

Jane Doe

vs.

Joseph Ladapo

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Deposition of:

Monica Mortensen, D.O.

September 28, 2023

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*Vol 2*



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.

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DEPOSITION OF

MONICA MORTENSEN, D.O.

VOLUME 2 (Pages 182 - 266)

Thursday, September 28, 2023

3:33 p.m. - 5:45 p.m.

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1 \* \* \* \* \*

2 (The deposition of Monica Mortensen, D.O.  
3 continued from Volume 1.)

4 DIRECT EXAMINATION (cont'd)

5 BY MS. CHRISS:

6 Q So Dr. Mortensen, just very briefly, we have  
7 discussed the development promulgation of the rules  
8 creating the standards of care for minors, the treatment  
9 of gender dysphoria. Now I'd like to ask a couple  
10 questions about SB 254 and the implementing rules and  
11 regulation -- or implementing rules. So I presume you  
12 are familiar that SB 254 was signed into effect on May  
13 17, 2023?

14 A Correct.

15 Q You are familiar with the content of that?

16 A Yes.

17 Q Okay. Do you have any understanding of why the  
18 legislature passed that law?

19 MR. PERKO: Object to form.

20 A No.

21 BY MS. CHRISS:

22 Q Are you aware that the companion bill to SB 254  
23 was called HB 1421?

24 A I'm not sure. I don't remember all the numbers  
25 and letters.

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1 Q Would you believe me if I told you it was?

2 A I think I could believe you on that, yes.

3 Q Okay. Did any of the members of the Board of  
4 Medicine play a role in the legislature's development of  
5 SB 254 or HB 1421?

6 MR. PERKO: Object to form.

7 A I personally did not. I don't know about the  
8 others.

9 BY MS. CHRISS:

10 Q Were you asked to speak to the legislature?

11 A No.

12 Q Are you aware that the Board of Medicine chair,  
13 Scot Ackerman, was invited to speak with the  
14 legislature?

15 A No, I did not.

16 Q So SB 254 required that the Boards develop  
17 emergency rules and informed consent forms; is that  
18 correct?

19 A Correct.

20 Q Just before we get into that, are you -- let me  
21 back up. You were one of the individuals who authored,  
22 drafted, the emergency -- the informed consent form?

23 A The emergency consents forms, yes.

24 Q And are there nonemergency consent forms?

25 A Well, my understanding is is that they need to

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1 go to -- this was just a draft and that there will be  
2 permanent consent forms.

3 Q Who's working on the permanent consent forms?

4 A It goes back to the Rules Committee.

5 Q Which you are on?

6 A Correct.

7 Q Do you know when that's happening?

8 A I want to say end of November there's going to  
9 be a meeting to discuss.

10 Q Okay. And is that about the informed consent  
11 forms for adults and minors?

12 A Correct.

13 Q Is there any other area of treatment where the  
14 Boards have required an informed consent form with this  
15 level of prescribed content?

16 A I don't know, I haven't reviewed what the  
17 Boards have done in years past.

18 Q You are not familiar with any of the other  
19 informed consent forms the Boards of Medicine have  
20 created?

21 A No.

22 Q Dr. Mortensen, are you aware of any informed  
23 consent forms that include substantive requirements  
24 within them?

25 A For pain management and for -- or opioid

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1 consents they do have requirements in them.

2 Q And what are those requirements?

3 A Typically, that you have to agree to see your  
4 counselor, that you have to have screenings for opioid  
5 use, whether it be a urine test, a hair test, that you  
6 agree to fill your prescriptions, that you agree not to  
7 misuse or abuse your prescriptions, that they will often  
8 be laboratory tests they have to do.

9 Q Have you, in your clinical practice, used any  
10 informed consent forms that included substantive  
11 requirements?

12 A In the center that I worked at in their  
13 behavioral health department they did have pain  
14 management consent contracts and forms.

15 Q But you, in your clinical experience, used  
16 those forms?

17 A I did not use those forms because I didn't  
18 prescribe those substances, but I did review those forms  
19 and discuss those forms.

20 Q So when you were drafting the informed consent  
21 forms for the Board of Medicine, you didn't look at  
22 other informed consent forms they promulgated in the  
23 past?

24 A That the Board did? No.

25 Q If we could turn back to Exhibit 1, which is



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1 your expert report. Page 9, paragraph 25.

2 A Uh-huh.

3 Q Where you discuss SB 254. This discusses  
4 how -- what we just discussed, that you were tasked with  
5 creating emergency rules. What is your understanding of  
6 why the legislature created requirements for adults?

7 MR. PERKO: Object to form.

8 A I don't know.

9 BY MS. CHRISS:

10 Q The Board of Medicine rules that we discussed  
11 previously did not affect adults, correct?

12 A Correct.

13 Q And why were you tasked with creating these  
14 informed consent forms?

15 A I think because I have experience with these  
16 medications and that I had drafted the consent form for  
17 our center, so I believe that's why I was asked to do  
18 it.

19 Q And that was the informed consent form for  
20 Nemours regarding puberty blocking medication?

21 A Correct.

22 Q Are you aware of why the SB 254 restricted  
23 APRNs, and NPs, non-physicians, from providing care?

24 A I do not know why.

25 Q The specific language of SB 254, are you

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1 familiar enough with it that you don't need to look at  
2 it or would it help to look at it?

3 A It would certainly help to look at it.

4 Q Dr. Mortensen, go to page -- luckily they are  
5 numbered on the bottom, so that's helpful.

6 A That will help me a lot.

7 Q Page 7 of 10, please.

8 A Okay.

9 Q So here it states: Is sex reassignment  
10 prescriptions or procedures are prescribed for or  
11 administered or performed on patients 18 years of age or  
12 older, consent must be voluntary, informed, and in  
13 writing on forms adopted by the Board of Medicine and  
14 the Board of Osteopathic Medicine. Consent to sex  
15 reassignment prescriptions or procedures, if voluntary  
16 and informed, only if the physician to prescribe or  
17 administer the pharmaceutical product or perform the  
18 procedure has, at a minimum, while physically present in  
19 the same room. And then there are three bullet points.

20 A states: Informed the patient of the nature  
21 and risks of the prescription or procedure in order for  
22 the patient to make a prudent decision.

23 B: Provided the informed consent form, as  
24 adopted in rule by the Board of Medicine and the Board  
25 of Osteopathic Medicine, to the patient.

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1 And C: Received the patient's written  
2 acknowledgment before the prescription or procedure is  
3 prescribed, administered, or performed. That the  
4 information required to be provided under this  
5 subsection has been provided.

6 Did I read that correctly?

7 A Yes, you did.

8 Q And that is the language that the, sort of,  
9 conferred the duty upon you-all to create these forms,  
10 correct?

11 A Yes, it did.

12 Q These were the only requirements that were by  
13 law had to be in the informed consent forms, correct?

14 A Correct.

15 Q There was no requirement that the forms reflect  
16 any particular risks or benefits, correct?

17 A Correct.

18 Q There was no specific language that had to be  
19 included, correct?

20 A Correct.

21 Q There was no requirement for any certain number  
22 of initials, places to initial?

23 A Correct.

24 Q Or for a witness to sign?

25 A Correct.

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1 Q And it says -- it says you must inform the  
2 patient of the nature and risks of the prescription.  
3 Does that -- would you understand that to mean the  
4 prescription at issue in the informed consent form, the  
5 prescription being prescribed?

6 A Yes.

7 Q And going back to Exhibit 1, on page 9,  
8 paragraph 26, you state: I and another member were  
9 asked to create draft consent forms to submit to the  
10 committee for review and further development. Who was  
11 the other member?

12 A Dr. Benson.

13 Q And that's the same Dr. Benson from -- who you  
14 wrote the letter with?

15 A Correct.

16 Q You say since -- the beginning of that sentence  
17 I left off, I apologize. Since I am also a pediatrician  
18 endocrinologist, I and another member. But you were  
19 tasked with creating the adult consent forms as well?

20 A Correct.

21 Q And you did say this earlier, but you don't  
22 have any experience treating adults?

23 A Correct.

24 Q And you don't provide treatment for gender  
25 dysphoria for adults or for minors?

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1           A       Correct.

2           Q       How did you create these forms?

3           A       So initially when my friend had sent me the  
4 ones for the pubertal ones, we also had ones for  
5 feminizing and masculinizing, because their center did  
6 all of that. So I still had those. So I used that,  
7 those two, as a basis, because many of the side effects  
8 and risks are going to be the same, but I reviewed it,  
9 and double-checked literature, and looked at the  
10 prescribing information guidelines, and all of that. I  
11 adapted it as best I could, then we then duplicated for  
12 the adults and took out certain language and tried to  
13 adjust it appropriately.

14          Q       And remind me who the friend is that sent those  
15 forms?

16          A       The ones from Texas I think were from Priti  
17 Patel.

18          Q       And has that been -- what pronoun does that  
19 person use?

20          A       She/her.

21          Q       Did she have any other involvement in this  
22 process?

23          A       No, not at all. And that was years ago when we  
24 first started with Nemours doing the consents.

25          Q       Did you confirm whether her institution had

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1 revised the informed consent forms in the years since?

2 A No, because I think she stopped doing  
3 transgender, I'm not 100 percent.

4 Q So you are not aware of what forms that  
5 institution uses today?

6 A Correct.

7 Q And did you work Dr. Benson on this?

8 A No.

9 Q So how did you come up with the same --

10 A He submitted his own.

11 Q So you had two separate drafts?

12 A Correct.

13 Q Do you know how he came about creating his?

14 A I didn't ask or talk to him, because of the  
15 Sunshine Law. We didn't want to make any risk that  
16 there would be any wrongdoing, so we didn't discuss it.

17 Q During the subsequent board meeting when the  
18 forms were discussed, and you were all asked many  
19 questions, did it -- did you then understand how he went  
20 about creating the forms?

21 A I don't know if he was specifically asked how  
22 he created the forms. I believe I shared, but I don't  
23 know if I was specifically asked or if I specifically  
24 shared either.

25 Q Have you ever previously developed an informed

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**1 consent form outside of your area of expertise?**

2 A I didn't develop, but I've reviewed, like I  
3 said, about the pain management contracts at the former  
4 center that I worked at.

**5 Q How long did you take to create the forms?**

6 A These consents.

**7 Q The first draft that you brought to the Board?**

8 A The first draft I brought to the Board? Oh, my  
9 gosh, at least 60 hours, if not more.

**10 Q 60 hours?**

11 A Yeah, at least 60 hours.

**12 Q Over the course of?**

13 A Several weeks. I think two, two weeks or so, I  
14 pretty much had a full day of work, come home, eat  
15 dinner, then I would look, read, research, write, and  
16 put in full days on the weekends as well.

