Jane Doe

vs.

Joseph Ladapo

Deposition of:

Monica Mortensen, D.O.

September 28, 2023

Vol 2

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

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

JANE DOE, et al.,

Plaintiffs,

v.

JOSEPH A. LADAPO, et al.,

Defendants.
_____/

DEPOSITION OF

MONICA MORTENSEN, D.O.

VOLUME 2 (Pages 182 - 266)

Thursday, September 28, 2023

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

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I N D E X

Volume 2

E X H I B I T S

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

DIRECT EXAMINATION (cont'd)

BY MS. CHRISS:

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

A Correct.

Q You are familiar with the content of that?

A Yes.

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

MR. PERKO: Object to form.

A No.

BY MS. CHRISS:

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

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

Q Would you believe me if I told you it was?
A I think I could believe you on that, yes.
Q Okay. Did any of the members of the Board of Medicine play a role in the legislature's development of SB 254 or HB 1421?
MR. PERKO: Object to form.
A I personally did not. I don't know about the others.
BY MS. CHRISS:
Q Were you asked to speak to the legislature?
A No.
Q Are you aware that the Board of Medicine chair, Scot Ackerman, was invited to speak with the legislature?
A No, I did not.
Q So SB 254 required that the Boards develop emergency rules and informed consent forms; is that correct?
A Correct.
Q Just before we get into that, are you -- let me back up. You were one of the individuals who authored, drafted, the emergency -- the informed consent form?
A The emergency consents forms, yes.
Q And are there nonemergency consent forms?
A Well, my understanding is is that they need to

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

Q Who's working on the permanent consent forms?

A It goes back to the Rules Committee.

Q Which you are on?

A Correct.

Q Do you know when that's happening?

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

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

A Correct.

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

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

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

A No.

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

A For pain management and for -- or opoid

consents they do have requirements in them.

Q And what are those requirements?

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

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

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

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

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

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

A That the Board did? No.

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

your expert report. Page 9, paragraph 25.

A Uh-huh.

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

MR. PERKO: Object to form.

A I don't know.

BY MS. CHRISS:

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

A Correct.

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

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

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

A Correct.

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

A I do not know why.

Q The specific language of SB 254, are you

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

A It would certainly help to look at it.

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

A That will help me a lot.

Q Page 7 of 10, please.

A Okay.

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

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

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

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

Did I read that correctly?

A Yes, you did.

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

A Yes, it did.

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

A Correct.

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

A Correct.

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

A Correct.

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

A Correct.

Q Or for a witness to sign?

A Correct.

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

A Yes.

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

A Dr. Benson.

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

A Correct.

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

A Correct.

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

A Correct.

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

A Correct.

Q How did you create these forms?

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

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

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

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

A She/her.

Q Did she have any other involvement in this process?

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

Q Did you confirm whether her institution had

revised the informed consent forms in the years since?

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

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

A Correct.

Q And did you work Dr. Benson on this?

A No.

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

A He submitted his own.

Q So you had two separate drafts?

A Correct.

Q Do you know how he came about creating his?

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

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

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

Q Have you ever previously developed an informed

consent form outside of your area of expertise?

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

Q How long did you take to create the forms?

A These consents.

Q The first draft that you brought to the Board?

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

Q 60 hours?

A Yeah, at least 60 hours.

Q Over the course of?

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

Q What did you research and read?

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

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

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

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

A I didn't.

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

A No, I did not.

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

A I'm not aware.

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

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

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

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

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

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

A They did not specifically say that.

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

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

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

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

A To the best of my knowledge, yes.

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

A As far as I know.

Q Okay. How many -- scratch that.

Were there multiple drafts of your informed consent forms?

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

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

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

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

MR. PERKO: Object to form.

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

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

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

BY MS. CHRISS:

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

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

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

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

Q Of your expert report?

A Correct.

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

A Yes.

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

A Correct.

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

A Yes.

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

A That is correct.

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

A I wasn't looking specifically for one thing.

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

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

Q Were there --

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

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

barriers to this care?

A What do you mean urged a lack of barriers?

