

Monica Mortensen, D.O
September 28, 2023

9

84:23	18 89:25	cite	143:5 145:3,
check	136:1	96:3	20 146:3
10:18 101:19	Childrens	cited	close
117:11	13:4 17:9	113:25	32:20
checks	28:3,11 54:2	clarification	clots
32:6,7	Chloe	5:12,14	76:15
chemical	131:22 132:10	clarify	Club
107:14	157:10	13:18 31:20	54:15
chemotherapy	choose	33:11 41:16	Coffman
177:12	153:10	42:8 81:4	161:13 162:7
Chen	choosing	96:19 127:5	coined
104:22	177:3	clear	147:18
Chicago	chose	96:24 150:2	Cole
12:1,5,16,18	136:13 151:24	154:8 169:12	131:22
20:18 28:11	Chriss	click	157:10,16
chief	4:12,14 7:11	55:7	collaborate
113:21	20:8 27:24	clinic	128:19
121:15,23	28:4 37:10,15	29:19 30:20	colleagues
child	53:11,16 80:9	39:13 63:7	27:18 41:22
40:12 85:7,9,	105:19 106:25	64:22 68:17	63:15 77:6
20 92:16	108:25 110:2,	71:25 74:3	99:19 100:21
138:13	23 114:4,16,	81:22 82:10	101:4 130:11
155:15,19	22 115:3,10,	105:11 142:10	143:3 145:9
child's	18 116:9	143:10,11	collectively
51:15	118:5,11,24	146:17	104:13
childhood	119:15,25	175:20,24	college
24:19	120:3,6,21	clinical	11:25 12:5
children	131:16 135:8	13:12 15:6	comfort
14:23 21:16,	136:22 140:17	17:5 19:8	102:9
22 68:13 69:5	141:12 153:22	20:21 47:4,20	comfortable
87:3 93:8	154:23 157:3	48:10 63:2,11	25:7,11 39:16
103:3,6	159:1,8	101:13 111:24	43:24 44:6
132:23 136:18	161:6,8,17	121:24 136:18	59:14 61:1
139:8,9,20	165:6 167:10	144:17,19	74:12 75:11
141:15 145:1	173:5 179:12	162:14 163:2	76:1 78:7
175:13 177:9,	chunk	164:2 172:4	80:17,25
13	69:17	174:23	92:20 100:4
children's	circumstances	clinics	127:24 143:22
79:9,10 85:4,	45:20 134:4	54:3 141:14,	
		20,22 142:4	

Monica Mortensen, D.O
September 28, 2023

10

commend 144:13	130:16	compromise 67:7 138:15	24:8 37:12
comment 117:18 128:16 152:24 155:7 156:18,23	communities 20:1	concern 40:16 41:6 42:25 65:3 85:1,3,10	confirmed 143:21
comments 48:17 128:15 132:15 133:17,18 157:20 158:8 160:8 172:12	community 36:5 85:23 87:6,11 99:14 168:5	concerned 85:12,13,25 134:13	confirming 68:7 89:17
Commission 180:17,18	compare 61:6	concerns 9:24 11:2 27:17 36:6 63:21 82:18 85:22 89:21 99:3,6,20 145:23	conforming 45:22
commissioned 147:12,16	compared 68:17	conclusion 142:7 143:7	confounding 179:5
committed 85:21	compelled 123:15	condition 102:3 138:19 139:2 140:19, 24 141:2,4	confused 40:17 171:8
committee 35:13,15,20, 23 37:4 116:24 117:4 126:16,23,24 127:2,6,18 128:1,3 136:16 151:14 161:23,24 162:18	compensated 11:4	conditions 15:14 21:17 41:12,13 66:3,19 74:18 78:10 88:10 96:1	confuses 138:14
committees 35:16,19 126:18,20	complaint 90:5 92:13 112:8	conduct 140:2 174:25 175:12	confusion 87:14
common 66:21 83:24 84:17 136:24	complaints 148:19,23 149:6 153:6	conducted 107:5	congenital 23:3
commonly 15:20 65:13	complete 6:9,12 86:23	conference 54:7	connected 78:22
communicate 100:1	completed 12:12,21 18:25	conferences 54:4,6 55:12, 17	connection 6:22 118:20
communications	completely 49:13	confirm	cons 168:7
	complex 110:19,20 111:5		consensus 23:12,14 54:19,21,24 55:1,4,6,7,10
	compliance 94:9		consent 17:14,15,20, 21,23 28:2 33:16 35:9 52:21,22,23 71:21 82:21, 22 83:11,16, 22,23 84:5,20 86:7,8,11,20 87:20,22 88:13 89:4,7, 10 91:2,4,5,
	complications 82:19		
	component 87:10		

Monica Mortensen, D.O
September 28, 2023

11

6,10,13 92:1 102:17 107:13,19,22 108:3,4,21 109:3,6,12, 14,16,20 110:4,19 118:8 126:25 137:17	contacted 124:2,5	conversations 7:21 8:7,12 42:16,25 44:4 100:25	93:10 97:24 100:18 103:6, 7 106:2 108:6 109:12 110:4, 6 115:14 117:2,3,5,10, 14 121:7,8, 11,13,19 122:14,16 123:14,25 124:1 126:4 127:15,16 129:25 130:24,25 132:5 137:7,8 139:15,16 143:13 153:11 158:11 163:4, 6 164:13 170:10 171:1, 12,19 173:22 174:15
consented 85:17	content 129:5	conversion 103:15	correctly 20:7 24:23 25:15 29:1 173:8
consents 9:24 11:2,3 17:12,16,19, 25 18:4 33:22,24 35:21 51:11 53:3 71:17,18 83:7 86:3 88:1,8 89:7,8 90:1 91:2,15 107:23 108:14 126:21	context 47:4 84:7,8 92:2	copies 89:7 131:7	cosmetic 71:11
consequence 86:1 88:24	continue 42:15 70:8 95:24	copy 36:22 37:8,11 71:21 72:6 86:8,11,12,14 107:8 158:22 159:2 160:19	cost 137:2
consequences 74:14 77:10 82:18 85:2	continued 24:25 75:12 80:4	correct 5:1 6:16,17, 20 11:6 14:25 15:2,4,13,15, 17 16:4,7,10, 13,14,17,19, 25 18:13,24 20:12,24 21:8,12 24:12,14,16, 17 26:4,7 27:2,3 28:14, 16,22,23 29:2,5,7,19, 20,25 33:25 34:2,8,19,20, 22,23,25 35:5,6,10 37:18,19 41:13 48:10 55:23 59:6 60:6 66:4,8, 12 67:15 68:6 78:12 79:18 80:18 81:20 82:8 84:24 89:3,5,20	counsel 7:22 8:7,14, 18 9:8,14 10:15 27:23 117:24
consideration 172:12	continues 179:16		counseling 103:15
considered 10:1,5 12:9 135:5 138:7 167:14	continuing 65:9 67:25		counting 154:20
consist 54:9	continuos 22:11		countries
consistent 107:6 133:12	contract 91:22		
consultants 115:6 116:4	contracts 111:12,13		
	contrast 61:7		
	control 15:22 23:1 76:16,21 137:19,21 140:21		
	controlled 139:13,18 178:20		
	conversation 44:3 52:25 83:17 90:9,14 142:17 143:21 164:3 177:14		

Monica Mortensen, D.O
September 28, 2023

12

46:22 47:3	criminalization	4:8 179:15	December
48:23 49:7,11	48:8	180:7	33:21 34:1
50:4 53:8	criteria	Danielle	123:25 127:13
country	25:18 68:3,8,	152:4 153:23	159:4 163:13
168:25	10,14 69:9,14	154:3,14	165:8
COUNTY	70:5,20 92:8	155:5,13	decide
180:4	143:20	156:13	57:24 75:7
couple	critically	data	78:6 83:22
177:5	144:16	36:8 51:17	125:5 143:14
courageous	cross	63:21 84:16	decided
42:16,25	60:11 73:1	88:22 103:12,	55:24,25
court	cross-hormones	24 104:4	75:9,10 80:24
4:24 5:8,18	25:8	135:2,6,16	81:24 82:2
85:17	cross-sex	136:18 137:23	109:23
cover	31:13 44:23	139:13,18	deciding
32:5	72:10,19	177:16 178:7,	72:24 115:13
coverage	75:13 80:6,25	17 179:5	decision
58:11 82:16	81:25 91:8	date	49:18 53:6,7
128:9	104:2 132:23	10:18 120:23	67:14,22
create	134:14 145:2	dates	80:16 162:13
64:22 76:24	cured	117:11 171:9	decisionmaking
109:16 165:10	97:2	day	87:5 115:12
166:23	curing	10:22 62:19	125:8 164:7
created	96:21	75:15 85:5	167:15,17
20:3 35:8	current	109:11 180:11	168:22
78:20 90:1	13:16 173:14,	days	decisions
91:2 92:1	17	161:3	148:11 149:12
115:7	CV	de-transitioned	177:7
creates	11:17,21	129:24	deem
76:22 77:24	14:19 136:5	de-	178:6
creating	160:13	transitioning	deemed
34:11 86:19	CVS	129:13	70:4
91:10 109:15	105:7	deadline	deep
150:13	cycles	157:21	42:8
creation	40:13	deal-breaker	deeper
116:4	<hr/>	162:24	43:1
credit	D	dealing	deeply
176:20	<hr/>	72:22	134:13
	D.O.		

Monica Mortensen, D.O
September 28, 2023

13

defendant 6:18 9:14	Densitometrist 15:18	69:1	devices 18:8 22:10 84:1
defendants 6:15 8:14 36:22 159:5	densitometry 125:20	desisted 69:6	DEXA 15:20
deficiency 22:19 74:21 138:5,10	density 15:19	details 147:22 148:2	diabetes 13:15 15:22 18:8 21:19 22:9 54:11, 23,25 62:8 77:16,23,25 84:1,2 139:5 175:25
defining 147:6	Department 102:23 105:16 108:8,21 113:12 147:12,16 171:15	deter 45:25	diagnose 24:3
definition 135:24	Department's 107:4	determination 80:5,16	diagnosed 23:9,18,25 24:7,24 25:15 29:1 80:13 81:3 119:2
degree 12:2 18:16, 18,21	depending 22:13 23:5	determine 24:14 25:23 26:6 51:11,16 56:19 65:17 107:5	diagnosis 24:5,8,9,10, 14 25:24 26:6 27:1 64:9 69:6,20 70:2 75:25 142:14
Delaware 63:8,12 79:1, 2,7	depends 134:23 153:4	detransitioned 90:21	die 85:10
delayed 21:18 22:4,7 74:23 76:20	deposed 4:18	detransitioner 131:22,24	differ 38:11
deliver 22:11	deposition 4:18 7:23,24 8:8,15,21 118:17 170:16 179:15	detransitioners 90:5 111:21 129:14,19,20 130:3,19 155:9 157:8 164:6	differed 166:3
demand 141:16 142:5	depositions 9:5	Detroit 12:11	differences 21:17
demanded 92:25	depression 77:14 95:5,9 96:3,5 98:2, 9,15 104:15	devastated 85:6	difficulty 138:8
demanding 92:9,15	depth 141:16	developed 50:12,18	dig 43:1
demands 85:24 93:3	describe 131:1 138:24	developing 40:14	
demonstrate 107:16	describing 80:25	development 21:18 61:22 102:14 118:19 150:12 158:11 159:15,19 160:8	
demonstrated 76:14 140:19	desist		
denied 93:22			