**17 Q What did you research and read?**

18 A So I went back to the stuff that was provided  
19 to us. I went back to the Endocrine Society and WPATH.  
20 And then I reviewed some of the literature that was  
21 attached to those, then I did a PubMed search as well.  
22 I went to Lupron's web site to verify side effects and  
23 information, prescribing guides from there.

24 I went to look up the testosterone, it's a  
25 generic, but I looked up brand for that. I reviewed

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1 stuff on birth control pills and different forms of  
2 estrogen. I even had gone to, like, you know, when you  
3 Google, I did Google, just because that's what people  
4 see, so I wasn't really using it for, like, a medical  
5 source, but sometimes it's very helpful to see what  
6 people are reading. So if people are reading that  
7 that's this, where is this information coming from, see  
8 if there's a medical link or whatever. So those were,  
9 kind of, a lot of different sources that I looked at.

10 Q What experts on the treatment of gender  
11 dysphoria did you consult with?

12 A I didn't.

13 Q Did you consult with anyone with experience  
14 treating gender dysphoria?

15 A No, I did not.

16 Q Have you ever -- are you aware of any other  
17 instances where an informed consent form was developed  
18 without the input of an expert in that treatment?

19 A I'm not aware.

20 Q I assume the answer is no, but are you aware of  
21 whether Dr. Benson consulted with any experts?

22 A I don't know. I also didn't know what I was  
23 privy to do either, because, unfortunately, if you are a  
24 member of the Board you have to be careful that you are  
25 not representing the Board. So, you know, part of the



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1 problem of reaching out to some of the experts is now  
2 they are talking to you as board member, and I can't  
3 talk as a board member. So there's, kind of, a lot of  
4 stipulations in that as well, so it's, kind of, hard to  
5 say, well, who am I allowed to talk to? Who can't I  
6 talk to? So I, kind of, felt since I was a board member  
7 and I'm not supposed to represent the Board, I didn't  
8 know I could go outside the purview of what I could find  
9 from my literature search and everything else. So I  
10 didn't know if I was allowed to reach out and contact  
11 various experts to help with the consents.

12 Q Did you ask anyone if you were permitted to do  
13 so?

14 A I think I got so imbedded in it that I just did  
15 what I could, the idea was this was an emergency consent  
16 that was never meant to be permanent and that we would  
17 be getting feedback as it was presented, and that  
18 would hopefully be good enough for the time being. And  
19 that we could then get further input as to how to change  
20 them.

21 Q So just to be clear, did anyone specifically  
22 tell you you couldn't reach out to experts outside of  
23 the Board?

24 A They did not specifically say that.

25 Q And did the Board -- you know, I understand the

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1 Sunshine Laws prohibit discussions outside of these  
2 public meetings, but during the various public meetings,  
3 hearings, and such, did the Board together discuss  
4 bringing in experts in the treatment of gender dysphoria  
5 to guide the development of the informed consent forms?

6 A I believe it was mentioned, but I don't know  
7 that we got any offers, or I don't know if anybody  
8 reached out on behalf of the Board to an expert.

9 Q So the best of your knowledge there were not  
10 outside experts consulted?

11 A To the best of my knowledge, yes.

12 Q And no one on the Board of Medicine or Board of  
13 Osteopathic Medicine, in your -- apologies. No one in  
14 your Rules Committee that was working on these has  
15 clinical experience in the area of gender dysphoria,  
16 correct?

17 A As far as I know.

18 Q Okay. How many -- scratch that.

19 Were there multiple drafts of your informed  
20 consent forms?

21 A We put in -- the first meeting I had submitted  
22 the Nemours one, I submitted the  
23 feminizing/masculinizing one, and the puberty blocker  
24 that my friend had given me. I think I had found  
25 another one or two that I had submitted. Then I'm not

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1 sure if Dr. Benson submitted anything. Then at the  
2 first meeting everybody felt there was so much to go  
3 through and in order to get this done in a timely manner  
4 it was better to task one person from the osteopathic  
5 and one member from the Board to pull it together so we  
6 had a working draft that we could edit.

7 Q You state in paragraph 27 of your report,  
8 expert report, Exhibit 1, you reviewed the guidelines  
9 from the Endocrine Society and WPATH and the medical  
10 literature. You say: I also wanted to view this  
11 process through the eyes of a patient to see what  
12 barriers or information they were receiving, so I went  
13 to chat rooms to see what concerns people were posting  
14 and Google search engine since this are common tools  
15 people use to gather information.

16 In your experience is it common to rely on  
17 things like chat rooms in developing an informed consent  
18 form?

19 MR. PERKO: Object to form.

20 A Sorry. I wasn't relying on them for the  
21 expertise of what would be in them, I was using them as  
22 a guide to see what people were seeing. So I think one  
23 of the examples in the forum was nipple discharge, and  
24 one of the experts saying, that's not true. And yet in  
25 the chat room there was a whole bunch of people saying

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1 that that's what they experienced and they were never  
2 told about it, they had no idea. Saying is this weird?  
3 Is this wrong? Is there something wrong? Do I have  
4 cancer?

5 So it was, kind of, a nice way of seeing what  
6 people knew and what they didn't know. Now, could they  
7 have already been told that? Sure, it's a possibility.  
8 But having it in writing, and having them sign off on it  
9 seemed to be a better route.

10 BY MS. CHRISS:

11 Q Did you correspond with any of these  
12 individuals to confirm the validity of what they shared  
13 online?

14 A No. But to be fair, I did not put nipple  
15 discharge in there because they said nipple discharge,  
16 it was already in the consent. So I didn't say they  
17 said they had these side effects and put that in my  
18 consent. In the consents were only what was found in  
19 the medical literature.

20 Q Do you recall the specific medical literature  
21 studies that you relied upon?

22 A I believe I put most of them in the  
23 bibliography.

24 Q Of your expert report?

25 A Correct.

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1 Q And you are familiar with the Endocrine Society  
2 Guidelines criteria for gender-affirming hormone therapy  
3 for adolescents?

4 A Yes.

5 Q And you are familiar with the WPATH standards  
6 of care statements that require -- specifically require  
7 that individuals -- that the provider assess the  
8 capacity of the individual to consent for this specific  
9 treatment, that their mental health concerns are  
10 addressed, and that they've been informed of affects  
11 impacting reproductive function?

12 A Correct.

13 Q Those are all already in the WPATH standard of  
14 care?

15 A Yes.

16 Q And the Endocrine Society Guideline also  
17 assesses the adolescents capacity to consent?

18 A That is correct.

19 Q Were you -- when you were looking at chat rooms  
20 and Google and such, were you searching for -- you  
21 stated to see what barriers or information they were  
22 receiving. Were you specifically looking for negative  
23 side effects or did you spend any time looking for  
24 individuals reporting positive experiences?

25 A I wasn't looking specifically for one thing.

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1 That's the things with chat rooms is anybody can put  
2 anything in it, so there's positive, but I have a  
3 feeling that people have a tendency more to complain and  
4 not so much say the positives. So I wasn't using that,  
5 as I stated earlier, as to what to put into the  
6 consents, I just wanted to see did I address some of  
7 that?

8           Some of the things that was happening at the  
9 meeting, which I like the public speaking, because we  
10 actually learned a lot of different things in the  
11 process of, you know, one of them was, Hey, my parents  
12 are in the military, my grandmother is my guardian.  
13 Does it have to be two? Does it have to be a parent?  
14 Can a parent go in via video, you know, talking about  
15 how often they are being seen, what timeframe. So, you  
16 know, it was really important to hear their side of what  
17 they were telling us was going to be the barriers that  
18 they were going to have, and that's what I was also  
19 seeing that, that's what they said, and they are saying  
20 it here online too.

21           **Q     Were there --**

22           A     Is there anything else that they didn't say  
23 this is on here?

24           **Q     Were there folks that provided testimony, like**  
25 **what you just mentioned, that urged -- urged a lack of**

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1 **barriers to this care?**

2 A What do you mean urged a lack of barriers?

3 Q Folks that have either had positive experiences  
4 with this care and need it for their well-being or, you  
5 know, parents whose children need access to this care  
6 who shared with you, you know -- you were talking about,  
7 I think, barriers in the context of risks and things  
8 like that, but did you assess and take into account the  
9 barriers that you were told these informed consent forms  
10 would create for people to get needed medical?

11 MR. PERKO: Object to form.

12 A I wasn't guided to what to put in the form, but  
13 that was one of the things of why we extended timeframes  
14 of, you know, one of the questions was that we were  
15 hearing from families and from patients was my current  
16 provider is afraid to prescribe to me now because the  
17 law has changed and the consent isn't there. But the  
18 consent isn't there and nothing is in place, so they  
19 should be doing business as usual. So they viewed that  
20 as a barrier, which I don't understand why. Like, why  
21 if you -- if the law has not been started and the  
22 consent is not in play, why are providers not providing  
23 care? I couldn't speak to that. I didn't know why.  
24 But that was one of the things about emergency consents  
25 is you guys got to get these done as soon as possible,

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1 my provider doesn't feel comfortable unless they have  
2 the consent there.

3           Then we didn't want to have, like, here's the  
4 day that the consents are in, you got to have them  
5 signed in 24 hours. We talked about, like, three  
6 months, four months, six months. And seeing that many  
7 people are supposed to be seen every three to  
8 six months, we said, why don't we do six months.  
9 Someone even brought up, like, telemedicine. I don't do  
10 all my visits in-person. So we're, like, let's at least  
11 give a six month window so they have at some time during  
12 that scheduled appointment between today and six months,  
13 they are likely to have a scheduled appointment, they  
14 can do the consent in-person at the time of their visit.

15           So we were listening as to what they were  
16 telling us were perceived barriers and trying to  
17 accommodate and adjust appropriately.

18           **Q     Do you have any reason to believe that**  
19 **individuals who are receiving this care hadn't already**  
20 **completed the informed consent process and signed**  
21 **a written consent form prior to initiating treatment?**

22           A     Some of the statements that the audience had  
23 provided on their experience did make me question as to  
24 what kind of consents that they either received or did  
25 they really understand. So one example is the bone



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1 mineral density scan. And a person had said, I get a  
2 blood test and that tells me how strong my bones are.  
3 I'm a bone specialist and I was, like, I don't know of  
4 any blood test that speaks to how dense somebody's bones  
5 are. So that person came up for the comment, because we  
6 said, hey, you had mentioned to Dr. Ackerman during the  
7 break, come up and speak more on what you are talking  
8 about, this blood test.