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

MR. PERKO: Object to form.

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

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

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

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

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

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

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

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

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

A I am not aware.

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

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

Q How do you mean?

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

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

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

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

MR. PERKO: Object to form.

A That is true.

BY MS. CHRISS:

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

A Yes. They can.

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

MR. PERKO: Object to form.

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

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

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

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

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

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

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

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

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

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

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

A Yes.

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

What will be different in the revised versions?

A Well, it all depends what happens at the

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

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

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

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

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

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

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

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

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

Q And who's that?

A She didn't say who it was.

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

A Do you have an exhibit?

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

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

A Yes.

BY MS. CHRISS:

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

What was the statutory authority for that

requirement?

MR. PERKO: Object to form.

A I thought that part was removed?

BY MS. CHRISS:

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

MR. PERKO: Object to form.

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

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

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

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

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

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

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

Q Right.

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

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

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

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

A That's only gender-affirming care.

Q -- the general population? Right. And are

those individuals, is the comparator, the general population?

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

Q What study was that?

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

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

A I do not know.

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

A Yes.

Q And do the informed consent forms include that information?

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

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

A Yes.

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

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

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

A Sorry, repeat that?

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

MR. PERKO: Object to form.

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

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

A Correct.

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

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

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

the Florida Department of Health Institutional Review Board?

A I'm sure I did.

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

A Not knowingly, no.

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

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

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

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

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

MR. PERKO: Object to form.

A I'm not sure what you are asking.

BY MS. CHRISS:

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

A What do you mean by discretion?

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

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

Q None of those are written consents?

A Correct.

Q Just for the treatment of gender dysphoria?

A Correct.

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

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

BY MS. CHRISS:

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

MR. PERKO: Object to form.

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

BY MS. CHRISS:

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

MR. PERKO: Object to form.

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

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

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

(Off-the-record discussion.)

BY MS. CHRISS:

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

A It depends on what indication you are talking about.

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

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

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

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

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

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

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

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

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

A Or that there isn't.

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

A Correct.

Q So Dr. Mortensen, you're mandating disclosure of a risk in these informed consent forms that you aren't sure is even a risk; is that your testimony today?

A There are some things it's unclear what the risk is, but that's the idea of an informed consent of saying that there's a fertility, so just so you are aware -- and that's the thing about people who go on puberty blockers, and even birth control pills, the likelihood is you are not going to be pregnant. There's still could be break through and you can get pregnant, so you have to think of that, but there also could be a risk that there's a likelihood that you are not going to be pregnant while you are on this medication.

Q But there is data to support that there's no impact on fertility?

A In the indication of using it for central precocious puberty.

Q And there's not data to support that there is a certain negative impact on fertility?

A It's hard to stipulate whether there is or

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

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

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

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

A Uh-huh.

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

A Uh-huh.

Q But the Lupron package insert says that these

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

A Correct.

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

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

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

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

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

A Correct.

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

A Correct.

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

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

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

A Correct.

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

A Correct.

Q Why is that?

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

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

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

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

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

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

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

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

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

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

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

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

A Correct.

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

MR. PERKO: Page 87 on 34?

A Item 87 on page 35.

BY MS. CHRISS:

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

A Correct.

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

A Correct.

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

What do you mean by that?

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

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

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

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

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

Q Is having dosing flexibility common?

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

Q So the process you just describe sounds very

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

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

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

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

A That is correct.

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

MR. PERKO: Object to form.

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

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

determine dosing?

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

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

A Exactly.

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

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

Q What detransitioners you are referring to?

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

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

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

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

to their patients, correct?

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

Q Can you point me to specific detransitioners?

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

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

MR. PERKO: Object to form.

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

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

A Not to my knowledge.

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

A Not that I know of.

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

this?

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

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

A Not in my personal experience, no.

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

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

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

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

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

MR. PERKO: Object to form.

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

BY MS. CHRISS:

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

MR. PERKO: Object to form.

A That is true.

BY MS. CHRISS:

Q And you can't name another detransitioner or

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

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

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

A No.

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

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

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

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

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

A Correct.