Monica Mortensen, D.O
September 28, 2023

14

Dipietro 173:7,11	73:7,10 75:4 76:18 83:18, 19 89:23 92:5 98:20 99:4 112:15 116:23 117:7 129:11 130:10 132:21 134:11	disorders 14:23 15:8,9, 10,24 21:20 22:12,13,23 23:2 32:15 39:13 61:22 138:6	doses 60:23 78:1
direct 4:11 147:8			Dot 52:10
directed 157:6			drafting 126:21
directly 41:19,21 43:12 50:21 176:21	discussed 18:14 64:14 70:6 71:1,13 72:8 82:20 96:16 113:4 115:24 127:11 130:19 132:25 133:1 149:24 153:8 160:7 162:12 174:17	dissuade 45:21,23,25	drafts 72:4
director 13:12,13,14 63:11 152:9 153:24		distinguish 98:14	draw 134:8
disabled 138:7		Divall 28:3	drew 118:20
disagree 102:3 169:19		dive 42:8	drive 62:11
disciplinary 35:17	discusses 106:19 107:2 129:11	Diverse 62:18	driven 26:12 33:23 58:12,17 59:8 84:5
discipline 29:17	discussing 130:21	divided 168:4,6	driving 87:16 138:8
disclose 94:21	discussion 48:23 49:5 57:2 69:22 117:9 130:2, 11 160:7 173:16 174:2, 11,19	division 54:3 121:15, 23	Drs 163:23 165:13
discourage 42:15		doctor 63:8 78:19	Drug 135:15
discover 144:1		doctors 74:16 123:16 128:19 171:21 176:20 178:10	drugs 61:4 136:16
discovery 117:25 118:15	discussions 42:21 129:3 163:15,19	document 7:7 53:4 83:17 120:10 137:15 168:20	DSD 21:22 30:5 59:13,15 62:4
discriminated 87:7	disease 32:15 50:13 77:15 125:18 170:6	documented 52:25 76:23	Ducatel 173:14
discrimination 27:11	disorder 23:6 176:1,2	documents 7:19 34:11 86:16 155:21	dues 136:10
discuss 24:7 42:14 55:14 58:16 71:15 72:16		dose 76:21 85:15	Duke 25:21 42:7 142:22,23,24 145:6,19,22 146:1,17

Monica Mortensen, D.O
September 28, 2023

15

178:6	6 95:21	152:23 159:14	elected
duly	96:18,20,21,	161:21 162:12	59:22 95:13
4:9 180:9	22 97:3	166:16	99:17,19,22
duplicated	98:16,17	early	100:2
175:9	99:18,24,25	76:19 104:2	elevate
Dutch	100:2,10,14	129:22	55:16
103:13,14,19,	101:10	easier	em-mail
24 104:5	102:11,20	5:8	155:13
111:19 142:18	104:6 105:10	easily	embarrassing
DUVAL	107:15 108:13	104:17	162:3
180:4	111:1,16	edits	emerged
dysphoria	113:9 115:21	129:8	104:5
14:10,14	119:3 122:2,	educate	emergency
15:1,16 16:2,	13,19 123:1,	55:15	33:16 34:14
16 17:15	6,20 130:24	education	35:8 102:16
18:12,18,19,	131:2 133:4	64:15	107:23 108:4
23 19:3,9	143:9 147:4	educational	109:6 118:8
20:19,23	148:19 149:14	54:4,5,8	emotional
21:2,11 23:9,	150:14	effect	172:16
16,19,25	170:16,21	33:14 34:7,13	employed
24:4,11 26:3,	171:22 172:5	effective	13:23,25 14:7
6,8 27:2,14		44:12,15,23	encounters
28:18,21	E	45:3,11,14	136:1
30:25 31:14	e-mail	135:12 140:24	encourage
35:4 39:6	10:19 120:10	effects	42:14,15
42:1,17	133:23 153:16	15:23 51:9	45:25 125:25
44:12,16,24	155:5 158:1,4	77:17 82:18	encouraged
45:4,12,15	e-mails	84:13 135:17	171:17
50:25 51:4	36:6	efficacy	encouraging
52:11,16	eager	107:16	127:10
55:22 56:15	5:5	effort	end
59:24 60:5,8	earlier	67:9	73:1 124:17
61:9 62:24	80:2,10 81:15	eggs	148:3 168:8
66:10 68:19	95:19 100:16	177:14	ending
69:6 71:3	113:15 118:6	elaborate	12:18
73:11 74:13	123:8 125:19	175:15	endocrine
75:2 79:20,23	130:22 132:25	elect	8:2 21:17
80:3,14,18	137:5 142:10	99:7 102:2	23:16 29:4
81:3 89:12	145:5 147:5		
90:24 91:11	149:20,21,24		
93:9,20 94:1,			

Monica Mortensen, D.O
September 28, 2023

16

32:18 36:2	energy	18	4:9
46:11 49:22	178:23	ethics	Excellent
55:7,21 56:8	England	151:12	133:21
60:16,19 68:9	104:22	euphoric	exception
70:5,22 94:20	enjoying	178:19 179:8	100:23
97:20 103:12	161:2	Europe	162:14,16
136:11,12	ensure	46:17 48:25	163:2 164:2,
169:21,22	84:6 155:8	49:24 50:2	12 166:4
170:1,12,17	156:3	61:3	173:15,17
175:4	entered	evaluate	excerpt
endocrinologist	39:25	29:21 69:23	161:10
13:2,11 32:10	entertain	evaluated	excess
68:4 70:19	176:7	64:4	77:12
85:20 105:9	epidemic	evaluation	exchange
122:17 127:21	111:11 148:16	24:18 40:7	153:17
146:21 147:1	Erin	41:8 68:2	excited
154:9	132:14	69:18	59:9
endocrinologist	establish	evaluations	excluded
s	29:22 64:1	26:25 61:11	162:20
8:25 26:14	75:5 82:9	144:3	executive
27:5 58:19	102:13 110:17	everyone's	152:8 153:24
59:5 70:21	established	168:3	exemption
74:12 81:14	118:6	evidence	141:9 171:18
101:5,9	estrogen	46:12 57:12	174:11,17
128:4,7	21:25 22:7	60:18 104:4	exercise
endocrinology	72:9,13,15	111:15	170:7
12:24 13:12	73:8 74:11,19	147:16,19	exhibit
15:8 31:17	76:2,14,15,	148:6 175:1	7:5,8 9:11
54:3,8 59:12	20,22 78:4	evidence-based	11:18 17:7
74:7 113:21	85:8 94:23	147:18 164:22	19:23 20:4
121:4,16	98:12,13	evolution	21:14 53:19
122:25 125:16	estrogens	132:19	106:17,22
126:22	76:23 77:2,3	exact	107:3,9
endocrinopathie	85:15	10:18 24:1	108:16,19,20
s	ethical	146:22	112:13 120:8,
123:19	112:9 140:23	EXAMINATION	18 131:13
endocrinopathy	141:1	4:11	153:16,19
94:7 123:22	ethicists	examined	158:22 159:6
energies	148:5 149:11,		161:10,14
59:20			

167:4,7 173:2	experimental	expires	facility
exhibits	107:13 108:12	180:17	27:7 78:14
120:13	115:22 134:21	explain	85:11
exist	135:5,9,10	31:9 38:18	fact
79:12	expert	67:11 88:19	50:2 76:24
expect	4:16 6:15,21	explained	101:11
29:13 137:1	7:18 8:1 9:2,	65:15 66:14	factual
expensive	5,9,10,17,22	explanation	117:25 118:14
87:16 136:10	10:13,16,24	38:6 164:1	128:23 146:23
experience	11:22 17:6,8,	exploded	169:9
17:5 21:15	11,14 21:14	176:16	failure
25:23 38:20	29:8 32:24	explored	21:18,24
39:12 41:23	33:2,22 34:9,	39:15 46:6	74:20,21,25
42:10 46:18	12 37:17,20	expose	fair
54:18 65:12,	46:23 49:23	140:9,10	24:10 28:14
20 66:6,12	53:18 67:5	exposure	34:4,6 135:22
73:22 74:10	114:11,17	76:20,21	137:4 159:14
95:7 111:24	118:3,5,18	expressed	faith-based
116:15 122:11	119:7 131:1,	169:18	19:17
126:22 129:14	4,11 147:6,8	expressing	fall
130:18 132:8	150:22	129:12	41:10 74:25
133:12 136:18	151:18,21	extensive	familiar
137:6 141:24	154:8 156:16	21:15 113:25	39:2 63:8,17
142:9 143:6	expertise	137:6 164:6	102:17,22
145:10	30:24 31:1	extent	104:25 105:5,
146:14,16,25	46:18 50:8	14:24 37:3,6	14,20 106:3,
156:4 172:4,5	61:8 62:25	external	12,18 112:23
176:13	91:10	38:14	114:6,8 115:4
experienced	experts	extracted	131:9,11
89:24 145:17	7:1 17:18	159:3	144:15 147:24
170:5	26:12 49:24	<hr/>	151:6 155:15
experiences	97:19 127:23	F	158:14 161:12
98:14,16	132:19,21	<hr/>	162:9 163:24
132:6	147:10 148:5	face	164:14,24
experiencing	149:10,16	45:8 81:22	167:11
40:1 42:12	150:22 151:3	82:13 149:25	familiarized
46:5 175:23	152:1 159:10	161:25	119:16
experiment	160:7 170:3,	faces	families
103:17	4,8,9,10,11	43:16 157:13	20:1 65:17
	experts'		66:16 84:14
	8:21		

Monica Mortensen, D.O
September 28, 2023

18

92:8,22 112:7 175:21	federally 125:13	86:17 91:21 92:16 127:23 174:8	5:6,7 fitting 38:22
family 43:9,10 67:22 76:18 83:19, 20 88:25 98:23 125:14	feedback 98:22	female 39:19 104:12	five-minute 53:12
fast 138:19,20	feel 25:7,11,17 38:23 39:12, 16 40:10 43:8 44:5 46:23 51:11,16,23 56:10,19 65:5,6,23 69:1 76:1 78:7 80:16,25 82:22 92:19 97:16 99:4 100:4 111:17, 22 127:22 162:22 168:8 170:1	females 77:18	flip 7:10 133:6
fatty 76:22	feeling 162:21	feminizing 45:7 71:10	Florida 13:5,24 14:5, 7 17:10 25:20 28:15 33:8 35:13,14 36:12 42:2 46:9 48:7 79:10 100:24 101:6,9 102:23 105:2, 16,24 108:8 110:16 113:12 114:24 119:3, 5 120:12 121:25 126:14 141:22 144:20 145:25 147:11,16 148:25 149:1 171:15,23 175:2,6,11 180:3,17
favor 35:4 119:17 128:9	feelings 46:5,7,8 96:22	fertility 86:1 87:24 177:11	Florida's 49:19
FDA 83:12 84:1,2 88:11 134:18, 25 135:4,14, 18 136:25 137:12 138:9, 12 139:2,7	fellow 81:14	field 46:18,19 49:25 56:16 83:2 147:6,9 168:14	Florinef 23:5
FDA-APPROVED 88:14	fellows 54:10	figure 157:11	focus 59:12,20 165:22,23
FDOH000042405 154:13	fellowship 12:14,15,19, 22 14:4 20:11,17	file 92:12 112:8 141:9	focused 89:16
fear 40:15	felt 44:8 59:14 60:19 61:1 64:23 65:1,3, 6,15,17 68:3 70:20 74:12 75:1 77:5	filed 148:20 149:6	folks 26:8 27:20,21
feasible 176:15		fill 153:9 157:23	
February 34:4 47:16 101:22,23 109:10 119:17 127:14 153:5 163:14 166:6 171:4,11 174:11,12		filled 155:8	
federal 47:23 48:12		find 140:20 168:3	
		Finding 144:2	
		findings 107:8 115:25 116:13	
		fine 100:8	
		finish	