9           And the blood test, as they described it, is  
10 what we refer to as a complete blood cell count. And  
11 that looks at your bone marrow, of how well your bone  
12 marrow is producing your white blood cells, your red  
13 blood cells, your platelet, it speaks nothing to how  
14 strong your bones are. But this person is adamantly  
15 saying that their provider said this is in lieu of a  
16 DEXAscan, I don't need a DEXAscan because I get this  
17 blood test. So it's hard to say is there a  
18 miscommunication? Is it the person who's providing the  
19 care? It's kind of hard to say. But at least having a  
20 consent in writing to say what a test is and why it  
21 should be done and why it's important to have this done,  
22 we felt was important to include in the consents.

23           **Q     Are you aware of whether that person signed an**  
24 **informed consent form or not?**

25           **A     I am not aware.**

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1 Q And are you aware of what that informed consent  
2 form might have contained?

3 A No. I'm also aware that many people knew these  
4 consents were coming and they never bothered to send  
5 their consents to the Board either.

6 Q How do you mean?

7 A Well, everybody knew that this emergency thing  
8 was passing and so you have all these people who were  
9 doing it and if they already had written consents they  
10 could have submitted their written consents to us to use  
11 as a basis.

12 Q Did the Board reach out to any of the providers  
13 provide in the state that provide treatment for gender  
14 dysphoria in multidisciplinary clinic setting and have  
15 extensive experience, did they request they send in  
16 their informed consent forms?

17 A No, we did not. To my knowledge we didn't  
18 request. I know I personally did not request.

19 Q So the Board can't say one way or the other  
20 what other entity's informed consent forms look like?

21 MR. PERKO: Object to form.

22 A That is true.

23 BY MS. CHRISS:

24 Q Do informed consent forms usually include  
25 potential benefits as well as potential risks?

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1 A Yes. They can.

2 Q Is there a reason why the informed consent  
3 forms that you-all developed don't discuss the benefits?

4 MR. PERKO: Object to form.

5 A The challenge is to say how much of a benefit  
6 it is as to the data isn't 100 percent secure as to  
7 whether or not it has great impact or not. So that's,  
8 kind of, the challenge, you don't want to falsely  
9 advertise and say this is going to take care of all of  
10 your depression and your anxiety and you're not going to  
11 any suicide risks if you take these medications.

12 Q So just to tie this up. The Board did not  
13 reach out to any providers in the state who provide  
14 gender-affirming care to this population for their  
15 inform on the informed consent forms risks or benefits?

16 A To my knowledge, I'm not aware if the Board  
17 did. I can only speak that I didn't.

18 Q Are you aware of any other informed consent  
19 forms that don't include benefits and only include  
20 risks?

21 A I don't. I'm not aware.

22 Q Okay. You state in paragraph 30 of your expert  
23 report on page 10: I was asked by the defendants to  
24 address the comments regarding the emergency consents.  
25 The other comments not related to consents will be

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1 addressed by other experts, however, there is some  
2 overlap. What you are you talking about here? First of  
3 all, who do you mean when you say defendants?

4 A I meant by where here it says the defendants.  
5 Joseph Ladapo. I was asked by counsel to give my expert  
6 opinion.

7 Q Okay. So in paragraph 30 -- so paragraph 29 is  
8 talking about public comment at the meeting, so I wasn't  
9 sure if in paragraph 30 you were talking about  
10 addressing the public comments or just addressing --

11 A No. No. Just addressing the comments in  
12 regards to -- as we stated earlier, there were seven  
13 expert statements that were sent by various people, but  
14 I was asked to specifically focus in on the consents.

15 Q Understood. Okay. So comments you meant  
16 expert reports?

17 A Yes.

18 Q I understand. You state in paragraph 31 on the  
19 next page that these were emergency consents that needed  
20 to be submitted swiftly. These were never intended to  
21 be the final consents and we addressed that we would  
22 need to make updates. The Rule Committee is currently  
23 working on updates.

24 What will be different in the revised versions?

25 A Well, it all depends what happens at the

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1 meeting, so it depends on what other people are going to  
2 bring to the Board and what other information is going  
3 to be submitted. So I think some of the things I  
4 mentioned in here about some of the timeframe, about the  
5 laboratory testing. So I -- pretty much, anything -- if  
6 this was going as-is, but if there was something I  
7 thought was going to be a potential change, I had  
8 mentioned it in my statement. As to what I would  
9 propose as a change, I can't speak for what the other  
10 board members are going to propose as far as changes.

11 **Q So all the board members get to provide input**  
12 **make amendments and such?**

13 A Yes. So what will happen is is they, well,  
14 like, I'm going to review it again, I'm going to make  
15 any kind of edits that I think are warranted. The  
16 surgical consents definitely need to be revamped. Then  
17 I will submit the draft, then people will also submit  
18 whatever it is they want to submit. Then a discussion  
19 and a meeting will be had.

20 **Q What do you mean the surgical consents**  
21 **definitely need to be revamped?**

22 A I felt that there was so much different options  
23 that it's also an evolving, and I'm not a surgeon, and  
24 so I was hoping to get more input from a surgeon, but I  
25 feel that it should be separated out for what are the

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1 surgeries that you would get as a trans-man versus a  
2 trans-woman. Just like we did feminizing verse  
3 masculinizing. So I feel like having the information  
4 for a surgery that you are not going to have seems  
5 irrelevant.

6 So I think it needs to be cleaned up a bit I  
7 think some of the verbiage needs to change in regards to  
8 this is evolving. There might be some procedures that,  
9 you know, they are going to do. We did say in our  
10 consent that your surgeon likely that's their own  
11 consent that will go over the risks and benefits of the  
12 specific procedure that you are having, but I  
13 definitely, from my opinion, feel like that needs to be  
14 revamped. So I'm planning on separating them out,  
15 putting them -- cleaning them up, submitting that as a  
16 draft, then seeing what everybody else's input would be.  
17 Then hopefully, other people will have submitted some  
18 examples as well.

19 Q Has the Board considered involving an expert in  
20 this treatment?

21 A I know Dr. DePietro said she was going to reach  
22 out to somebody that she knew who was doing  
23 gender-affirming surgeries to see if they could help  
24 review and provide consents.

25 Q And who's that?

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1 A She didn't say who it was.

2 Q Are you aware of the letter that you-all  
3 received from JAPC who sent in a letter about a concern  
4 about the informed consent forms?

5 A Do you have an exhibit?

6 Q I sure do. Hoping I could get you talking  
7 while I find it. The Joint Administrative Procedures  
8 Committee. I've handed you what we marked as  
9 Exhibit 11, a letter from the Joint Administrative  
10 Procedures Committee. The first page is directed at, it  
11 appears, the Board of Medicine. And the second one is  
12 directed at the Board of Osteopathic Medicine. Do you  
13 see that?

14 (Plaintiffs' Exhibit Number 11 was marked for  
15 identification.)

16 A Yes.

17 BY MS. CHRISS:

18 Q And it appears that they asked you to explain  
19 the Boards statutory authority for requiring that adults  
20 receiving these medications undergo a thorough  
21 psychological and social evaluation performed by a  
22 Florida licensed board certified psychiatrist or a  
23 Florida licensed psychologist before beginning HRT and  
24 every two years thereafter.

25 What was the statutory authority for that

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1 requirement?

2 MR. PERKO: Object to form.

3 A I thought that part was removed?

4 BY MS. CHRISS:

5 Q Right. So I think it was removed as a result  
6 of this letter. I was just wondering if you knew what  
7 the statutory authority was for those requirements?

8 MR. PERKO: Object to form.

9 A I think when we were establishing guidelines  
10 that we, kind of, looked and we were concerned about the  
11 psychological impact, and there is a high association of  
12 depression, anxiety, ADHD, neurodivergent population  
13 that we felt that the risk was still there for suicide,  
14 that it would be important for them to be evaluated and  
15 assessed, but we removed it.

16 Q And what's your understanding of why you  
17 removed it?

18 A Well, one of the things is I believe that it  
19 wasn't in the guidelines for WPATH, and for Endocrine  
20 Society for the adults. So it seemed reasonable to  
21 remove that, based on that, you know, so I felt, like,  
22 yeah, that seems reasonable that we can remove that.

23 Q Is it your understanding that the remainder of  
24 the informed consent form requirements are aligned with  
25 the Endocrine Society and WPATH Guidelines?



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1           A     I think a majority is, but I think there is  
2 some deviation from them, but I can't remember what off  
3 the top of my head what are the deviations.

4           **Q     Okay. We'll come back to that. Where did your**  
5 **decision, I guess, to include that requirement initially**  
6 **come from?**

7           A     Well, we initially had it in the pediatric one.

8           **Q     Right.**

9           A     So we moved it over, we, kind of, talked about  
10 should we include it or not include it? So because of  
11 the high risk for that population we decided to include  
12 it, then we decided, nope, we probably shouldn't include  
13 it, so we removed it.

14          **Q     Are you aware of any research showing that**  
15 **these treatments significantly reduce suicidal ideation?**

16          A     I'm sure there is some literature, there's all  
17 sorts of different literature, but I think there was  
18 this study from Norway that was showing 20 to 30 years  
19 out after treatment that they still had a high risk and  
20 association of depression, anxiety, and thoughts of  
21 suicide.

22          **Q     Is that compared with individuals that did not**  
23 **receive gender-affirming care or --**

24          A     That's only gender-affirming care.

25          **Q     -- the general population? Right. And are**

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1 those individuals, is the comparator, the general  
2 population?

3 A I believe it's just comparing within its own  
4 population, saying that out of this population  
5 40 percent of them still had thoughts of suicide or  
6 depression in their lifetime.

7 Q What study was that?

8 A I want to say it was out of Norway, I might  
9 have included it in my statement. So I'm not sure where  
10 the reference is. I do have on page 25, Item 68, where  
11 it says: Suicidality is still a huge concern in the  
12 adult population as well, because the estimate lifetime  
13 prevalence of suicide attempts among transgender  
14 population, as high as 40 percent, this is with treated  
15 patients. So I have to actually look at the reference,  
16 but I'm fairly certain that was from the study from  
17 Norway.

18 Q And are you aware whether the patients in that  
19 study received gender-affirming care as minors?

20 A I do not know.

21 Q Okay. You mention needing to inform folks  
22 about the risk of suicide when receiving  
23 gender-affirming care. Is it equally important to  
24 inform folks of the risk of suicidal ideation and  
25 suicide when not receiving these interventions?

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1 A Yes.

2 Q And do the informed consent forms include that  
3 information?

4 A I think it's in the very -- I'm looking at it,  
5 I thought this was the consent. I think it's where it  
6 says other, in the first or second page, where it talks  
7 about other options. It talks about seeing psychology,  
8 and that they should still have mental health  
9 assessments.