Monica Mortensen, D.O
September 28, 2023

19

28:15,17	formed	free	future
30:23 41:14	76:8 86:13	50:6	137:2
66:5 69:12	116:24	Friday	
76:1 80:4	forming	154:4	
81:18 90:17	66:11	friend	
132:3 133:13	forms	86:12	Gadea
146:13 152:23	17:21 21:25	friends	165:14
157:8,20	22:6,10 35:9	26:14 27:13,	Gainesville
166:20	71:22 86:20	15 81:10,11	29:23
follow	89:10 91:5,13	82:4 89:6,17,	Galvin
32:14 39:7	92:1 102:17	22 91:21	131:24
94:16 95:23	107:22 108:3,	143:3 178:8	gap
97:23 103:17	4,14,16,21	front	12:17,20
120:11 170:12	109:3,14,17,	8:24 35:24	20:25 105:21,
follow-up	20,24 110:4	42:18 44:6	23
93:25 94:3	118:8,20,21,	134:7 154:25	GAPMS
133:9	22 177:6	160:17	106:6 113:5
Food	forthcoming	frontal	115:4,20
135:15	50:9	177:6	116:5
Ford	forum	full	gather
12:11 19:2	54:8 90:14	10:4 37:2	167:22 174:25
Forgive	150:8 153:7	fully	gathered
78:21	forums	177:6	96:4
form	62:12	functional	gave
11:1 42:23	forward	14:21 138:6,	85:8 86:12
49:20 76:11	53:6 82:2,3,5	22	gay
80:7 91:4,6,	113:6 143:16	Functioning	40:21,22,24
10 104:8	168:16	104:23	41:4,5 43:9,
105:18 108:23	found	fundamental	11,14
109:12,25	82:24 89:7,8	20:2	gender
110:21 114:2,	115:21 135:25	funded	14:10,14,16
15,20 115:1,	175:16	144:14	15:1,16 16:2,
8,15 116:6	fourth	funding	15 17:15
134:22 136:19	19:24 154:18	125:14	18:11,17,19,
140:11 141:5	160:11	fuse	22 19:3,9
148:12 157:2	Fox	85:8 138:18	20:19,22
165:3 169:3	121:14,15	fusion	21:2,10 23:9,
176:23	fraudulent	138:16,19,21	16,19,25
formal	51:23		24:3,11 26:3,
26:9,21			6,8 27:2,14

28:18,21	147:4 148:18	145:7 158:23	gravitated
29:9,11,24	149:14 150:14	166:12 178:23	38:22
30:24 31:14	164:22 167:6	giving	great
35:4 37:24	170:16,21	6:8 61:2	5:11,21 6:7
38:2,6,7,10,	171:22 172:5	140:14,16	34:9 59:23
13 39:1,6,16	gender-	178:22	81:9 85:1,3,
40:18,22	affirming	glanced	22 95:17
42:1,17	31:7 114:19	89:15	104:18 121:1
44:12,16,23	128:10 132:20	glucose	148:13 152:11
45:4,12,15	gender-firming	22:11	160:11,15,25
46:2,10 50:24	169:1	Gnrh	161:20 168:10
51:4 52:11,16	general	65:13,21	173:23
53:9 55:22	12:13 15:7	66:7,20,24	Gregory
56:15 59:23	19:6,13 59:11	God's	161:12
60:5,8 61:9	87:3 106:5	20:3	group
62:18,24	112:18 117:13	gold	54:9 58:16
66:10 68:18	130:3	139:14	60:25 63:20,
69:6 71:2	generally	gonadal	24 64:14
73:11 74:13	17:14 56:7	21:18,24	82:23 122:17
75:2 79:14,	67:10,11	gonadotropin	140:21 148:4
20,23 80:3,	89:11 107:6	74:21	149:9 164:19
13,17 81:3	170:13,14	good	167:5 177:23
89:12 90:24	generic	40:6,10 56:17	groups
91:11 93:9,20	143:23 146:22	69:17 120:2	164:15 169:24
94:1,5 95:21	genetics	126:23 129:7	grow
96:17,20,21,	54:13	167:20 168:9	72:19 138:21
22,23 97:2	genital	government	growth
98:16,17	45:8	148:15	15:24 21:20
99:18,24,25	Genspect	Governor	22:2,18,19,20
100:2,9,14	164:19,24	126:4	67:7,8 85:9
101:10	Ghrh	grade	137:6 138:4,
102:10,20	66:2	51:19 58:2	5,9,10,14,17,
103:2,5,10	girls	graduated	19,25
104:6 105:9	40:12 77:11	20:13 97:12	guess
107:15 108:13	give	granted	15:6 38:5
111:1,16	4:4 6:11 23:4	153:7	56:10 57:9
113:9 115:21	87:20,21	grants	76:4 77:5
118:12 119:3	94:11 121:3	110:16	134:23 143:10
122:1,13,18	126:17 140:4		173:25
123:1,5			
130:24 131:1			
133:4 143:9			

guidance 102:23 103:1 105:16 106:6	177:17 179:10	99:21,22 121:17 129:15	hearing 41:17 53:23 130:18 131:22 157:18 164:6 165:25 166:7, 9,11,17,20 167:5,22 170:24 171:1, 3,4,21,24 174:20 175:21
guidelines 8:2,3 23:13, 14 29:4 36:1 46:11,24,25 54:5,19,22,24 55:2,4,6,8, 10,21,22,24 56:9 57:5,13, 24 58:1,6,16 60:16,17 61:12 63:21, 22 70:6 71:4 75:4 80:24 97:19 103:21 142:16 170:12,17 176:7	happened 69:15 79:12 113:2 116:20 119:13 142:22 145:14	Hashimoto 94:17	
	happening 41:7 48:24 49:18 50:10 55:18 143:1 145:10 159:20 175:2	head 5:19 27:24 68:24 69:10 100:3 112:4 144:18	
guys 129:13	happier 179:7	health 13:5 17:9 19:25 24:21 42:21 48:4 78:18 87:10, 11 95:10 97:4,5,8 102:23 103:14 105:10,15 113:12 125:13,21 147:12,16 151:2 171:15 178:22	hearings 134:1 152:19 157:17
<hr/> H <hr/>	happily 92:20	Health's 105:16 108:8	hearsay 41:22 129:19
half 41:6 93:7	hard 38:21 61:5 171:10 175:19,23 176:3 177:22 179:4	healthcare 15:3 19:14 20:9 105:1 106:7 107:5 114:13,24 149:5	heart 22:17 50:13 77:15 125:18 170:6
hand 120:8 180:11	harder 122:8	hear 40:15 172:17 175:18,19	heartbreaking 172:16 175:15,16,20
handful 32:11 40:8 92:24 96:11 98:4 144:7	harm 178:15,16	heard 41:21 42:5,6 113:11,20 114:5 129:17 143:3 146:8 172:14 176:24	heavily 62:13
handing 156:7	harming 99:6		height 32:6 67:9 138:6,15,22
happen 33:24 47:24 48:2 65:5 77:25 88:2,4, 5,6 134:1	harvest 177:13		helped 63:23 116:4 120:25
	Hasan 58:21 59:4,25 61:17 65:22 66:1 69:13 70:12 82:3 93:2 95:11		helpful 163:22
			helping 11:1 99:5
			helps 52:23,24 90:12 122:6 138:16
			hemoglobin

Monica Mortensen, D.O
September 28, 2023

22

178:23	14,19,20 23:4	129:5	identify
Henry	67:8 87:15	human	38:24 46:1
12:10 19:1	103:4 106:20	15:23 20:2	identifying
Hey	132:23 138:5,	175:18	69:7
94:10	9,10	Hunter	identity
HH	hormones	151:6 163:25	14:16 37:25
180:18	25:6 29:6	Hunter's	38:2,6,10,13
hierarchy	31:13 40:16	164:14	39:1 40:2
78:24	44:22,23	Hurray	45:22 46:2
high	45:14 50:23	155:3	idiopathic
76:21 77:15	51:3 52:10,	hydrocortisone	138:11
85:15	14,15 61:2	23:5	Illinois
higher	72:19 75:8,13	hyperlipidemia	19:18
78:1 79:7	76:10 80:6,25	77:16	image
111:20	81:25 87:5,18	hyperplasia	20:3
highest	91:8 104:2,24	23:3	impact
87:17	134:14 145:2	hyperthyroidism	97:7,9 172:19
history	horrors	22:15	178:21
76:18 143:19	40:14	hyphen	impacting
hits	hospital	58:25	87:18
87:8	12:10 19:2,6,		impacts
hold	14,18 79:10	I	144:20
17:13 47:13	95:10		implants
162:20	hospitals	i-viewer	45:8
holistic	79:9 136:1	36:15	implemented
20:1	hour	idea	33:10,12
home	11:5 53:11	40:13 51:10	implementing
79:7	142:13 156:18	56:17 59:9	34:14 102:16
honest	170:7	76:6 88:1	119:6
11:12 42:18	hourly	98:18 120:2	importance
honestly	11:5	125:9 126:23	40:6
67:1 124:6	hours	ideations	important
hoping	19:8 20:21	104:16	43:4 49:17
168:3	108:15 157:1	identification	88:25 138:2
hormonal	Howler	7:9 20:5	144:16 174:25
62:10	113:21 171:25	106:23 120:19	improve
hormone	hubris	131:14 153:20	15:22 67:9
15:24 22:2,3,	17:17	159:7 161:15	96:5 103:16
	huge	167:8 173:3	

Monica Mortensen, D.O
September 28, 2023

23

141:3	inclusion	industry	inherited
improved	162:16	18:10	58:14
51:8 97:3	income	infantile	inhibitors
improvement	13:20	85:9	137:9 138:3
71:5 95:4	incorrect	inferior	initial
97:5,10 98:2,	17:1	140:10	80:5,23 108:2
9 103:23,24	incorrectly	infertility	109:19 117:6
104:12,13,14,	146:5	107:18	initialed
18 178:25	increase	influence	90:8
improvements	92:7 93:12	38:16,25	initialling
104:6	178:24	influences	90:7
in-depth	independent	38:14	initially
24:18 41:7	58:3	influx	46:16 75:3,17
142:6,8,17	independently	56:12	111:19 126:17
143:14	58:15	inform	initials
in-person	indication	84:5,22	110:13
133:25	65:15 69:21	information	initiate
in-state	83:13 84:2	9:15 10:1,4	100:23 101:11
32:4	88:12,15	28:2 36:7	106:13 109:8
inappropriate	134:19 135:3,	56:17 59:18	112:16 113:17
44:9 128:23	16,19 139:7	62:14 67:21	115:25 117:7,
178:6	indications	86:13,22	10
inappropriately	138:10	163:10 170:25	initiated
149:7	indiscernible	174:2	48:1 81:12
inartfully	137:22	informed	102:24
80:21	individual	9:24 17:14,	initiation
include	17:2 44:9	19,20,21,23,	47:21
10:4,6,9 61:8	101:18 113:14	25 33:16 35:9	injections
75:21 164:18	117:18 122:11	47:13 51:10	145:8
included	155:13	52:20,21 53:7	input
10:3 89:23	individually	82:21 86:20	124:23
160:22 162:19	82:24	90:6,8 91:10	insistent
166:4	individuals	102:16	86:3
includes	19:25 132:7,	107:18,22	instances
34:12	16 148:24,25	108:3,14,20	44:14 45:12,
including	169:1 170:25	109:3,12,14,	13,24 116:16
21:17 107:17	171:11 178:3	16,20 110:3,	Institute
110:18 111:4	induction	19 118:8	48:4
156:15 171:25	61:1	126:9,25	
		128:21 177:7	

institution 20:10 112:5	Internal 91:16	87:5 98:19 116:7 119:14	<hr/> J <hr/>
institutions 27:7 175:7	internationally 49:18	136:2 149:12, 17	Jacksonville 13:5,13 14:5 56:23 79:5,8
instructed 5:24	internship 12:8 19:1	involvement 73:13,15 118:18 146:15 157:15	January 166:1
insufficient 107:15	interpret 179:4	IRB 47:20 48:19 91:16 100:16	Jennifer 28:10 156:14
insulin 22:10,11 77:16 84:1	interpretation 72:21 134:23	IRB-APPROVED 101:13 162:14 163:1 164:1 174:23	job 5:8 125:17
insuline 77:24	interrupting 73:24	irregularities 22:23	Joe 122:21
insurance 32:2,5 82:16 87:16	intervention 132:22 139:15 140:10 144:13	irreversible 107:17	jog 120:25
intend 32:25	interventions 90:18 107:14	issue 27:19 34:3 51:19 67:6 86:20 94:9 102:7,24 114:25 116:17 125:21 127:3 140:20,24 146:8	John 113:11
intent 169:10	interviews 132:11	issues 24:21 32:18 51:22 62:10 81:22 82:12, 16 87:11 95:8 98:7 130:16 138:4,25 151:2	join 33:20 126:17, 18 127:17 128:1
interacting 41:14	intro 131:10	invited 61:21 112:19 150:22 151:17,19,20, 23	joined 165:15
interaction 157:15	introduction 65:8	inviting 151:23	joining 133:3
interest 30:6 61:23 62:2,4 101:17	investigate 127:23	involve 91:9	joint 12:11 47:17 116:23,24 126:15 128:3 151:14 165:25
interested 62:8,11	invited 61:21 112:19 150:22 151:17,19,20, 23	involved 17:20 18:3 21:7 56:21 57:1 64:19	Jonathan 63:16
interesting 54:16 57:23 72:3 78:2 82:24	inviting 151:23	item 53:23 57:21	Joseph 131:17
interests 15:7,21 16:3	involve 91:9	viewer 133:20	journal 54:15 63:2 104:22
interim 64:10	involved 17:20 18:3 21:7 56:21 57:1 64:19		

journals 36:4 54:15	72:23 86:1,2, 13 88:1 90:4	labeling 136:17	lead 105:8
judge 139:14	95:11 96:23 127:22 128:19	Labor 10:22	leading 26:12 169:8
judgement 30:10	129:16 130:9 141:7 153:4	lack 23:4 78:21 136:17	leads 77:14,15
July 106:12 130:17	Klinefelter 74:24	Ladapo 106:5 112:18 113:4,8 117:13 130:3	lean 46:15
June 106:4 107:8	knew 63:25 64:2 74:13 86:24	Laidlaw 151:25 154:7, 9 158:19 160:20 161:4	learn 26:23,24
jury 44:25	129:6 174:7, 19	Laidlaw's 160:16	learned 174:3
justify 50:24 51:3 52:10,15	knowing 43:5 77:6 78:4	language 52:8 159:20 160:8	learning 41:15 59:21
<hr/> K <hr/>	knowingly 140:9	largest 144:13	leave 44:3
Kaley 123:3	knowledge 11:9,13 21:10 33:1 48:24	Larry 121:14,15	leaves 165:19
Kaltiala 151:20	76:3 78:21 86:23 102:12	law 4:24 33:23,24 100:12 130:7	led 33:15 118:19 124:8
Kelly 180:6,16	110:10,12 113:25 116:21	laws 79:2	left 65:6 145:6
kids 30:5 32:12,13 38:20 39:14 40:9 41:7 62:6 68:18,23 73:19 93:13 95:7 96:11 111:18 138:25 147:24 175:25 176:18 177:11	123:9,10 126:8 130:23 142:25 143:2 171:13 174:1	lawsuit 85:5 114:12	legal 82:18 91:17
kind 26:12,13,25 29:15 32:7 40:9 41:1,5 49:5 60:24 61:5 62:4	knowns 132:21	lawyer 91:23	legality 94:9
	<hr/> L <hr/>	lawyers 83:1 91:24,25 152:16	legislative 126:16 127:18 128:3 148:8, 10
	L-O-U-R-N-I-S 58:25	lay 148:5 149:11	Legislature 119:5
	lab 32:4		length 76:18
	labeled 11:19 71:25		letter 70:1 104:25 105:6 106:5

Monica Mortensen, D.O
September 28, 2023

26

120:11,15	52:11,15	124:19 142:18	21,25 170:1,
121:1,7	lines	long-term	11 179:5,6
123:11 127:4,	142:1	63:21 78:6	Lou
6,9 128:17,	link	85:1,11 88:24	59:1,4 100:7,
20,22,24	147:19	107:16 135:7	8,9 122:5,6,
129:9,10,11	Lisa	175:25 178:16	10
130:20 134:11	30:18 64:24	longer	Lournaris
139:12 141:13	list	59:25 69:1	58:21
142:12	15:6,21 16:9	93:8 165:12	love
143:17,23	34:10 84:17	longitudinal	72:6
144:10,12	100:6 126:17	144:13	low
146:22 147:11	127:19 138:12	looked	46:12 51:18
148:3 174:24	141:23 146:2	57:21 116:1	57:5,25
letters	148:22 154:4	125:17 135:23	low-grade
144:4 160:3	155:6 156:14	loose	121:5
level	157:5	176:8	lower
48:3 61:6	listed	loosely	77:23
LGBTQ-PLUS	15:16 18:7	26:12 51:18	Loyola
87:6	132:21	lost	12:1
licensed	listened	85:18	lunch
73:14	172:15,16	lot	120:1
life	lists	10:10 24:20	Lupron
26:24 51:20	62:24	26:22 38:3,4,	22:6 83:10
99:2 177:4,8	literature	5,20 40:17	94:23 100:12
life-	10:10 58:13	41:5 45:9	138:24
threatening	62:21 135:2	49:1,23 50:7	Lurie
140:5	167:24	51:18 55:6	28:11
lifesaving	litigation	60:19 65:4	Lutheran
51:24 52:5,6	86:2 114:18	68:18 77:8	12:13 19:6,13
likelihood	living	82:17 85:18	
177:12	176:25	87:8,11 93:15	
limit	lobe	95:8 98:21	<hr/> M <hr/>
53:9	177:6	103:14,22	made
limited	logo	119:21 125:14	5:23 48:17
46:21 64:25	20:12	129:20 130:7	78:2,5 80:5
88:21 110:18	long	133:14 135:6	126:4 144:16
139:13 144:3	13:6 20:13	143:16 146:6	163:10 170:2
146:14	55:18 65:10,	147:9 150:20,	173:14
limiting	11 77:9 93:7	21 152:15	main
		160:3 169:20,	

Monica Mortensen, D.O
September 28, 2023

27

104:22	March	129:8 137:21	Medicare
major	33:14 34:7,13	Mcmaster	128:9
17:3 168:24	marijuana	147:13,17,21	medication
169:13	127:20,24	meaning	24:24,25
majority	mark	153:2 156:15	28:25 31:13
40:3 70:13	7:5 19:22	means	51:10 71:2
72:18 73:1	106:16 120:8	134:18 135:18	82:7 83:18
94:15	131:5 153:16	meant	84:18 88:13,
make	158:21 161:9	122:10 150:2	14 135:12
5:7,9,21 7:14	167:3 172:24	med	137:12,13,20
30:2 50:11,16	marked	26:23 140:15	138:16 146:24
56:18 64:8	7:8 9:11 20:4	media	178:22 179:9
67:14,22	106:22 120:18	49:1	medications
86:22 87:9,	131:13 153:19	medial	6:7 18:10
13,19 88:3	158:25 159:6	38:14	21:21 22:21
96:7 100:18	161:14 167:7	Medicaid	33:6 45:17
133:9 145:1	173:2	114:19	48:5 53:9
149:4,11,25	mass	medical	60:1,4,9
151:1 155:7	178:24	11:10 12:4	78:10 82:17
174:15 176:9	mastectomies	13:14 14:9,12	83:8,15 88:9
177:7	85:16	18:16,21	92:2 94:22
makes	materials	22:10 30:19	111:2 119:1
47:1 50:7,10	9:8 35:12,22	31:7 32:18	121:5 135:20
120:3 122:8	36:23 166:24	50:22 51:2	138:3 139:17
making	math	52:10,14	142:15,19
53:7 77:13	173:23	54:10 67:10	medicine
129:8 148:11	matter	90:18 101:5	6:19 12:6
male	4:15 10:17	107:7 119:1,	29:13 33:8,9,
39:19	17:8,11,14	8,9,12 127:20	13 34:1 35:2,
man	106:10 150:22	132:22 138:18	8,13,14 36:13
77:8	151:3,18,21	139:20,21	47:18 78:19
manage	152:1 156:16	141:2,3 148:5	83:2 95:14
46:7	159:10 160:7	149:1,11	102:14,18
management	162:22	167:23,25	104:22
54:25 111:12	Matthew	168:4,24	105:24,25
148:4 149:10,	120:10 121:9	169:13 170:20	106:5 109:2
16	131:11	176:1,2	112:14,15
managing	Mauras	medically	116:22,25
32:11	121:20,21,22	70:17 169:2	117:1,7,9

Monica Mortensen, D.O
September 28, 2023

28

16 121:12	9 158:7	77:1	met
123:12,13,25	159:20 160:23	Mendez	8:17 25:17
124:14 126:15	163:21 164:10	165:14	26:13 27:4
127:10,14	171:20	menopause	63:9 68:3,14
131:20 132:4	173:11,18,19,	76:20	70:20 75:3,15
133:9,24	20 174:3,16	menstrual	91:1 112:15
142:3 147:18	meetings	15:8 22:23	116:23
149:13,22	36:14 48:16	40:13 76:17	metabolic
150:12 159:24	61:11 62:15	menstruation	15:23
161:19 162:8,	63:20 64:11,	76:19	Metabolism
11,25 163:3	13,15 98:20	mental	54:4
164:11,22	101:1,2	24:21 42:21	Meter
166:2,4	131:20 132:4,	87:10,11	114:5,23
171:18	25 134:2	97:4,5,7	115:6 116:3,
172:11,25	153:2 156:7	103:14 176:2	10
173:10,12,16	164:17	mention	metformin
Medicine's	member	22:22 47:3	23:1 77:19
36:13 126:15	6:19 121:12	73:13	139:4
149:13,23	124:9 126:14	mentioned	methinozole
150:13	136:6,8	24:13 30:17	22:15
medicines	151:14 159:23	31:6 34:3,13	Miami
97:6	161:23 162:2	41:10 54:2	101:16
meds	163:9,17	56:25 58:17	Michael
135:4	169:5,8	64:16 66:6	113:21
meet	members	78:8 80:22	151:17,25
8:7 43:21	47:17 54:11	81:19 89:19	154:8 160:13
68:4 69:9,14	116:25 117:1	93:23 95:19,	171:25
70:5 92:7	128:2 140:21	24 100:16	mid-puberty
143:19	163:15,18	121:17 125:19	104:1
meeting	165:17 169:4,	129:17,22	middle
36:19 56:21	17,22 173:1,	130:22 137:5	155:4 156:12
57:3,8,11,16	12,16	149:20,21	midst
58:7 61:10	membership	158:3 166:15	87:13
80:23 82:1	164:18	175:14 178:5,	Midwestern
101:20,21,22	memorize	9	12:5
114:25 117:6,	159:25 162:3	mentioning	mild
7,8,9,16,17,	171:9	113:14	97:10
23 131:21	memory	merged	mind
133:19 150:23	120:25	86:13	39:18 59:3
153:4,5	men		
156:24 157:1,			