10 Q So what I am asking is in the same way you  
11 advise that the risk -- the increased risk of suicide  
12 ideation for receiving this treatment, should there also  
13 be a parallel in informing them of the risk of suicide  
14 and suicidal ideation when not receiving this treatment?

15 A Yes.

16 Q Is that something you intend to include in the  
17 next iteration of the consent forms?

18 A I guess we can make it clear, but I thought in  
19 the opening paragraph of other options that it was  
20 included. I'd have to -- I don't know if you have a  
21 copy of the consent?

22 Q Not at the moment. Do you know of any other  
23 evidence that gender-affirming treatment for gender  
24 dysphoria does not reduce suicidality?

25 A Sorry, repeat that?

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1 Q Do you know of any other evidence, other than  
2 this, what you mentioned previously, any other evidence  
3 that the treatments for gender dysphoria don't reduce  
4 suicidality?

5 MR. PERKO: Object to form.

6 A I don't know that there's enough data just for  
7 whether it does or it doesn't, because there's not  
8 enough studies that have actually said that. That's the  
9 problem of all of this being low grade data, there isn't  
10 anything saying this is a population that was treated  
11 and this is a population that wasn't treated.

12 Q So you are not aware of the risks of  
13 withholding treatment or banning treatment?

14 A Correct.

15 Q When you were creating the informed consent  
16 forms did you consider these statements provided by  
17 medical providers who provide treatment for gender  
18 dysphoria in Florida, including Dr. Kristin Dayton,  
19 who's a pediatric endocrinologist, who has been  
20 providing care for this population for six years through  
21 a multidisciplinary clinic?

22 A Yes, I looked at all the data that was  
23 submitted.

24 Q And did you consider the recommendation of Dr.  
25 Paul Arons who is a physician and the former chair of

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1 the Florida Department of Health Institutional Review  
2 Board?

3 A I'm sure I did.

4 Q In your clinical practice would you present  
5 information to your patient that you knew to be untrue?

6 A Not knowingly, no.

7 Q When you provide informed consent for your  
8 patients for the various endocrine disorders that you  
9 mentioned treating, do you individualize the informed  
10 consent or what you are sharing with them to the needs  
11 of that patient?

12 A I usually will not skip, I will say these are  
13 the side effects going from most common to least common.  
14 For example, a birth control pill. So there's a risk of  
15 blood clots. What gives you that risk? Being over 35,  
16 not an issue. Being a smoker. Here's an opportunity,  
17 do you smoke? If they say, yes. It's a risk, we need  
18 you to stop. Or if they say no, I say, please don't  
19 start. Is there a family history of blood clots? A lot  
20 of times the patient isn't going to know, but the parent  
21 will be, like, actually, my sister had a blood clot when  
22 she was on a birth control pill. Well, that's an  
23 absolute risk. So is there anyone else in the family?  
24 Maybe I need to do some other testing to look for  
25 clotting disorders before I proceed with this treatment.

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1           So I usually list them, but focus more in on  
2 the area that might pertain more to. I think the  
3 example was one of the experts was talking about acne,  
4 and that's the idea of consent. You don't really have a  
5 history of liver disease and you don't have a family  
6 history of this? Correct? Correct. But, you know, I  
7 am worried about the acne, let's have a conversation  
8 about the acne and what your risks are and what that is.  
9 It's meant to be used as an open forum to assess a  
10 person's risk and say, that's of little to no risk for  
11 you, I'm not really concerned.

12           And a parent might say, actually, I'm  
13 concerned. I was just diagnosed with breast cancer. So  
14 it gives an opportunity for the family and the patient  
15 to assess what their concerns are and then the doctor to  
16 assess and address what their concerns are.

17           **Q**     So in the prescribing of puberty blocking -- or  
18 Lupron, the testosterone, estrogen, the other  
19 medications you mentioned earlier, you are able to have  
20 back and forth dialogue and, sort of, tailor the  
21 informed consent process to the patient. Are you aware  
22 of any other medication that you prescribe that  
23 requires -- that removes your, what's the word I'm  
24 looking for here? Discretion. Discretion in what you  
25 discuss with the patient?

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1 MR. PERKO: Object to form.

2 A I'm not sure what you are asking.

3 BY MS. CHRISS:

4 Q In any of the treatments that you provide for  
5 your patients that have endocrine disorders that might  
6 require things, like, Lupron testosterone and estrogen,  
7 you have discretion in the informed consent process you  
8 engage in, correct?

9 A What do you mean by discretion?

10 Q What you were just describing, was your  
11 professional expertise in knowing what to discuss with  
12 the patient, what might be relevant to the patient. You  
13 have discretion in how that informed consent process  
14 takes place, correct?

15 A I'm not quite sure I understand, but, I mean, I  
16 basically go through the risk and all of the risk and  
17 how I think a potential risk might be towards a certain  
18 person versus another. So is there some  
19 individualization? Yes, but it starts with a  
20 generalization going over all of the effects and zeroing  
21 in on the ones that I might have more concerns on or the  
22 family might have more concerns on.

23 Q None of those are written consents?

24 A Correct.

25 Q Just for the treatment of gender dysphoria?

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1 A Correct.

2 MS. CHRISS: If we can take five minutes, that  
3 would be great.

4 (Break taken at 4:26 p.m. until 4:40 p.m.)

5 BY MS. CHRISS:

6 Q Dr. Mortensen, just returning for a moment to  
7 an earlier topic. Is it appropriate for someone who's  
8 not an expert in an area of care to create informed  
9 consent forms on that area of care?

10 MR. PERKO: Object to form.

11 A Well, the challenge is that we were advised  
12 that we had to do it, so someone had to do it. No one  
13 else stepped up. No one else delivered, so we did the  
14 best that we could.

15 BY MS. CHRISS:

16 Q Right. Sorry, so not specific to what you-all  
17 did, but, generally, do you think it's appropriate for  
18 someone to create informed consent forms who is not an  
19 expert in the provision of that type of care?

20 MR. PERKO: Object to form.

21 A I would say that consent forms typically are  
22 not drafted by just one person, there is usually a  
23 committee and a review process as well. So, for an  
24 example of a trainee, they are going -- they might not  
25 be an expert of having ten years plus experience, they



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1 are going to develop a consent form, but it will be  
2 reviewed by the IRB, usually there's an ethicist,  
3 there's usually a lawyer, there's usually their mentor.  
4 So can consent forms be written by someone who's not an  
5 expert? Absolutely. But usually they're not completed  
6 and signed off on until a committee or group approved  
7 them.

8 MS. CHRISS: My colleague just noted that the  
9 lap top is on mute.

10 (Off-the-record discussion.)

11 BY MS. CHRISS:

12 Q So moving in paragraph 78 of your expert  
13 report, which is on page 30, you discussed fertility.  
14 Is it your view that puberty blockers have permanent  
15 negative effects on fertility?

16 A It depends on what indication you are talking  
17 about.

18 Q Just, generally, is it your view that  
19 puberty --

20 A I think it's hard to generalize, because  
21 puberty blockers are used for different scenarios and  
22 have been approved for different indications. So if you  
23 are going to ask me is generally when you use a puberty  
24 blocker for the indication of central precocious puberty  
25 is there a concern for fertility, I often bring it up

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1 with families, and they often mention is that the data  
2 supports that there isn't, but there's always a  
3 possibility.

4 Q So in the informed consent form you state that  
5 puberty blockers can interfere with fertility, but isn't  
6 it accurate that the Endocrine Society Guidelines state  
7 there's no data on its impact on fertility?

8 A So if you are currently using a puberty blocker  
9 you are likely not to get pregnant, so you are having  
10 issues with fertility while you are on it. It doesn't  
11 state long-term fertility.

12 Q But what evidence do you have to support that  
13 it does have permanent impacts on fertility?

14 A There's not enough evidence to support if it  
15 does or it doesn't because 90 percent of kids who go on  
16 puberty blocker go on to testosterone and estrogen,  
17 which can also impact fertility. Many of them will  
18 often have a gonadectomy, whether they are removing the  
19 testicles or the ovaries, and that's going to have an  
20 impact on fertility. So even the long-term data is hard  
21 to say because there's not a lot of cases of people who  
22 were just on puberty blockers for this indication who  
23 did not go through the rest of the cycle to see what's  
24 going to happen.

25 Q So there isn't data to -- there isn't data to

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1 support that there is a long-term impact on fertility?

2 A Or that there isn't.

3 Q Right. There isn't data to suggest either way?

4 A Correct.

5 Q So Dr. Mortensen, you're mandating disclosure

6 of a risk in these informed consent forms that you

7 aren't sure is even a risk; is that your testimony

8 today?

9 A There are some things it's unclear what the

10 risk is, but that's the idea of an informed consent of

11 saying that there's a fertility, so just so you are

12 aware -- and that's the thing about people who go on

13 puberty blockers, and even birth control pills, the

14 likelihood is you are not going to be pregnant. There's

15 still could be break through and you can get pregnant,

16 so you have to think of that, but there also could be a

17 risk that there's a likelihood that you are not going to

18 be pregnant while you are on this medication.

19 Q But there is data to support that there's no

20 impact on fertility?

21 A In the indication of using it for central

22 precocious puberty.

23 Q And there's not data to support that there is a

24 certain negative impact on fertility?

25 A It's hard to stipulate whether there is or

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1 there isn't, because there hasn't been published data to  
2 say there is or there isn't.

3 Q Is there any medical reason to think that an  
4 adolescent who is given puberty blockers to treat gender  
5 dysphoria and then ceases taking those will not regain  
6 fertility?

7 A It's likely that they will regain fertility if  
8 they don't take the hormone replacement therapy, it's  
9 very likely. And that was when I was doing it that I  
10 would say, that we don't know, but that's also what your  
11 experts testified as well, when we used it for  
12 precocious puberty we didn't really see an issue with  
13 fertility down the road. We haven't really used it in  
14 this age group for this duration, even if that's one,  
15 two, or three years, so we don't know what the outcome  
16 is. If we are basing it on data from a different group,  
17 it doesn't seem likely, but there's always a risk.

18 Q In paragraph 80 of your report you state on  
19 page 31, you state that the quoted statement comes  
20 directly from the Lupron package insert?

21 A Uh-huh.

22 Q The documents states that, quote: Puberty  
23 blockers can interfere with fertility.

24 A Uh-huh.

25 Q But the Lupron package insert says that these

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1 changes are, quote, reversible upon cessation of  
2 treatment. Correct?

3 A Correct.

4 Q Is there a reason that the full statement was  
5 not included?

6 A It also, I believe, in the consent said that  
7 many of these things can be reversible, but some of them  
8 can be permanent.