Monica Mortensen, D.O
September 28, 2023

29

120:9 172:17	misuse	119:15 120:7	myriad
mine	111:14,15,21	122:4 131:7	141:14,20
41:22 167:17	mixed	133:15 137:5	142:4
mineral	104:9	158:23 162:12	
15:19	models	179:15 180:7	
minimal	132:23	Mortensen's	
146:15	moderator	118:3	name's
minor	134:8	motion	4:14
67:13 177:20	modify	173:13,14,17,	named
minors	173:13	20 174:16	6:18 117:18
34:19,21 35:4	moment	Mouras	132:1 154:15
47:25 48:9	48:23 87:23,	145:9	names
49:9 69:3	25 120:9,13	move	11:12 27:6,9,
101:12	134:11 152:4	53:6 82:2	16 124:7
102:15,20	170:23 172:24	113:5 160:25	129:6 131:10
109:10 118:7	175:14	162:11 168:16	157:8,13
127:12 149:14	money	moved	161:20 162:4
150:14 172:4	85:18 136:13	175:23	nation
minutes	Monica	moving	175:7
101:19	4:8 122:4	82:3,5 172:16	national
117:17,23	179:15 180:7	multidisciplina	47:15 48:3,4,
131:21 157:1	monitor	ry	20
163:21 173:24	31:9 148:14	25:9,10,19	naturally
mirror	monitored	26:2,21 29:9,	77:13
173:15	31:5,6,24	11,12,19	needed
misdiagnosing	monitors	30:20 54:13	29:16 30:19
148:21	22:11	64:1,22 79:14	32:2,4,6
misdiagnosis	month	82:10 105:10	33:24 73:20,
111:25	10:21 75:16	multiple	23 79:25
misprescribing	124:21	91:5 110:19,	92:17 175:4,5
111:25 148:20	morphologies	20 111:5	176:11
mission	14:22	171:21	negative
19:24,25	Mortensen	multistage	97:7,9 176:14
20:14,16	4:8,13 11:7	79:19	178:1
misstate	20:17 27:17	multitude	Nemours
80:11	32:23 37:16,	40:5	12:19 13:4,19
misstating	24 41:9 53:17	muscle	14:4 17:9
79:18	102:13 104:25	178:24	21:1 29:18
	109:8 118:5		54:2 55:19
			56:22,23

63:7,15	note	oath	134:13,17,20,
71:18,22	32:8 83:17	4:20,23 180:1	24,25 135:4,
78:16,22	84:23	obesity	11,17,21,24,
79:10 121:10,	notes	76:22 77:16	25 136:2,24
24 122:17	84:23 137:15	object	137:15
132:25 133:3	143:16	42:23 49:20	offer
neurodivergent	notice	76:11 80:7	43:22
38:21	126:10	104:8 105:18	offered
neurologically	notices	108:23 109:25	174:4,18
85:6	165:25	110:21 114:2,	offering
neurology	November	15,20 115:1,	33:4
54:14	124:18 163:1,	8,15 116:6	office
neurosurg	12,20 170:24	134:22 136:19	63:13 79:7
54:13	171:6,7	140:11 141:5	93:14
neutral	174:9,13	148:12 157:2	offices
97:10	number	165:3 169:3	93:16
news	7:8 16:6 17:1	176:23	official
36:4 129:20	20:4 24:1	objection	180:11
newspaper	32:19 40:10	5:22	offset
49:3	53:19 56:14	Objections	137:2
niche	67:1 69:10,11	5:22	Oftentimes
59:11 62:5	92:6 93:12	observe	88:20
NIH	106:22 110:22	96:16	one-sided
104:10 144:14	111:20 120:18	obtaining	155:2
179:10	131:7,13	137:2	one-years
nod	153:19 156:10	Occasionally	12:23
5:18	159:6 161:14	5:21	online
non-physician	167:7 173:2	occurred	36:12 37:2
146:14	numbers	145:20	89:8 124:15,
non-research	96:16 159:25	occurring	24
91:19,20	160:3	50:11 144:20	onset
nonprofit	nurse	October	24:21 67:6
19:18	9:1 54:9	124:17 154:2	open
normal	122:24 123:4	155:5 156:13	38:1 50:6
67:7 138:14	<hr/>	158:9 159:4	85:23 90:13
Notary	<hr/>	180:12	120:11,15
180:17	O	off-label	121:1 128:16
	O'MALLEY	45:18 83:14,	139:12 144:12
	131:12	15,18 88:19	147:11 150:8

Monica Mortensen, D.O
September 28, 2023

31

153:7 172:17 174:24	61:6	outcome	p.m.
openings	order	51:8 67:9	53:15 120:5
124:13	12:23 83:5	88:22	173:11,19,21
openly	96:19 143:7	outcomes	179:14
129:12	173:11,15,24	45:7 50:11	pace
opine	ordered	71:9 85:2	142:20
9:22	32:4	95:17 97:22	pages
opining	organization	135:7	107:1 108:5
34:18	169:13 170:20	outcry	120:11 155:21
opinion	organizations	79:24	167:2
4:16 33:22	165:2 169:18	outlined	paid
36:7,8 40:16	original	79:17	114:23 116:16
46:4 49:24	14:13 16:24	outweigh	pain
51:18 76:8	162:16	51:8	111:12
119:7 121:3	Orlando	outweighed	Palmer
141:1 146:4	30:21 56:23	65:18	78:19 79:10,
172:19,20	78:14,16	outweighs	11
opinions	79:4,5,8	51:12,13	palsy
26:15 32:24	93:24	141:10	85:6
33:4 53:18	osteopathic	ovarian	paperwork
54:18 118:3,6	12:6,8,10	14:22 22:24	152:15
opioid	19:1 33:8,13	32:14 74:20,	paragraph
111:11 148:16	34:1 35:2,8,	25 77:12	17:6 18:14,25
opoid	14 36:13	ovaries	19:24 21:13,
111:12	47:18 102:18	16:12	15 23:7 29:8
opportunity	105:25 109:2	ovary	33:2 34:9
166:12 175:10	112:14 116:22	16:12	35:1,11 53:19
opposed	117:1,9 119:4	over-diagnosed	54:1 61:20
46:2 76:6	123:13,24	111:23	65:9,10,11
148:7	124:12 126:15	over-prescribed	67:25 79:17
opposes	127:14	111:23	80:12 81:9
170:21	149:13,23	overstep	84:25 92:5
option	150:13 152:7	42:11	106:19 107:3,
103:2,5,11	159:23 163:2	<hr/>	12 108:11
options	164:11 166:2,	P	110:15 118:24
70:6,7,8	4 171:17	<hr/>	paragraphs
oranges	172:11,25	P-R-I-T-I	89:18
	173:10,12	28:8	parent
	Osteopathic		32:9 40:20
	6:19		

Monica Mortensen, D.O
September 28, 2023

32

44:4,5,6	28:6,8	112:7 123:18,	13:1 93:16
67:12 132:1	path	19,21 129:23	151:11
155:9	59:10 65:23	137:14 139:4	pediatrician's
parental	168:13,17,18	142:20,22,24,	93:14
155:15,19	pathway	25 143:6	pediatricians
parents	60:25 66:11	145:6,12,16	141:25
40:23 51:15	69:15	146:7,10,17	pediatrics
62:17 85:7,17	patient	147:3 172:8	15:24 19:1
92:16	32:9 44:3	176:22 177:20	125:12,15
part	51:11,15	178:11,12	135:21,25
19:14 35:7	52:2,24 53:1,	Patrick	136:6,24
36:21 45:1	3 56:13	151:6 164:14	170:3
73:25 74:1,5,	67:12,22 68:2	Paul	peer
23 77:17	77:19 83:5	171:25	38:15
86:16 105:23	84:6 85:5	pause	peer-reviewed
109:12,14	90:20,23 94:6	46:25 47:1	16:24 17:2
112:21 115:12	129:18 143:9,	50:7,15,17	peers
117:4 118:23	15,18,24,25	72:22 90:10	49:5
125:7,16	144:5 146:19	177:15,18	penalty
129:11 138:5	147:8	pay	4:25 48:8
140:13 152:19	patients	166:22	pending
158:15 159:1,	19:9 20:22	PCOS	6:4
3 162:17	22:22 26:18	15:8,23 23:1	people
164:7	30:9,19 31:6,	76:17 94:17	14:14 17:18
participant	7,11 39:13,20	pediatric	21:5 28:1
140:10	41:18,24,25	8:25 12:12,23	29:12 36:6
participate	56:20 60:1,2,	13:2,11,12	38:4 39:6,7,
48:9 84:6	7,8 61:22	15:8,10 54:3,	10 41:9 42:16
132:24	63:22 64:3	8 58:19 59:4	46:17 48:15,
participated	65:16 66:16,	63:3,11 74:7	18 64:15
130:2,17	23 70:7	85:20 88:17,	65:5,6 70:3
166:9	71:13,15	18 101:5,8	72:18 82:2,15
partner's	79:11 82:6	105:8 113:21	89:19 90:3
40:23	89:24 93:25	121:4,16	104:15 121:3,
pass	94:13,16,25	122:16,25	6 134:3,5,25
134:3	95:2,20,23	125:16 126:22	142:1,11
past	96:4 97:22	127:21 128:3,	144:22 146:1
37:17	98:1,8 99:18	7 136:12	148:5,22
Patel	100:2,9,13,	169:20	149:11 150:9
	15,23 102:2	pediatrician	152:17 153:5
	105:11 111:24		

Monica Mortensen, D.O
September 28, 2023

33

155:6 156:3, 8,14 158:8 162:23 168:4, 8 169:20,21, 22,24,25 170:1,9 174:17 176:4 177:1 179:6	13 80:7 104:8 105:18 108:23 109:25 110:21 114:2,15,20 115:1,8,15 116:6 117:24 118:9,13,21, 24 119:11,20 120:2 134:22 136:19 140:11 141:5 148:12 154:21 157:2 158:25 161:4 165:3 169:3 176:23	pertaining 35:21 petition 106:13,17 109:8 112:16 113:17,24 115:25 117:7, 9 167:4,5 petitions 166:17 171:1, 12 pharmacy 35:18 philosophy 20:1 PHQ9 96:6 phrase 134:17 phrases 38:3 physical 107:17 physically 71:10 physician 29:14 32:5 35:17 75:23 83:6 127:25 165:19 175:17 176:5 physicians 11:14 26:22 54:9 57:7 58:8 120:17 146:13 148:4, 13,14 149:10 PI 18:1	picked 41:2 49:3 pile 134:9 pills 23:1 76:16,21 pioneers 46:19 pitfalls 140:12 place 33:21 79:21 86:7 165:9 176:11 placebo 140:13,15 places 81:19 89:22 92:20 145:11 146:2 plaintiffs 4:15 11:8,11, 13,15 plaintiffs' 7:5,8 20:4 106:22 120:18 131:13 153:19 158:21 159:6 161:9,14 167:7 172:24 173:2 plate 138:17 plates 85:9 138:15, 20 play 126:19 145:25 148:16
perceived 102:9 percent 20:15 25:22 36:17 49:12 51:20,23,24 52:2 55:25 68:25 88:22 99:11,12 101:2 111:7 136:1 151:12 158:7 percentage 44:17 perception 53:2 95:11,16 Perfect 160:6 performance 110:18 111:4 performed 18:1 periods 85:13 perjury 4:25 Perko 5:21,24 7:6 27:25 37:10, 12 42:23 49:20 76:11,	permanent 74:14 84:13 Permuy 122:21 perpetuate 76:24 person 38:7 44:1 45:21,25 46:5,23 60:24 64:24 116:16 141:2 175:18 person's 38:10 personal 41:23 95:7 132:8 142:25 143:2,6 166:14 172:4 personally 21:3,4 117:20 146:9 161:16 178:4 180:8 perspective 97:4		

played 11:1 125:23	positive 172:8 176:21	85:14	25:2,11
playing 75:23	possessed 107:12	premature 138:16,21	65:13,21
plenty 175:6	possibly 29:14	preparation 9:15	66:6,20 74:11
point 47:10 52:21 72:10 78:2 79:11,15 133:7	posted 126:12	prepare 6:21 7:22 8:7	76:9 80:17
points 110:8	potential 73:2 88:4	preparing 8:14 9:10	81:7 97:6
policy 23:15	Powerpoint 160:16	prepubertal 69:3,4	122:11 142:5
political 148:8,10	practice 15:6 35:3 55:11,15 63:3	prepubescent 70:16	prescription 78:10 84:9,12
polycystic 14:22 16:12 22:23 32:14 77:11	67:20 102:19 110:17 111:4 121:4 125:14 127:25 165:19	prescribe 21:21 22:22 24:24 25:5 29:6 74:19 75:22,24 78:11 79:21	88:9
poor 46:12	Practices 62:17	80:6 81:25 83:8,10,14 88:10,13,14, 15 98:11,13	prescriptions 67:3 97:14
poorly 81:13	practitioner 9:1	138:2,24 139:4,17	present 8:17 54:16 152:21 166:6 173:1
population 45:1 58:11 62:4,8 79:25 84:4 87:1,19 88:17,18 96:9	practitioners 54:10 105:1 122:24 123:4	prescribed 22:25 28:24 45:18 66:2,9, 24 67:3,11 85:21 92:3 94:1 95:21 97:14 103:4 112:2 137:9 139:9 141:15 142:21 145:2 146:12,13	presentation 158:18,23 160:16,20 161:4 164:4
Poquiz 63:16	pre-fill 156:3		presentations 14:18,20,24 15:1
position 13:8 14:1,6 66:16,18 124:25 126:13	precocious 14:20 15:9,23 18:9 21:19 22:4,5 66:21, 24 84:10,13		presented 103:12,24 105:24 106:14 113:17 114:8 115:11 116:10 146:23 166:16
positions 13:19 165:11	predating 33:18	prescriber 112:11	press 49:1
	prediabetes 77:20	prescribing	pressure 32:6 38:15
	pregnant		presume 26:1 29:23 112:25 143:11
			pretty 55:9 58:1 80:5,22 125:22

Monica Mortensen, D.O
September 28, 2023

35

prevent 6:8 77:23 138:16	20 111:2,5	141:14	protect 39:18 52:24 83:5,6 87:22 90:12
previous 165:16 174:9	proceed 105:2	prolonged 76:20,21	proved 177:2
previously 4:18 39:23 62:3 93:24 102:5 127:11 153:8 158:3 160:7 170:16 174:22 178:9	proceeding 74:12 75:2,8	prominent 157:11	provide 9:14,19,25 15:12,14 21:1 26:3,17,19 28:17 32:25 35:25 58:10 65:2 67:20 89:2 92:17,21 101:9 102:10 122:1,18 123:1,5,16 124:23 128:14 152:24 171:22 176:8
principles 179:6	Proceedings 4:2	promise 63:22	provided 8:20 9:7 23:17 27:14 28:1 31:12 34:24 35:12, 22 36:7,18,20 37:3,7,14 44:8 48:19 49:4 53:18 80:11 89:6 100:17 108:16 113:8 119:7 130:23 133:8 142:3 157:21 158:18 163:25 170:25 178:4, 10
printed 159:2	process 66:17 79:19, 21 81:5 91:9 102:17 105:14 106:1 108:1,2 109:15,20 115:13 116:8 118:13,15,19 119:13,16 124:8,19,23 125:1,8 126:7,25 150:7 152:25 156:5,6 158:16	promote 77:4	proposal 108:9
prior 6:5 33:10 36:14,18 56:23 113:2 123:12 126:24 130:15 133:3 162:10 167:1	produced 36:22 159:5	promoting 76:15	propose 142:16
priti 28:6,8	profession 101:5 151:10	prompted 56:8	proposed 39:8,22 47:10 48:12 95:18 108:6,16,21 111:20 165:25
privy 163:10,19	professional 13:16 107:7 166:13	proper 25:24 148:7	proposing 46:24
problem 51:16 60:24 141:8 165:18	program 12:11,22 14:4 29:10,11,24 90:2	promulgated 33:18 35:2 149:23	pros 168:7
problems 21:20 22:18 51:21 52:3 137:6	programs 30:15 41:2 141:14	promulgating 102:19	prospective 139:13,18
procedure 50:12,15,16, 19	projects 47:12	proper 25:24 148:7	provider 43:20 44:8 52:24 53:4 90:13 94:4
procedures 107:6 110:19,	proliferation		

112:2 146:16 175:11	146:20	37:2,8 52:5 72:4 79:24	purposes 49:15 109:19
providers 42:22 48:7 52:1,4,7,23 93:13 100:5 105:5 146:14 148:20 149:7	psychologists 61:21 62:6,7 64:9 146:15 148:4 149:10, 12	112:22 117:17 131:20 132:15 133:18 149:22 150:6,11,16 151:2 152:19, 24 155:7 156:18,23 157:20 158:9, 15 159:3,5 160:8,22 161:11 165:25 166:11,12 172:12 180:17	pursue 58:9 59:22 70:9 95:13 100:5 115:13
providing 20:22 21:6 28:20,22 31:17 47:4 48:8 59:23 81:12,17,18 82:6 86:4 121:18 122:12 133:4 146:5 149:7 170:15	psychology 26:22,23 63:3		pursued 70:11,13
provision 133:1 168:25 170:13	Psychosocial 104:23	publication 62:16	put 27:18 46:25 47:1 50:15,16 89:14 134:6,7 177:15,18
psyche 39:19	psychotherapy 70:9 75:25	publications 16:6,9,18,21 17:3 36:3	<hr/> Q <hr/>
psychiatric 51:22	pubertal 15:9 22:5 61:1 75:11 76:24	publicized 50:3	QI 125:14,15
psychiatrist 9:1	puberty 14:20 15:9,23 17:24 18:9 21:19 22:4,5, 7,8 24:21,22 25:3,5,12 28:24 31:13 32:6 44:11,15 50:23 51:3 60:12 64:7 65:14 66:22, 25 67:7,8 70:9,11 71:2, 8,16 72:18,25 73:5 74:23 76:25 82:7 84:9,10,12,13 91:7 98:3 99:8 103:4 104:1,2 132:22 134:13 138:13	publish 55:1	qualified 125:13
psychological 51:8 71:5 141:17 168:1 178:21		published 36:12 54:15 62:21 63:2,16 104:9 107:8 165:24	quality 46:12 57:5,25
psychologically 178:24		PubMed 57:18	quantify 145:18
psychologist 9:2 24:6 29:14 30:4,16 40:6 43:21,22 54:12 57:1 63:12 68:3 98:18 143:12	public 36:10,16,21	pull 57:19	question 5:6,13,15,22, 24 6:4,5 23:2 27:21,23,25 38:1 41:6 80:22 87:21 96:20 123:3 133:21 146:12 157:4 169:11
		pulled 57:18	questions 4:16 5:17 60:16 65:4 115:20
		purpose 55:12 97:6 121:2,3 150:25 166:11	quick 7:10 161:12

quickly 76:9 80:5,22 138:14	178:7	receive 12:2 14:9 18:15,17 19:2 20:18 21:9 76:2 90:18	REDBURN 118:4,16,23 119:23 120:1
quote 62:20 80:11 136:21	ready 72:11 73:5	received 10:19 20:11 149:1,4 172:8 178:5	reduce 77:2
<hr/> R <hr/>	real 176:17	receiving 31:12 41:25 43:17 81:12 94:23 96:17 143:23 178:12	reducing 50:6
raised 27:18	reality 53:2 168:12	recently 146:6	refer 41:20 72:14 88:20 146:10
random 153:13	reason 6:11 12:20 31:2,17 118:17 174:22	recognize 7:6,13,17 38:24 157:8, 10	referenced 108:12
randomized 137:19,21 139:21 140:2	reasonable 39:9 58:10 63:23 156:25 176:15 177:16,18	recognized 41:3	references 60:21
randomly 56:13	reasons 40:5 56:14 93:2 95:12 136:23 138:12 176:6 178:20	recommendations 60:18 103:8	referencing 57:20
range 10:21 16:18	reassignment 103:5 106:21	recommended 103:1 109:24	referral 44:2 100:6
rapid 67:6 141:13 142:19	rebuttal 6:21	recommending 55:3 76:1 106:20	referrals 56:12,14 92:6 93:12
rate 11:5 22:17	rebutting 6:24	record 5:23 32:10 112:22 150:3 154:12 158:15 179:13	referred 15:20 25:19 30:19 36:9 55:11 65:13 68:19 69:12 89:18 92:20 93:13 94:14 97:22 105:11
reach 43:20 64:21 98:24 145:22	recall 56:2 112:4 113:20 120:15 124:6 130:13, 21 131:19,22 132:14,17 141:17 145:21 146:7 148:8 149:17 164:3, 5 167:3 171:20,24 172:3,7	records 11:10 57:9	referring 33:9,17 47:9 55:21 57:6,19 74:15 79:16 81:11 93:17, 19,24 95:2 104:19 141:21 146:2,4,18 147:13,25
reached 44:7 61:17 82:4 101:15		redact 72:1,5	reflect
read 20:7 26:16 107:10 125:20 155:20 168:7 174:5			
reading 15:19 20:6 166:24 167:23			

Monica Mortensen, D.O
September 28, 2023

38

103:21	43:9	171:18	reported
reflected	relative	173:14,17	31:1 81:15
117:23 157:1	26:10 147:9	174:12,16	111:18
refresh	relaying	175:10	reporter
147:23	145:12,13	removed	5:18 180:16
regard	release	85:16 164:2	reporter's
71:16 72:9	23:20	165:14	5:8
regret	released	repeat	reporting
89:23,24	23:13 27:6,9,	51:1 52:13	36:4 95:16
90:17 129:12	16 49:2 56:4,	101:7 114:14	reports
regrets	17	repercussions	8:21 9:3,9,17
90:4	relevance	168:15	23:11
regretted	115:8	repetitive	represent
90:24 129:24	relevant	10:11	4:14
regulation	10:7 57:23	rephrase	representative
35:12,15	relied	5:13 101:7	17:9 101:15
47:12,23,24	9:20 27:19	140:25	represented
48:17,20	34:15 37:7	replacement	48:16
111:13 148:15	62:13 86:19,	22:14	reproducibility
176:17	21	replacing	103:18
Regulations	rely	165:11	reproductive
35:20 37:3	115:12	report	85:19
regulatory	relying	6:21,24 7:18	reputable
111:11	170:4	8:1 9:11,16,	143:21
Reham	remaining	20,23 10:1,4	request
58:21	25:14	11:22 16:9	37:10
reject	remember	17:6 21:14	requested
113:24 164:11	8:11 89:8,9	27:19 29:8	171:3
174:10	112:11 134:14	32:24 33:2	requesting
related	141:24 144:7,	34:10,12,16	105:25 106:9
14:13 16:11,	9 147:14,22	53:18 67:2	requests
15 24:21 35:9	148:1 149:15	79:6 80:10	166:16,20
62:10 94:7	161:25 164:8	92:6,13	require
relating	removal	105:21,23	71:10 83:7,
81:14	163:14 164:12	106:6 107:2	11,23 84:20
relation	174:10	113:5 115:4,	88:8 110:4,
17:12,16	remove	7,11,21 116:5	11,13 137:17
relationship	47:19 162:13	118:25 129:23	
	163:1,5	147:21	