9 Q Does the informed consent form include this  
10 language, that they are reversible upon cessation of  
11 treatment?

12 A I believe that it is more in the beginning that  
13 even with the feminizing and masculinizing that many  
14 things can be reversible.

15 Q Paragraph 85 of your report on page 34  
16 regarding cognitive development. You say that there's  
17 no long-term data on cognitive impacts of puberty  
18 suppression medications to treat gender dysphoria.  
19 Correct?

20 A Correct.

21 Q But that is not what the informed consent forms  
22 say. The informed consent forms state that puberty  
23 blockers may cause stalling of typical cognitive or  
24 brain development in minors. Correct?

25 A Correct.

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1 Q Yet there's no long-term data to support that?

2 A Correct. But it also depends on if you are  
3 taking a look at someone who's going through puberty and  
4 they get testosterone and estrogen, the brain is going  
5 to change. Someone's 12, 13, 14 and they are going  
6 through puberty, their cognitive and mental development  
7 is going to change when exposed to cross-sex steroids.  
8 By giving them a puberty blocker that progression and  
9 maturity isn't going to happen. That brain development  
10 is not going to happen because it's not being exposed to  
11 hormones that it's usually exposed to at that time.

12 Q As you state in your report, there's no  
13 long-term data on these cognitive impacts?

14 A Correct.

15 Q Okay. Dr. Mortensen, earlier in your  
16 deposition you testified that you didn't include the  
17 information I asked about with regard to benefits of  
18 this treatment because, as you stated, there wasn't  
19 long-term data, yet you are including risks in the  
20 informed consent forms that equally have no long-term  
21 data.

22 A Correct.

23 Q Why is that?

24 A Because there's limited data as to what the  
25 benefit is, and it's very -- by looking at the data it's

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1 hard to say it can help with some, it might not help  
2 with others, it might worsen others, it really hard to  
3 say whether or not how much benefit someone gets. So  
4 typically when someone is going through a treatment and  
5 they are going to say, Doc, is this going to cure me of  
6 cancer, what are my odds? Doc, what are the odds that  
7 I'm going to have this, that, or the other? You're  
8 purely speculating as to, yes, this is going to help you  
9 or not help you, you don't know.

10 So part of the informed consent, the people who  
11 are giving the consent should be able to explain what  
12 their experience is, and I have no doubt that they are  
13 saying, in my experience, this is the benefit that I  
14 see. And that is likely -- and in the community they  
15 are all sharing the benefits that they are seeing. They  
16 are sharing some of the sad things that happen too, but  
17 I think that it -- if I'm sitting here saying, and you  
18 are asking me my opinion as to does this 100 percent  
19 cause improvement or is it shown 100 percent, or even a  
20 high percentage, I can't say that. I can say that some  
21 studies show that there may be improvement.

22 Q So that's not the question, Dr. Mortensen, as  
23 to why you didn't say this 100 percent will improve.  
24 The question is why, if there's no data to support it,  
25 including the risk of puberty blockers may cause

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1 stalling of typical cognitive or brain development in  
2 minors. Why is that not speculative?

3 A I don't think I understand what you are asking.

4 Q You've made clear that there's no long-term  
5 data supporting this, and when explaining why not to  
6 include benefits you said, because there's no long-term  
7 data, it is speculative. The statement that you  
8 included in the informed consent form about the impact  
9 on cognitive development is equally speculative, yes?

10 A In your opinion, but not in mine. I don't view  
11 that as speculative.

12 Q So no long-term data to support benefits is  
13 speculative, no long-term data to support risks is not?

14 A In the consent it says that, and you can phrase  
15 the consent, but we don't know, there isn't data that  
16 supports it one way or the other. But in the Endocrine  
17 Society Guidelines it says limited data is available  
18 regarding the effects on brain development. And there's  
19 animal data that suggests there is. So it's hard to  
20 say. I mean, you have the Endocrine Society Guidelines  
21 saying that they don't really know, there's limited  
22 data.

23 Q Dr. Mortensen, looking at paragraphs 86  
24 through -- well, start with paragraph 86 of your report  
25 regarding masculinizing and feminizing medication



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1 dosing. The informed consent forms for masculinizing  
2 and feminizing medications for minors state that, quote:  
3 This medicine and dose that is recommended is based  
4 solely on the judgement and experience of the minor's  
5 prescribing physician. Correct?

6 A Correct.

7 Q Paragraph 87 you state you agree -- or let's  
8 turn to paragraph 87 on page 34. Apologies.

9 MR. PERKO: Page 87 on 34?

10 A Item 87 on page 35.

11 BY MS. CHRISS:

12 Q Paragraph 87, page 35. You say they are  
13 correct that there are clinical practice guidelines in  
14 the Endocrine Society Guidelines and they should be  
15 followed by clinicians to guide treatment regimens.  
16 Yes?

17 A Correct.

18 Q And in the Endocrine Society Guidelines the  
19 guidelines provided gradually increasing dose schedule  
20 for the induction of puberty in minors using  
21 testosterone or estrogen?

22 A Correct.

23 Q Your report states: However, this is not  
24 always the case.

25 What do you mean by that?

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1           A       So there are guidelines on to -- I go on to  
2 say: The dosing for adolescents is based on hypogonadal  
3 adolescents and pubertal induction.

4                   And so there are different centers that do  
5 different things in regards to pubertal induction and  
6 dosing. When you look at the research as to what dosing  
7 and what regimens were used, different dosings at  
8 different centers, and even when we contacted in regards  
9 to that publication for the New England Journal and  
10 asked if they could provide what doses they used, they  
11 couldn't even stipulate as to all the centers, because  
12 it was a multicenter trial that were doing the exact  
13 same pubertal induction.

14                   So it's a guideline as to how people should do  
15 it, but not everybody follows the guidelines. And  
16 sometimes that's from their own expert opinion. I'm not  
17 saying that it's wrong. I think that's, kind of, how  
18 this statement is being misconstrued, that your provider  
19 has experience in this, they are going to do it based on  
20 their experience. Some people for replacement of  
21 estrogen therapy and pubertal induction in Turner  
22 Syndrome use estrogen patches, some of them use pills,  
23 some of them have use injections, none of that is  
24 necessarily wrong, they are just going based on because  
25 there isn't even some longitudinal data on that as well.

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1           So it's not saying the provider is doing  
2 anything wrong, it's saying that your provider is -- it  
3 was actually designed to help support the provider or  
4 the physician in saying that you are going to go based  
5 on their experience. You know, my experience is I  
6 prefer to use estrogen patches because it bypasses the  
7 liver, there's less risk of liver dysfunction. Johnny  
8 Jones down the road might like the pills because that's  
9 what they are very comfortable with doing. Is Johnny  
10 Jones wrong? Am I wrong? No, they are both options,  
11 they are both in the guidelines, but there's also  
12 recommendations and some people might push them quicker  
13 or later based on how old they are.

14           So even though they have the recommendations in  
15 there, it also depends on the age the patient presents  
16 for treatment. It's vastly different from treating  
17 somebody on a pubertal blocker inducing their puberty  
18 starting at zero versus somebody who presented at 16 or  
19 17, has already been fully virilized that you are  
20 starting estrogen in, like, an adult.

21           **Q     Is having dosing flexibility common?**

22           A     Yes. That's why there are so many different  
23 doses of medication. What works for one might not work  
24 in another.

25           **Q     So the process you just describe sounds very**

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1 individualized, based on the expertise of the provider.  
2 Why does this need to be included in these informed  
3 consent forms that the provider is not allowed to  
4 modify?

5 A So that statement actually helps protect the  
6 provider, so it's interesting to me they view as a  
7 negative and want to modify it. It actually gives them  
8 a lot more accessibility and also a chance to  
9 individualize. We are not saying you stick to these  
10 guidelines and dose it exactly like that. We are saying  
11 you are going to rely on your person and their  
12 experience with using these medicines to dose  
13 accordingly they would.

14 I did quote an article in here about looking at  
15 transgender population and how they change their doses  
16 and why they change their doses, and part of it is  
17 because they don't believe their doctor is prescribing  
18 them enough. Some of them think their doctor is  
19 prescribing them too much. So it's actually in an  
20 effort to establish that relationship with the patient  
21 of this is my area of expertise, I dose it based on the  
22 patients I have worked with.

23 Q Is this dosing flexibility is not unique to  
24 gender-affirming care, right?

25 A That is correct.

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1 Q We're talking about, you know, patient-doctor  
2 relationship. Do you think it undermines the informed  
3 consent process when the physician has to state, you  
4 know, these are not risks that are supported by data, I  
5 don't agree with these, and this didn't reflect my views  
6 or my experience with this treatment?

7 MR. PERKO: Object to form.

8 A So a lot of times when we have it, and you are  
9 going through an informed consent because when we are  
10 doing medications that are new or different or new  
11 procedures or techniques, you say here's what we believe  
12 some of the risks are. Here are some of the known  
13 beliefs that we know that could happen because of this  
14 scenario. This is why I believe this is a reasonable  
15 path for you because you have limited risk based on X,  
16 Y, and Z, and based on my opinion, I think this would be  
17 a right regimen for you. But you are the patient, I'm  
18 informing you, you tell me are there any things you are  
19 concerned about in regards to this? Let's have a  
20 conversation, then you ultimately decide if this is the  
21 course you want to pursue.

22 Q And in paragraph 87 you criticize the lack of  
23 high quality studies to determine dosing and timing  
24 schedule. Are all of the medications that you prescribe  
25 in your practice supported by high quality studies to

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1 **determine dosing?**

2 A No. I previously stated that even for Turners  
3 Guidelines they change over the years, but there's  
4 different guidelines. Even the Endocrine Society  
5 Guidelines have different regimens of whether it's pills  
6 or whether it's patches. There are some studies, but  
7 some of them are limited. I often explain that. Many  
8 times it's, this is my experience in using this  
9 medication. This has been the experience, based on this  
10 group that has done this, this is the literature that  
11 has it. You just explain what you know and what you  
12 don't know.

13 **Q So this sounds like a common experience with**  
14 **prescribing medications, generally?**

15 A Exactly.

16 **Q So why just the treatment of gender dysphoria**  
17 **do we need these rigid consent forms?**

18 A I think it stems a lot from the  
19 detransitioners, and I think it stems a lot from  
20 lawyers. No offense.

21 **Q What detransitioners you are referring to?**

22 A So there's a lot of detransitioners in the  
23 media, a lot of them are saying I was not aware, I  
24 didn't realize this was a side effect, I didn't realize  
25 that this could happen, they didn't inform me of this.