required 12:22 82:22 94:20 109:16	77:16,24 resolution 64:21	55:14,24 56:8,18 57:12,15 60:17 71:24 86:22 91:3, 14,17 128:22 147:19 158:18 167:4	risks 50:22 51:2 52:10,14 65:15 66:15 67:11,13,17, 21 70:25 71:13,15,19, 20 72:16 73:7,10 78:7, 8,9 83:19 84:10,22 88:4 90:15 96:12 135:17
requirements 107:19	resources 26:16 30:3,14		
requires 5:2	64:1,23,25 82:14	reviewed 8:1,2 10:10 11:10 18:3 34:11 35:11 54:4 55:20 57:17 58:6,15 60:15 80:23 91:1 128:25 131:20 132:15 135:15,18 150:16 166:24,25 167:9,19 168:19	road 73:2 82:19 88:2,6,7 168:15 177:18 179:11
research 14:13 15:21 16:3,25 18:1, 2,5,6,8,9,10, 11 46:16,17, 21 47:8,11, 12,14,23,24 48:2,10,12,13 49:15 55:3 59:16 60:24 62:12 78:3 83:9,24 84:5, 7,8 86:22 88:20 91:16 92:2 101:17 103:22 107:13 121:5,24 135:1 139:20, 22 140:12,14 141:7,8 162:19,23 171:18 173:15,17 174:17 175:4, 5,8,12	respect 27:17 respond 156:19 rest 98:7 143:2 177:3 restricted 46:20 47:3,7 49:8,13 restricting 50:5 52:11,15 restrictions 52:17 79:3 restrictive 135:24 resulted 109:9 retained 6:15 10:16 114:12,18 retaliation 27:12 returning 48:22 53:17 170:23 revenue 137:2 review 9:4 36:18 54:19,20	Richie 132:14 rights 85:19 155:16, 19 risk 51:7,8,12,13, 14 53:5 65:18 67:19 76:19 77:15 87:17 96:7 107:17 137:16 140:14 141:10 148:4 149:10,16	Robbins 28:10 robust 107:18 role 11:1 14:2 34:21 45:10 46:3,16 47:8, 15 74:9 75:23,24 125:23 132:9 152:13 roles 35:19 126:18 rolling 64:6 Ross 100:3 round 130:2,16 131:9
researchers 147:12,17			
residency 12:7,9,12,18 19:5,11 26:24			
residents 54:10 148:25			
resistance			

Monica Mortensen, D.O
September 28, 2023

40

route	23,24 127:3, 56:20 59:22 72:24 127:24 168:2	150:9	SEGM	
routed	161:23,24 20:2	school 12:4 14:9,12 18:17 26:23	164:21,24 selected 124:20 125:10 151:4	
routes	168:17	schools 73:18	selection 126:7	
rule	35:1,2,5 47:19 114:19 127:3 128:9 158:10 159:15,16,19, 22 160:8 162:14,16 166:2,3,4 167:5 173:13, 16	run 67:2 78:18, 23,24 132:12	self-described 165:2 self-referrals 93:15	
rulemaking	106:1,13 108:1,2 109:8,20 112:16,22 113:6,18 115:25 117:8, 10 118:1,10, 15,23 119:13 149:14 150:6, 25	<hr/> s <hr/>	sell 51:24 send 32:8 128:21 154:4 158:1	
rules	4:17 33:9,12, 16,17,21 34:3,12,14 35:9,12,15,20 37:3 102:14, 16 105:3 109:9,11 111:13 115:13 118:7,8,12 119:6 126:16,	safe 42:11 44:19 135:12 172:21 safety 107:16 151:2 salaried 14:7 sample 96:15 San 28:9 Santiago 59:1 Sara 28:3 sat 58:15 151:15 SB 33:10,15,18 34:13 35:9 102:15 107:24 109:15 118:7 119:5 scans 15:19,20 scheduled	Schwemmer 165:13 science 12:3 168:16 scientific 36:4 scope 10:4 scores 96:4,9 scratch 138:23 screening 125:17 seal 180:11 seats 53:24 Seattle 28:3 85:4,18, 22 86:18 89:25 seconded 173:18 section 47:19 100:3 110:15 163:14 seek 43:20 136:25 sees 68:16	sense 5:9 120:3 sentence 95:3 separate 57:3 58:3 98:15 115:19 178:18 separately 58:8 158:25 September 10:23 120:22 127:9 130:20 180:8,17 serve 19:25 sessions 144:1,2 set 33:7 35:19,20 79:6 119:3 set-up

Monica Mortensen, D.O
September 28, 2023

41

25:10	Shortly	90:7 129:6	slowing
setting	124:4	similar	50:3
46:21 141:7	show	71:18,20	small
settings	7:4 19:22	145:10 146:12	32:11 68:16
110:18 111:4	120:8 131:5	Simone	69:11 85:7
seven-year	132:12 152:23	4:14	92:24 144:7
12:20	153:15 172:24	simplest	177:23,25
severe	showing	38:5	smaller
85:6	137:23	simply	40:4
sex	shown	119:8	SME
21:17 38:11	141:3	single	156:15
46:1 106:20	shuffled	57:21 145:2	Snyder
sexual	134:7	sit	122:15
40:1 61:22	Shumer	12:23 33:18	social
sexuality	7:2	126:23 143:11	29:14 30:3,4
40:18	shut	153:24 163:3	38:14 54:11
sexually	130:9	site	65:1 73:14,
39:17	side	36:13 79:1	15,17,18,19,
SGA	51:9 77:17	sites	20,21,24
138:11	82:18 84:13	79:5	103:1,10,14,
shakes	98:21 124:14	sits	23
27:24 144:18	135:17 176:14	169:5	socially
shame	sign	sitting	103:25 104:7
43:8	110:11 128:24	174:4	societies
share	134:4	situation	169:6,8
32:10 82:12	signatories	140:6 143:22	society
100:22 101:6,	129:4	situations	8:2 23:16
10 106:16	signature	145:10	29:4 36:2
130:5 137:24	110:5	size	46:11 55:7,
145:22	signed	96:15	10,21 60:20
shared	105:6 121:7	skimmed	68:9 70:5,22
27:20 43:12	126:19 128:19	62:19	97:20 103:13
71:12 145:10	129:1	slightly	136:11,12
sharing	significance	166:3	164:21
42:9 106:6	14:21	slow	169:21,22
short	signify	138:20	170:2,12,17
137:10	136:17	slowed	175:4
138:11,25	signing	50:9	Society's
			49:23

Monica Mortensen, D.O
September 28, 2023

42

Solu-cortef 23:5	151:24 153:6, 7,10 156:4	spent 75:18 129:7	standing 48:13
solve 52:3	166:12 167:17 169:25 172:13 174:1	split 162:19	standpoint 77:4 83:24 166:14
someone's 165:8	speaker 156:3	spoke 26:14 27:13 28:10 63:10 82:23 117:13 128:8 132:13 170:24 171:12 176:21	stands 173:14
Sophia 131:24	speaking 17:7 78:9	spoken 11:14 50:18 52:4 169:16	start 22:8 64:3 65:7 68:2 72:13 81:21 86:6 100:13 142:14
sort 58:10 60:17 66:16 79:17, 18,20 80:4 97:21 100:22 109:7 112:8,9 123:15 144:5 162:13 165:1	special 30:6 62:5	sponsored 14:5	started 6:14 13:10 24:19 30:5 55:18 57:19 61:16 64:17 73:5 75:12 81:10 90:1 92:6 93:12 142:18 146:23 175:8 176:13
sorts 152:15	specialize 59:20	sponsors 136:25	starting 12:19 15:6 23:19 39:21 64:7 103:25 104:2 111:18 169:24
sought 29:21 81:21 93:23 94:19	specialized 21:10 30:7 64:25	spreading 46:25	starts 154:2 157:6
sound 105:11	specializes 61:21	stable 98:6	state 17:7 18:25 21:15 23:7 28:15 29:9 32:3,4 35:11 42:3,7 46:9 47:15,23 48:7,16,20 61:20 63:19
sounds 96:20 127:5 163:24	specialty 26:11,13 30:15 63:12	stack 134:6	
source 13:20 143:21	specific 18:17,19,22 27:1 29:17 89:11 97:15 104:19	staff 29:16	
sources 34:11	specifically 10:8 14:11 21:23 30:12 35:1 64:13 85:4 89:13 90:20 93:19 110:25	stages 176:19	
space 42:12	speculating 90:3	stamp 154:13	
speak 5:5 8:13 30:3 47:7 49:16 77:5 79:13 82:23 112:19 116:16 126:6 150:9,22	speed 112:25 113:1	standard 55:2 102:19 108:6 139:14 148:7 150:13	
	spend 19:8 177:3	standards 35:3 39:2 107:7 110:17 111:3 125:17	

Monica Mortensen, D.O
September 28, 2023

43

67:25 69:5 74:10 81:19 87:21 92:19 98:1,8 101:6, 9,15 105:2 114:12,18 121:25 130:7 131:20 139:12 141:13 142:1, 4 144:12 147:11,15 148:3 169:10 170:4 171:22 175:2,11 180:3,17	55:10,11 166:25 169:6, 9,23 states 50:1 61:3 107:3,11 110:15 117:16,17 144:23 147:10 154:1 155:6 156:10 159:19 stating 26:11 80:22 174:24 statistics 68:24 stature 137:10 138:11 statute 138:25 Statutes 110:16 Stella 131:12 STENOGRAPHER 4:3 Stenographic 180:16 stepped 93:2 sterility 107:18 stipulation 117:25 118:2 119:22 stop 46:25 47:1 86:4 93:5 99:7,17,19,22	100:2 102:2 136:8 stopped 60:8 93:1 121:17 stories 41:18,21 133:8,10,13, 14 167:23 175:21 strength 60:17 stress 96:23 Strickland 154:15 strike 106:3 152:11 157:4 strongly 168:8,9 struggle 175:24 struggles 175:22 176:3 struggling 176:4 stuck 10:11 students 54:10 studied 39:23 84:16 studies 48:6 57:6,12, 25 61:4 77:8 135:1 139:24 study	56:8 60:16 88:21 104:5, 10,19 107:5 135:23 137:24 144:20 179:9 stuff 89:15 91:16 129:20 Sub-i 18:2 subgroup 64:18,19 subject 17:8,11,13 150:22 151:3, 18,21 152:1 156:15 159:10 160:6 submit 127:9 143:17 157:21 158:8 169:4 submitted 9:18 10:22 11:22 36:1 71:24 86:15 91:25 121:1 123:11 124:22 127:4,6 133:18,22 134:12 153:6 155:20 158:3 160:20 162:10 169:6 subsequently 85:20,21 subset 40:4 84:3 substance 8:6 178:20
state's 102:24			
stated 18:21 25:18 32:13 37:1,16 62:3 70:6,19 80:2,10,12,15 81:2 84:25 89:6,21 93:11 97:16,17 99:17 100:22 101:1 106:17 123:8 142:10 169:13 170:16 174:22			
statement 18:7 20:14,16 23:15,17 36:2 63:22 65:18 70:2 85:3 136:16 144:15 162:10 169:7 170:2,4			
statements 10:11 27:19 36:5 49:23			