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1 I don't know if they did or they didn't, but having it  
2 written makes it a lot easier. Having a signed document  
3 that I did review this with you, instead of going in  
4 front of a judge and saying, I reviewed the side effects  
5 and blah, blah, blah. But did you list out every side  
6 effect? Is that just a smart phrase that you are saying  
7 that says you covered all that? It he said versus she  
8 said of what was really said, what was really  
9 documented.

10 I think the most concerning thing with the  
11 detransitioners is they are saying they were not  
12 informed and that they also weren't well-diagnosed and  
13 that they were misdiagnosed. And I think a lot of  
14 people in the transgender society would state that those  
15 detransitioners were probably never trans to begin with.  
16 But that's a means to protect everybody in the  
17 situation. This is a very different situation,  
18 especially for children. These medicines can have an  
19 impact for the rest of their life. So to pause and  
20 spend 10 minutes to review things as to risks and  
21 possibilities for something that's going to impact you  
22 for the rest of your life seems like a fair use of time.

23 **Q You have no basis upon which to believe these**  
24 **providers weren't already spending those 10 minutes, or**  
25 **probably much more, providing these risks and benefits**

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1 to their patients, correct?

2 A If you go based on what some of the  
3 detransitioners.

4 Q Can you point me to specific detransitioners?

5 A I believe Chloe was one of them saying that she  
6 wasn't really aware and that she really didn't  
7 understand what all of it meant.

8 Q So setting a standard of practice for the  
9 provision of medical care for an entire community based  
10 on one individual's experience, is that something you've  
11 seen happened in other context?

12 MR. PERKO: Object to form.

13 A I don't think it's one individual's experience,  
14 because the number of detransitioners seem to be going  
15 up. As I state earlier, in Europe they put, kind of, a  
16 pause on things.

17 Q Did a single detransitioner state that they  
18 received treatment in the state of Florida?

19 A Not to my knowledge.

20 Q Did a single detransitioner name a Florida  
21 medical provider or institution where they received care  
22 that was inappropriate?

23 A Not that I know of.

24 Q Can you name another detransitioner, other than  
25 Chloe Cole, who's experience has impacted your views on



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1 this?

2 A I mean, not by name, just by things I've seen  
3 or read or saw.

4 Q In your clinical experience, you never  
5 witnessed or experienced a person regret the treatment  
6 they received for gender dysphoria?

7 A Not in my personal experience, no.

8 Q Two follow-up questions, one, what is the basis  
9 for your statement that the number of detransitioners  
10 are going up?

11 A I don't know where I had read it, I don't know  
12 if I put it in here, but it seems like, number one,  
13 there was a dramatic rise in the number of people  
14 stating they had gender dysphoria and that there's also  
15 been a rise on -- all of the published data on the  
16 detransitioners seems to be before 2019, and not after  
17 this big shift, this big drive, especially here in the  
18 United States. Because in 2017 it wasn't very mainstream  
19 to use these medications for this indication.

20 So the data of detransitioning is based more on  
21 overseas data, and some data here, up to 2017, '18.  
22 It's not -- I believe someone had said it's up to  
23 30 percent. I even think on the NIH funded one that was  
24 in JCM where they said the number of patients that they  
25 had, I think that they had 300 patients and it went down

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1 to 200 patients that they had studied. So that means  
2 they had a 30 percent or more dropout in their  
3 population, which in a research study is, kind of,  
4 unfathomable that you would have that much of a dropout  
5 rate.

6 Q Is it true, and I won't go through the entire  
7 administrative record with you and all the public books,  
8 we've both read them, is it accurate that there are a  
9 tremendous number of statements from transgender  
10 individuals who have received gender-affirming care and  
11 have had positive experiences?

12 MR. PERKO: Object to form.

13 A I don't know how much you mean by tremendous,  
14 but, yes, there was some very positive statements that  
15 were made.

16 BY MS. CHRISS:

17 Q And is it true that at least at the  
18 February 10th, 2023, hearing there were a vast majority  
19 of individuals testifying about their positive  
20 experiences with this treatment and imploring the Board  
21 to allow them to continue accessing this treatment?

22 MR. PERKO: Object to form.

23 A That is true.

24 BY MS. CHRISS:

25 Q And you can't name another detransitioner or

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1 individual that you heard of, other than Chloe Cole, who  
2 came from out of state to provide this care at the  
3 request of the state?

4 A I mean, I'm very bad with names, but I don't  
5 recall from the state of Florida.

6 Q Are you aware that the detransitioners whose  
7 names we looked at earlier who testified at the public  
8 hearing were -- almost of them were retained as  
9 witnesses by the state of Florida in the case of Dekker  
10 v. Weida?

11 A No.

12 Q You stated earlier that detransitioners and  
13 lawyers were driving this. What did you mean by lawyers  
14 driving this?

15 A Well, that what one of the things that my  
16 friend from Seattle General had said, that they were  
17 very concerned of the lawsuit that they had and it  
18 seemed based on what they were seeing there were  
19 concerns there's likely going to be detransitioners and  
20 there's likely going to be lawsuits. And that was back  
21 in 2017. I think it's fair to say there's lawsuits  
22 worldwide from detransitioners. So it wasn't something  
23 that wasn't predictable that was going to happen.

24 So in an effort to protect patients so that  
25 they're fully informed and consented and to protected

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1 the provider and to protect the institution as well,  
2 that's why we created informed consents for our center.

3 Q The incident that you mentioned that your  
4 friend relayed to you was regarding an individual with  
5 cerebral palsy, correct?

6 A Correct.

7 Q Who's not receiving treatment for gender  
8 dysphoria?

9 A Correct.

10 Q Is it fair to say there are many medical  
11 malpractice lawsuits brought all the time for all sorts  
12 of inappropriate treatment provided?

13 A I'm sure there are.

14 Q And that people regret treatment they receive  
15 in various areas of medicine?

16 A I'm sure they do. That's why there's lawsuits.

17 Q And has the Board adopted rules or consent  
18 forms about any other area of treatment based on  
19 malpractice lawsuits or a suggestion of inappropriate  
20 care not even within the state that the Board is  
21 regulating?

22 MR. PERKO: Object to form.

23 A The Board -- oh, sorry. The Board hasn't  
24 adopted, but why do you think there are surgical consent  
25 forms? Why do you think there are consent forms every

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1 time you walk into a hospital to consent to treat? When  
2 you walk into a clinic you have to sign a form to  
3 consent to treatment. When I do genetic testing I have  
4 to sign it, I have to have a witness sign, I have to  
5 have a parent sign it, and that's just for a genetic  
6 test.

7 BY MS. CHRISS:

8 Q When you say the Board hasn't adopted, what do  
9 you mean?

10 A Well, when you are saying -- I thought you had  
11 asked had the Board adopted any of those types of  
12 consents or any other medical conditions related to  
13 adopting consents.

14 Q Does the Board adopt rules and consent forms  
15 for any condition in which there's a fear there might be  
16 a rise in lawsuits about?

17 A I believe they had the rules in regards to the  
18 Brazilian butt lift, rules for that because there was  
19 misuse, abuse, and lawsuits for that too.

20 Q But that demonstrated misuse, abuse, and  
21 lawsuit --

22 A Yes.

23 Q -- not speculative, correct?

24 MR. PERKO: Object to form.

25 A Correct.

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1 BY MS. CHRISS:

2 Q Moving to paragraphs 89 and 90 where you  
3 reference WPATH. And you quote from WPATH. Is it  
4 correct that these are quotes from WPATH Standards of  
5 Care 7?

6 A Might be 8. I think we are at 8 now for WPATH.

7 Q I believe these statements are from WPATH 7,  
8 but.

9 A I have to check and see.

10 Q Okay. Are you aware that the SOC8 does provide  
11 a specific hormone regimen with specific doses provided?

12 A From WPATH?

13 Q Uh-huh.

14 A No, I'm not aware.

15 Q That's for both adolescents and minors -- I  
16 mean adolescents and adults. You are not aware?

17 A No.

18 Q Okay. Paragraph 90 -- paragraph 93 on page 37  
19 you discuss the permanency of certain effects of  
20 testosterone. Dr. Bruggeman rebutted this statement in  
21 the informed consent forms that certain effects could be  
22 permanent. You say that she should provide references  
23 to prove this. Dr. Mortensen, what references do you  
24 have to support the suggestion in the forms that these  
25 changes from testosterone are permanent?

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1           A       Well, I can certainly look them up for you, but  
2 there are -- there's documented literature of people  
3 going on testosterone that it has given them permanent  
4 voice change that can't go back, that have permanent  
5 facial hair or chest hair that can't go back. That have  
6 impacted fertility or caused polycystic ovarian syndrome  
7 that can't be reversed.

8           **Q       Is there any evidence to support your statement**  
9 **that testosterone has any negative impact on bone**  
10 **density for transgender men?**

11          A       I think that that was something we were going  
12 to revise, because it didn't seem based on the most  
13 recent data that it would impact transgender men, we  
14 were going to revise in the consents.

15          **Q       For your statement in paragraph 93 regarding**  
16 **the permanent impact of testosterone, can you provide**  
17 **your source for me today that you relied upon?**

18          A       For?

19          **Q       For this statement that the following changes**  
20 **could be permanent with regard to testosterone.**

21          A       I mean, I'd have to look it up, I can't say it  
22 off the top of my mind. But I think it's been very well  
23 established that if you take testosterone your voice  
24 will permanently change and the hair will permanently be  
25 there.

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1 Q Are there other permanent effects from  
2 testosterone?

3 A There can be fertility, that's been  
4 demonstrated in polycystic ovaries.

5 Q And what data supports those statements?

6 A I'd have to look and see, but I'm pretty sure  
7 it's in the bibliography, because I believe it was  
8 brought up later in one of my statements.

9 Q Those aren't the -- okay. In paragraph 94, in  
10 support of this statement on the forms that treatment  
11 with testosterone increases the risk of certain cancers,  
12 you treat to WPATH's statement that there's not enough  
13 evidence to determine the type and frequency of cancer  
14 screenings for this population.

15 How does that lack of evidence support the  
16 statement in the informed consent form that there's an  
17 increased risk?

18 MR. PERKO: Sorry, counsel, are you referring  
19 to paragraph 94?

20 MS. CHRISS: Yes. Current where she says: Dr.  
21 Shumer and Dr. Bruggeman state currently they do not  
22 support that testosterone increases the risk of  
23 endometrial, ovarian, or breast cancer, et cetera.

24 A So the WPATH statement says there's not enough  
25 to determine the appropriate type and frequency of



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1 cancer screening for this population, but breast and  
2 uterine cancer are listed in the Endocrine Society  
3 Guidelines on Table 10 as medical risks. And I did  
4 provide a reference, as well, that talked about cancer.

5           So it's been .95 there's been documented cases  
6 that demonstrated trans-men can develop endometrial  
7 carcinoma while on endogenous testosterone therapy. The  
8 prevalence of endometrial cancer in trans-men is not  
9 clearly identified. The incidents have let it hard to  
10 determine, will often be different if their uterus is  
11 removed. It's also been well-documented in women with  
12 polycystic ovarian syndrome that they have a higher rate  
13 of endometrial cancer, and that's because they make  
14 their own testosterone. So we know testosterone can  
15 cause a risk in endometrial cancer for women with  
16 polycystic ovarian syndrome. Then it also looks like  
17 based on Dr. Seay's data as well.

18           There's also, in Section 97, talking -- going  
19 on breast cancer as well, saying there's still a role  
20 and that there have been trans-men who have been found  
21 to have breast cancer. Then .973 cases ovarian cancer  
22 in trans-men undergoing gender-affirmation are recorded  
23 in the literature. All three received testosterone  
24 therapy. That's from --

25           **Q       You cite to Seay, S-E-A-Y, to say: The**

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1 prevalence of endometrial cancer in trans-ment is not  
2 clearly identified. But the fact that -- that there  
3 is -- that cancer is a potential is not -- does not  
4 support the statement that there's an increased risk,  
5 correct?

6 A If you are a biological female and have too  
7 much testosterone, whether it be from polycystic ovarian  
8 syndrome or congenital adrenal hyperplasia, it's  
9 well-documented in the literature that you have an  
10 increased risk of endometrial cancer. The challenge of  
11 the data is that many transgender men end up undergoing  
12 a hysterectomy. So the risk is gone once they remove  
13 the uterus, but we also don't have a lot of long-term  
14 data, but we do know those that still have their uterus  
15 have a risk for it.

16 Q Going back to just the conversations we've been  
17 having about fertility and cancer risks and cognitive  
18 risks, et cetera, when you are talking about these  
19 risks, I'm trying to understand if there's no long-term  
20 data supporting that these -- that there are long-term  
21 negative effects, help me understand why including those  
22 risks on these forms is not speculative?

23 MR. PERKO: Object to form.

24 A Because there is -- I'm sorry.

25 Because there is some data that already shows

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1 that cancer has happened.

2 BY MS. CHRISS:

3 Q So talking about then --

4 A So I'm not speculating, there's actually cases  
5 that have been demonstrated.

6 Q So when it comes to fertility and the impacts  
7 on cognitive, the things where you agreed in your  
8 testimony, that there is no long-term data suggesting  
9 permanent impacts, long-term impacts, do you apply the  
10 same standard of certainty when you are looking at risks  
11 and benefits?

12 MR. PERKO: Object to form.

13 A I often tell families that there are many  
14 things in medicine that we just don't know yet, and this  
15 is what I know at that point that's been demonstrated  
16 and documented. This is what is speculative, or could  
17 be likely, based on this happens in this. Then there's  
18 also the category of we just don't know. That's why you  
19 have an individualized person of determining whether or  
20 not they want to assume that risk or not. Oftentimes --  
21 that's with pretty much almost everything.

22 So even though I prescribe growth hormone and  
23 it's been well-used over 30-plus years, I often say,  
24 sometimes we don't know how your child -- could that bad  
25 reaction have been from growth hormone? It hasn't been

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1 demonstrated in the literature, but who's to say it's  
2 not possible?

3 BY MS. CHRISS:

4 Q What level of evidence is required to list a  
5 risk?

6 MR. PERKO: Object to form.

7 A For what I listed in here is whatever I came  
8 cross in literature that had shown. So if there was  
9 nothing that was shown, that there wasn't any breast  
10 cancer or there wasn't endometrial cancer, I wouldn't  
11 have included it. If there was already demonstrated  
12 data that this has happened, it was typically included.

13 Q What long-term data supported permanent --  
14 potential permanent impacts on fertility?

15 A So there was data on here to support that going  
16 on testosterone can cause polycystic ovaries, but can  
17 also cause ovarian issues, and that that could impact  
18 fertility, so that's already been demonstrated in the  
19 literature. Then, again, once they have surgery or had  
20 their ovaries taken out, they're definitely going to be  
21 infertile, but that's also the case for the men as well,  
22 that estrogen is going to have an impact on their sex  
23 drive, it's going to have an impact on their sperm  
24 count, it's going to have an overall impact on their  
25 fertility as well. It doesn't mean -- nothing in there

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1 says you will 100 percent become infertile, it says that  
2 there's risks.

3 Q So what level of evidence is required to list a  
4 benefit?

5 MR. PERKO: Object to form.

6 A I don't know, but that's when I often say what  
7 evidence do I have? And the evidence that I have is  
8 from the Endocrine Society that's all low-grade,  
9 peer-reviewed, or group data, that says there could be  
10 some benefit. None of them were high-grade data. Very  
11 few were moderately-grade data.

12 BY MS. CHRISS:

13 Q Is it important to let people know how likely a  
14 risk might be?

15 A Yes.

16 Q Is it important to let people know how likely a  
17 benefit might be?

18 A Sure.

19 Q So why are there no indications of the benefits  
20 of these treatments?

21 A Because I don't think the jury's out on how  
22 much benefit there is and that it doesn't benefit  
23 everybody.

24 Q Does it have to benefit everyone? Does  
25 everything on here, does every risk on here apply to

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1 **everyone?**

2 A No, but I don't know that if you are going to  
3 put somebody on a medication that can impact them down  
4 the road for the rest of their life that you have to  
5 have some kind of certainty that that is going to help  
6 that person. And a lot of the data doesn't support that  
7 a majority of people -- I mean, for the adults a  
8 40 percent risk of suicide and death. That doesn't seem  
9 like a high -- that this medication management is the  
10 greatest route to go.

11 If I was giving somebody something for their  
12 blood pressure and it only helped 60 percent, I don't  
13 know that that would be the best treatment route for  
14 this person.

15 **Q Do you inform these folks of the percentage**  
16 **risk, the risk of suicide of not receiving treatment for**  
17 **gender dysphoria?**

18 A I don't know --

19 MR. PERKO: Object to form.

20 A Sorry. I don't know what the risk is, and I  
21 haven't seen any data that says here's a group of people  
22 that we didn't treat and that they committed suicide.

23 BY MS. CHRISS:

24 **Q So you don't list any potential benefits**  
25 **regardless of the quality of evidence that supports**

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1 **them?**

2 A In the opening statement it says that there has  
3 been some studies to show some benefit.

4 **Q But throughout the form it is solely risks?**

5 A If you ever see a consent for a surgical  
6 procedure the whole thing is all about risk. The  
7 opening line is about benefit. If you are getting your  
8 appendix removed because if you don't it's going to  
9 rupture and you could die. And here are the 50 million  
10 things that could potentially go wrong. Then the  
11 surgeon goes through and says, you know, there's a risk.  
12 Same thing with thyroid removal, there's a risk that I  
13 might -- there might be an nick, there might be  
14 bleeding, I could have damage to your vocal chords, I  
15 could damage your parathyroid glands. If that happens  
16 you're going to need this, you're going to need calcium  
17 and Vitamin D. So all of those are discussed in a  
18 surgical consent of the vast majority.

19 Even commercials out there for medications have  
20 the side effects may include blah, blah, blah, blah,  
21 blah, blah, blah, blah, blah. So a vast majority of  
22 consents don't focus on the positive, it focuses on the  
23 negative or the unknown.

24 **Q In paragraph 98, on page 39, the informed**  
25 **consent form states: Taking testosterone causes or**

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1    **worsens migraines.**

2           A     Uh-huh.

3           Q     You respond to Dr. Shumer and Bruggeman by  
4    saying that the data is limited and you cite a study  
5    that was inconclusive on the effects of gender-affirming  
6    hormone therapy on migraines. How does this study  
7    support the assertion that testosterone causes  
8    migraines?

9           A     So in that study it did say that there were --  
10   it was a limited sample, but that 16 reported ongoing  
11   pain, 13 whom endorsed headache, and a majority had  
12   headaches prior, but that's a majority had headaches  
13   prior, they are people that had headaches that didn't  
14   have migraine headaches before they started treatment.

15          Q     Is it true that this study was inconclusive on  
16   the effects of gender-affirming hormones causing  
17   migraines?

18          A     It basically said that more data needed to be  
19   collected.

20          Q     When more data needs to be collected, you take  
21   that to mean it is a risk worth listing on the informed  
22   consent form, but when more data needs to be collected  
23   about the benefit of a treatment that doesn't warrant  
24   being on the informed consent form, correct?

25          A     I'm kind of lost on what you just said there.



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1 Q More data needs to be collected.

2 A Uh-huh.

3 Q That's of sufficient level of evidence for you  
4 to list the risk of increased migraines, increased risk  
5 of migraines, but more data needs to be collected is  
6 also the reason you're stating you are not putting the  
7 benefits of these treatments on these informed consent  
8 forms, correct?

9 MR. PERKO: Object to form.

10 A The consents says that more data does need to  
11 be collected in regards to the benefit, but there were  
12 some studies that showed there can be benefit.

13 BY MS. CHRISS:

14 Q Paragraph 101, on page 41, you discuss the  
15 Finasteride.

16 A Yes.

17 Q We agree Finasteride is not used to treat  
18 gender dysphoria?

19 A It's used to treat a side effect from the  
20 treatments of gender dysphoria.

21 Q Even if this medication is likely to be used by  
22 transgender men experiencing hair loss, why is it  
23 included in the section title how is testosterone taken?

24 A I'd have to take a look at the consent.

25 Q And in paragraph 104 on page 42 you state that

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1 Dr. Shumer's statement that, quote: Trans-women should  
2 follow the same guidelines for breast cancer. Did I  
3 skip -- sorry. Should follow the same guidelines for  
4 breast cancer --

5 A Number 104?

6 Q Yes.

7 MR. PERKO: That's not what it says.

8 A That's not what it says.

9 BY MS. CHRISS:

10 Q You are correct. Which one -- apologies. 103  
11 you say: Dr. Shumer's statement that a transgender  
12 woman -- trans-women should follow the same guidelines  
13 for breast cancer screening in non-transgender women is  
14 very misguided. Hold on. Yeah. Sorry. The last  
15 sentence of paragraph 103: Dr. Shumer's -- I think you  
16 meant Shumer -- statement that trans-women should follow  
17 the same guidelines for breast cancer screening and  
18 non-transgender women is very misguided. But his report  
19 cites to a 2019 peer-reviewed study to support this  
20 assertion, correct?