substantive 53:18	46:11	sworn 4:9 180:9	127:23 128:12 129:13 144:16 172:14
successful 45:6 95:15 97:17	supporting 107:14 137:20	syndrome 14:20,22 16:12 21:18, 24 22:24 32:14 59:13, 15,16 74:24 77:12	talked 43:2 73:2 162:6 174:17
sudden 50:14	supportive 70:2	system 19:14 58:2	talking 76:5 78:15 110:25 118:21 147:21 164:5 178:8
sue 92:14	supports 51:17 168:25	systematic 147:18	Tampa 30:22 42:5 93:24 101:16
sued 85:19	suppose 174:8	T	Tapazole 22:16
suffering 175:18	supposed 50:13 72:1 159:1	T-O-R-R-E-S 58:25	taught 145:7
suggested 39:8,11	surgeon 29:15 106:4 112:18 117:13 130:2	T1dm 15:11	teaching 14:1,2,6
suicidal 96:14	surgeons 8:25	T2dm 15:11	team 9:17 42:14,19 43:3 54:11 73:25 74:1,6 80:24 86:17 91:1 152:16
suicide 85:21 87:17 96:7,11,12,13 104:16	surgeries 33:7 45:9 104:3 119:2	T3 22:15	teams 42:22
suicides 104:16	surgery 45:3,7 71:10 73:10 103:5 106:21	T4 22:15	technologies 45:5
summarizing 173:19	surgical 50:12,15 107:14 111:2	table 130:2,17 131:9	technology 15:22
summary 33:3,4 118:25	surprise 105:13	takes 152:15	teenaged 87:14
Sunshine 130:7	surprising 41:1 136:3	taking 6:5 49:21,22 60:9 100:11 120:9 163:13 178:21 179:1	telling 7:21 8:6 42:10 51:19 97:20 162:2
support 26:16,20 29:15 31:17 36:8 49:19 81:23 135:2, 6,16 169:14 176:9,10 177:17	suspected 24:15 25:15	talk 17:4 43:7 46:16 70:3	
supported	swear 4:3		
	switch 53:24		

tells 167:19 168:7	4:4 6:9,12 123:16 128:14	things 5:19 17:18 39:22 42:10 49:3 50:3 57:20 72:22 78:22 83:3 88:2 98:6,20, 25 99:1,2,5 110:22 111:11,17,22 130:8 138:8 140:7 152:20 155:20,21 174:5 176:14	time 5:6 6:1 11:5 19:15 20:13, 14,19 21:2 23:21 25:13, 20 26:10 28:8,18 34:5 38:21,24 50:2 54:19 56:4,6, 22,24 57:8 58:13,23 61:15 65:23 66:11,13,20 69:23 72:17, 20 74:19 75:1,9,14,19 78:19 79:12 86:24 89:25 94:24 100:3 107:22 113:1 116:19 119:21 126:21 129:7 133:2 138:21 142:18 145:24 151:22 153:16 155:25 156:19,22 157:22,25 162:7 163:10 174:5,6
temporarily 38:23	131:21 133:25 164:6 172:7 175:14,16 176:20 178:7, 11	thinking 87:24,25 177:10	
temporary 38:16 97:10		thought 25:4 28:25 57:22,23 58:9 64:5 101:14 124:13 164:1 171:8	
Ten 147:7	testosterone 21:25 22:7 72:13,16 73:8 74:11,19 76:2 77:11,12,18, 23 78:1,5 94:23 98:10, 11 142:21 145:8 178:19 179:1	thoughts 46:5,7,8 96:14	
term 77:9 147:17		threats 92:11	
terminology 38:4		thrilled 42:9	
terms 64:21 108:1 150:6	Texas 28:9 86:12, 14,15	throwing 177:23	
Terrell 152:5 153:23 154:14 155:5, 13 156:13	therapeutic 139:14	Thursday 156:13	
Terrell's 152:12	therapies 141:15 142:5	thyroid 14:23 21:20 22:12,13,14 32:15	timeframe 19:10 158:5,7
terrible 124:6 157:13	therapist 24:6 43:2,25 98:23,24 99:13 142:12 144:9	thyroiditis 94:18	timeline 75:3,5 93:4 102:13 109:7 130:15
testicular 74:20,25	therapists 64:9		times 8:10,12 32:21 53:1 89:18 140:1,6 143:16 158:6
testified 4:10 37:17, 20,22 118:16 132:3 148:22 157:9	therapy 30:8 78:5 97:17 103:4, 15 106:20 136:17		
testifiers 154:4	thing 6:3 79:3,4 83:4 90:5,11 94:18 130:7		
testify 5:2 152:24			
testifying 4:24 157:16 172:3			
testimony			

tissue 76:22	total 156:14,18	94:19 95:13 99:19,23	11:7 23:8,18 24:1 31:15
title 13:8 104:17 152:10	touched 136:4 152:23	104:12,23 114:1 119:2	32:16 39:25 80:3,13 81:3
titled 62:16	trained 26:23 29:17 30:13 170:5	121:6 123:20, 23 130:8 144:14,20 167:25 169:1	93:8 95:19 123:21 147:3
Titles 13:10	training 14:9 18:19,22 19:2 20:18 21:9 26:7,9, 21 27:1 30:7, 11 82:15 146:25	transgender- affirming 32:17	treating 11:14 19:8 21:16 31:16 39:6 41:11,19 42:17,19 43:20 44:7 60:3 94:4,5 97:23 98:19 99:17 100:9, 14 102:2 123:22 137:6 172:4
today 4:14,16,21 6:7,12 7:19, 23,24 99:4 142:15	trans 87:11	transition 40:11 41:4 46:10 53:9 56:11 72:11 73:19 103:2, 10,14,23 104:7	44:7 60:3 94:4,5 97:23 98:19 99:17 100:9, 14 102:2 123:22 137:6 172:4
told 25:17 43:12 105:8 124:24 133:10,13,14 156:25	trans-female 178:18	transitional 111:1	treatment 14:10 15:14 16:15 17:15 18:11,17,22 19:3 20:19,22 21:1,7,10 25:25 26:2,3 27:14 28:17, 20 30:20,24 31:8,14 34:18,24 35:3 42:1,22 43:17 44:8,12,15,23 45:4,15 46:10 47:5,25 49:8 50:24 51:4 52:16 55:22 59:23 61:9 66:10 67:16, 18,23 68:10 69:2 71:2 73:25 74:1,13 75:2,12 76:2
Tom 117:18	trans-females 179:8	transitioned 25:8 39:21 65:25	
top 59:18 68:24 69:10 112:4 153:18 154:14	trans-male 178:19	transitioning 30:4 40:20,25 43:11,13 76:5 103:25	
topic 62:22 104:17 129:21 130:9, 20 166:13	trans-males 179:7	transparent 90:13	
topics 150:10	transcribing 5:8	travel 43:23	
Torres 58:25 59:14, 25 61:17 65:22,25 69:13 70:12 82:2 129:15	transcripts 8:21 9:4	traveled 137:23	
Torres-santiago 58:22	transfer 78:13	treat 34:21 41:21 77:11 88:25 100:15 108:13 123:19 167:22	
	transgender 14:14 15:3 21:6 26:15 30:8 32:13 33:7 40:2 45:21 55:9 62:18 78:18, 20 81:10,11, 17 82:6 89:14	treated	

Monica Mortensen, D.O
September 28, 2023

47

79:20,22	162:14	type	unaware
83:21 89:10,	trials	21:19 22:9,13	113:10
11 90:24	47:4,20 48:10	26:20 54:25	uncertain
91:11 92:9,	137:20,21	77:15 81:22,	75:17
17,18,21,25	139:13,18,21	23 84:2 85:25	uncertainty
93:20,22,23	140:2 144:17,	139:5 153:4	65:16 66:15
94:11,19	19 174:23,25	types	unclear
95:4,21,25	trouble	14:21 15:11	44:13
96:17 99:7,	162:9	17:21 18:5	uncomfortable
23,25 100:24	true	21:21 67:22	40:11 75:1,7
101:10,12	6:8,11 24:8	82:12 138:3	76:9 77:5
102:10,15,20	39:1 47:2,16,	170:13	97:16
103:2,11	22 50:5 64:1	typical	undergoing
105:9,10	74:4 90:17,19	156:2 160:9	31:7 138:18
107:13,15	127:8 135:20	typically	underlying
108:15 111:1	trust	22:19 24:5,6	23:6
113:9 115:21	30:10	35:25 134:2	undersigned
118:7,12	truth		180:6
121:18 122:1,	4:4,5	<hr/> U <hr/>	understand
12,18 123:1,5	truthfully	UF	4:20 5:1,11,
127:12 130:1,	5:2	29:22,23	16,20,25 6:6
24 132:23	Tuesday	30:20 42:6	88:3,4 101:2,
133:4 140:19,	54:7	78:14 93:24	3 110:24
21,23 148:18	turn	101:15 105:10	119:18 121:10
150:14 168:3,	11:17 14:18	113:22 145:24	147:15 177:15
14,17,18	15:5 17:6	146:3	179:7
170:15,21	21:13 53:19	uh-huh	understanding
171:22 172:9	108:19 154:1,	5:19 36:11	20:2,10 29:10
177:21 178:4,	12 156:9	63:5 64:20	35:21 37:13
5	160:15 173:6	70:24 74:8,17	38:2 48:11,
treatments	Turner	81:8 95:1,22	14,21 49:17
60:5 80:17	14:20 21:18,	96:2 122:22	70:15 100:22
85:8 86:4,6	24 59:13,15,	133:11 145:15	101:6,11
94:1 108:12	16 74:24	153:3,12	109:1 119:9
111:16 169:14	turning	155:11 172:2	126:5 148:24
176:17,22	134:10 158:9	unanimously	150:8 152:12,
tremendous	two-year	164:11	22,25 153:13
176:21	179:9	173:18,20	156:2,5
trial		174:10,12	157:20
32:25 100:16			158:10,12,13
101:13 144:13			

159:17,21	113:5,24	versus	47:18,19
162:15,18,20	urging	51:7 53:5	109:10,11
163:7 165:13	105:2 166:20	90:15	127:13,14
166:1,5,18	usual	vice-chair	159:23 162:25
understood	50:7	121:24	163:5,8
5:14 136:15	uterus	victimized	164:11
140:18 155:24	85:16	87:7	174:10,12
unethical		victims	175:10
140:2,9,20	<hr/> v <hr/>	39:14	voting
unh-unh		view	127:2 172:12
5:19	vaccinations	29:12 96:24	vulnerability
unheard	125:18	121:4 124:14	87:12
129:21	vague	views	vulnerable
unit	60:22	40:17	87:1,2,3,4,6,
95:10	vaguely	Vila	9,19
United	148:1 164:3	163:23,24,25	<hr/> W <hr/>
49:25 61:3	validity	violated	wait
144:23 147:10	55:14	85:14	177:5
University	Van	violating	waiting
12:1,5,16,18	114:5,23	118:2 119:22	142:18
13:23 14:5,7	115:6 116:3,	violation	waitlist
17:10 20:18	10	112:9	60:12
147:13,17,21	vast	virilization	wanted
unknown	65:12,20 66:6	77:14	26:17,19
74:14 84:10	70:13 72:18,	visit	47:22 48:18
unknowns	25 94:15 97:5	43:6 53:3	58:8 65:24
65:4 83:2,20	125:22	142:21 145:3,	72:12,24
84:19 86:25	venue	7,9	75:18 85:7,9,
132:22 172:21	59:13	vocalized	11 128:24
unsupported	verbally	149:25	153:6 170:18,
136:17	89:2	Volume	19 176:6
unwilling	verbatim	179:16	warrant
92:17	141:23	vote	73:15
updated	Vernadette	49:18 119:17,	warranted
158:6	154:3,7	19 162:13	73:14
updates	155:12	163:13 174:9	wasting
11:21	version	voted	119:21
urged	127:14	34:4 35:4	

Monica Mortensen, D.O
September 28, 2023

93:11 100:19
105:25
130:15,19
141:20 142:6
146:10

young

21:16 40:12,
19 129:12

younger

39:22 71:9
111:18 176:18

youngsters

141:17

your-all's

146:4

youth

29:9,11,24
33:7 43:12
62:18 79:19
104:6,23
114:1 119:2
129:12 138:4
144:14,21

Z

zone

102:9