21 A I believe so.

22 Q That study made the same recommendation?

23 A I believe so. But I think the WPATH Guidelines  
24 said that they aren't -- that it hasn't been established  
25 what kind of guidelines that they should have, whether

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1 or not -- because some of the cases that have been found  
2 have been in 30 and 40-year-old transgender men, which  
3 normal breast screening for cancer usually occurs after  
4 the age of 40.

5           So it's not really clear as to when they should  
6 start screening, but at the very least they should be  
7 made aware that breast cancer is a risk. Like every  
8 woman they should be doing breast cancer screening on  
9 themselves, checking for lumps and bumps. It's quite a  
10 challenge when they have breast implants, because  
11 sometimes the breast tissue is under the implant, so  
12 doing a self-breast examination monthly for breast  
13 cancer can be quite challenging. And I guess that's  
14 basically it. They are recommending the same as other  
15 woman, but they are not really sure what the screening  
16 should be, if it should be sooner or later. And I don't  
17 think I said in the consents they needed to start the  
18 screening, I think I just said that breast cancer is a  
19 risk. I'm leaving it up to the physicians to do their  
20 job and tell them about monthly screenings, see if  
21 there's also a family history, if their mother had  
22 breast cancer they would have a risk just like a  
23 biological woman has a risk. Those are conversations  
24 that need to be had, and this opens the door to those  
25 kinds of conversations.

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1 Q Sounds like what you are saying supports that  
2 Dr. Shumer's statement that trans-women should follow  
3 the same guidelines for breast cancer treatment as  
4 non-transgender women isn't misguided?

5 A Oh, no, no. What I said was misguided was  
6 these are exceedingly rare in the adolescent population.  
7 Saying that breast cancers are exceedingly rare in the  
8 adolescent population.

9 Q Moving down to paragraph 104, you -- rebutting  
10 Dr. Bruggeman discussing the permanency of certain  
11 effects of estrogen therapy. Dr. Bruggeman disagreed  
12 with the statement that these effects could be  
13 permanent. And your response is, quote: Again, no  
14 long-term data to support her claim. What references do  
15 you have, or what studies do you cite to, to support the  
16 suggestion in a forum that these changes are  
17 irreversible?

18 A So there is some data about some things, some  
19 are listed, but there's some data to support that some  
20 are irreversible, but she has not shown the data.  
21 There's no long-term data. There's no controlled  
22 studies to show it, but she hasn't showed the controlled  
23 studies that show that it doesn't either.

24 Q And you haven't shown the controlled study that  
25 show that it does?

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1           A       Correct, but I don't know, so that's why we  
2 explain we don't know if it's temporary or permanent.  
3 Some of them have already been known. We know when  
4 women with PCOS who make exogenous testosterone become  
5 virilized and sometimes they can have acromegaly and  
6 deepening voice and hair, and we know that those are  
7 definitely irreversible. That's been well-demonstrated  
8 and documented.

9                       But there are not a lot of circumstances  
10 where in history people have been giving testosterone to  
11 14-year-old females to say whether or not they are going  
12 to come off if, if those effects are going to be  
13 permanent or lifelong, because this is still a  
14 relatively new field in the United States and they've  
15 not been really forthcoming with the data overseas.

16           **Q       Just to be clear, your criteria for listing**  
17 **potential risks is to include every possible risk,**  
18 **including those only reported in a few individuals when**  
19 **causation was not determined, regardless of the level of**  
20 **evidence?**

21                       **MR. PERKO: Object to form.**

22           **A       Correct.**

23 BY MS. CHRISS:

24           **Q       Dr. Mortensen, in paragraph 108 you reference**  
25 **cipro -- I'm not a doctor. Ciproterone acetate, if the**

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1 purpose of these informed consent forms are to inform  
2 and educate, wouldn't it also be prudent to also include  
3 that this is not a treatment that's available in the  
4 United States due to its risk?

5 A I believe that it said in the consent that it's  
6 not available in the United States.

7 Q I don't believe it does. If it isn't  
8 available, what's the point of including it on the  
9 informed consent form at all then?

10 A As I said in my statement that these patients  
11 are very well-educated, they talk, and actually some of  
12 them come from other countries where it is available.  
13 Many of them want to seek options, they can also buy it  
14 online on the Internet, you can get it from Canada. So,  
15 again, if that's the option that they are hearing from  
16 their peers or something they've experienced overseas  
17 and they want to do it, it's important to inform them  
18 it's not a good idea.

19 I don't know why it serves as to confuse in  
20 fear. It's just you might be reading about this, you  
21 might be hearing from your friends, you might be seeing  
22 online that this is a medication that's used. And it is  
23 used overseas, but it's not available here in the United  
24 States and here are some of the risks that are  
25 associated with it and why it's not available here in

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1 the United States. It's just designed to inform, not  
2 confuse and cause fear. It's everyone talks.

3 **Q When -- scratch that.**

4 MS. CHRISS: We are just about done. Let's  
5 take five minutes and we'll come back.

6 (Break taken 5:34 p.m. until 5:41 p.m.)

7 BY MS. CHRISS:

8 **Q Dr. Mortensen, I have one more question for**  
9 **you. Paragraph 52 in your report on page 18.**

10 MR. PERKO: What paragraph, counsel?

11 MS. CHRISS: 52.

12 BY MS. CHRISS:

13 **Q You state: There are also an overwhelming**  
14 **number of physicians and clinicians in the world that**  
15 **understand these are low-quality studies and vague**  
16 **guidelines. What is the basis for you statement that**  
17 **there are and overwhelming number of physicians and**  
18 **clinicians in the world who feel that way?**

19 A Well, it's my opinion that when we are taking a  
20 look at in the world, even here in the United States  
21 it's really hard to quantify a number, but the vast  
22 majority of people that I speak with feel that this is  
23 low-quality evidence. And I think it's also  
24 well-supported and the guidelines themselves say it's  
25 low-quality, low-grade evidence, and that they are

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1 vague. But if all of these physicians agreed that this  
2 was all high quality and the way to go, then why are  
3 they pausing it?

4 Q High quality is not a subjective term that the  
5 physicians determines, correct?

6 A Correct.

7 Q And you understand the grading criteria, we  
8 went over that earlier --

9 A Correct.

10 Q -- that quality does not denote efficacy and  
11 safety in a population.

12 MR. PERKO: Object to form.

13 BY MS. CHRISS:

14 Q So my question is not about the low-quality  
15 studies with vague guidelines, my question is the basis  
16 for your statement that an overwhelming numbers of  
17 physicians and clinicians. So I guess I'm asking who  
18 are these clinicians and physicians?

19 A Well, a number of people that I know, a number  
20 of people that have spoken out. There has been a lot of  
21 news reports with different physicians from different  
22 types of specialties, there's been a lot of specialists  
23 around the world also saying it as well.

24 Q Can you name these folks?

25 A No.



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1           Q     And can you tell me any provider, physician, or  
2     clinician who provides gender-affirming care and has  
3     expertise in this area providing this care in Florida  
4     that agrees with this statement?

5           A     I can tell you that Dr. Hasan and Dr. Torres  
6     who were providing care thought this was vague  
7     guidelines.

8           Q     They did not provide blockers --

9           A     Think did blockers.

10          Q     -- or they provided only blockers, but not  
11     cross-sex --

12          A     That is affirmative care. Gender-affirming  
13     care. But they agreed these were low-grade and that it  
14     was very vague guidelines. It seemed to be very  
15     wishy-washy on when you start, when you don't start.

16          Q     These individuals no longer provide this care?

17          A     Correct.

18          Q     Can you name anyone else that has expertise in  
19     the provision of this care in the state of Florida?

20          A     No.

21                   MS. CHRISS: We don't have any further  
22     questions.

23                   MR. PERKO: Just one question.

24                                   CROSS EXAMINATION

25     BY MR. PERKO:

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1 Q Dr. Mendleson -- Mortensen, you just mentioned  
2 that the other countries are putting a pause on these  
3 type of treatments. What did you mean by that?

4 A So it seems that there have been an  
5 announcement that they're reducing the availability to  
6 the general population and limiting it to research and  
7 very extreme cases.

8 MR. PERKO: Okay. That's all I have.

9 MS. CHRISS: Just one quick follow-up.

10 REDIRECT EXAMINATION

11 BY MS. CHRISS:

12 Q Again, you are not aware of any country that  
13 has restricted care when it comes to adult population,  
14 correct?

15 A Correct.

16 Q And you are not aware of any country that has  
17 banned gender-affirming care for minors?

18 A Correct.

19 MS. CHRISS: No further questions.

20 MR. PERKO: We'll read.

21 (Witness excused.)

22 (The deposition of MONICA MORTENSEN, DO, was  
23 concluded at 5:45 p.m.)

24 - - -

25

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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

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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 2, pages  
11 182-262, is a true and complete record of my  
12 stenographic 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  
Stenographic Reporter  
LEXITAS

23

24

25

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1 October 8, 2023

2 MONICA MORTENSEN, D.O.  
3 C/O Holtzman Vogel  
4 119 South Monroe Street, Suite 500  
5 Tallahassee, FL 32301  
6 IN RE: JANE DOE, et al., v. LADAPO, et al.  
7 Civil No. 4:23-cv-00114-RH-MAF

8

9 Please take notice that on September 28, 2023, you gave  
10 your deposition in the above cause. At that time you  
11 did not waive your signature.

12 The above-addressed attorney has ordered a copy of this  
13 transcript and will make arrangements with you to read  
14 their copy. Then please execute the Errata Sheet, which  
15 can be found at the back of the transcript, and have it  
16 returned to Lexitas at the email address below for  
17 distribution to all parties.

18

19 If you do not read and sign your deposition within 30  
20 days, the original, which has already been forwarded to  
21 the ordering attorney, may be filed with the Clerk of  
22 the Court.

23

24 If you wish to waive your signature now, please sign in  
25 the blank at the bottom of this letter and return to the  
email address listed below.

26

27 Respectfully,

28

29 Kelly G. Broomfield, FPR  
30 LEXITAS  
31 Reference Job No. 329487

32

33 I do hereby waive my signature.

34

35 \_\_\_\_\_ DATE \_\_\_\_\_  
36 MONICA MORTENSEN, D.O.

37

38

39

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September 28, 2023

1 E R R A T A S H E E T

2 DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE

3 IN RE: JANE DOE, et al., v. LADAPO, et al.  
4 Civil Number: 4:23-cv-00114-RH-MAF  
5 Deposition of MONICA MORTENSEN, D.O.  
6 Taken on Thursday, September 28, 2023

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

22  
23 DATE MONICA MORTENSEN, D.O.

24 Email completed Errata to fl.production@lexitaslegal.com

25 Reference Job No. 329487

Monica Mortensen, D.O.  
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