Q Who's not receiving treatment for gender dysphoria?

A Correct.

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

A I'm sure there are.

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

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

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

MR. PERKO: Object to form.

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

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

BY MS. CHRISS:

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

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

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

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

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

A Yes.

Q -- not speculative, correct?

MR. PERKO: Object to form.

A Correct.

BY MS. CHRISS:

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

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

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

A I have to check and see.

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

A From WPATH?

Q Uh-huh.

A No, I'm not aware.

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

A No.

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

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

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

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

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

A For?

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

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

Q Are there other permanent effects from testosterone?

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

Q And what data supports those statements?

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. PERKO: Object to form.

A Because there is -- I'm sorry.

Because there is some data that already shows

that cancer has happened.
BY MS. CHRISS:
Q So talking about then --
A So I'm not speculating, there's actually cases that have been demonstrated.
Q So when it comes to fertility and the impacts on cognitive, the things where you agreed in your testimony, that there is no long-term data suggesting permanent impacts, long-term impacts, do you apply the same standard of certainty when you are looking at risks and benefits?
MR. PERKO: Object to form.
A I often tell families that there are many things in medicine that we just don't know yet, and this is what I know at that point that's been demonstrated and documented. This is what is speculative, or could be likely, based on this happens in this. Then there's also the category of we just don't know. That's why you have an individualized person of determining whether or not they want to assume that risk or not. Oftentimes -- that's with pretty much almost everything.
So even though I prescribe growth hormone and it's been well-used over 30-plus years, I often say, sometimes we don't know how your child -- could that bad reaction have been from growth hormone? It hasn't been

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

BY MS. CHRISS:

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

MR. PERKO: Object to form.

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

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

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

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

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

MR. PERKO: Object to form.

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

BY MS. CHRISS:

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

A Yes.

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

A Sure.

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

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

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

everyone?

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

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

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

A I don't know --

MR. PERKO: Object to form.

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

BY MS. CHRISS:

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

them?

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

Q But throughout the form it is solely risks?

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

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

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

worsens migraines.

A Uh-huh.

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

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

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

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

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

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

Q More data needs to be collected.
A Uh-huh.
Q That's of sufficient level of evidence for you to list the risk of increased migraines, increased risk of migraines, but more data needs to be collected is also the reason you're stating you are not putting the benefits of these treatments on these informed consent forms, correct?
MR. PERKO: Object to form.
A The consents says that more data does need to be collected in regards to the benefit, but there were some studies that showed there can be benefit.
BY MS. CHRISS:
Q Paragraph 101, on page 41, you discuss the Finasteride.
A Yes.
Q We agree Finasteride is not used to treat gender dysphoria?
A It's used to treat a side effect from the treatments of gender dysphoria.
Q Even if this medication is likely to be used by transgender men experiencing hair loss, why is it included in the section title how is testosterone taken?
A I'd have to take a look at the consent.
Q And in paragraph 104 on page 42 you state that

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

A Number 104?

Q Yes.

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

A That's not what it says.

BY MS. CHRISS:

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

A I believe so.

Q That study made the same recommendation?

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

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

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

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

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

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

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

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

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

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

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

MR. PERKO: Object to form.

A Correct.

BY MS. CHRISS:

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

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

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

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

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

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

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

Q When -- scratch that.

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

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

BY MS. CHRISS:

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

MR. PERKO: What paragraph, counsel?

MS. CHRISS: 52.

BY MS. CHRISS:

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

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

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

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

A Correct.

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

A Correct.

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

MR. PERKO: Object to form.

BY MS. CHRISS:

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

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

Q Can you name these folks?

A No.

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

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

Q They did not provide blockers --

A Think did blockers.

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

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

Q These individuals no longer provide this care?

A Correct.

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

A No.

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

MR. PERKO: Just one question.

CROSS EXAMINATION

BY MR. PERKO:

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

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

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

MS. CHRISS: Just one quick follow-up.

REDIRECT EXAMINATION

BY MS. CHRISS:

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

A Correct.

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

A Correct.

MS. CHRISS: No further questions.

MR. PERKO: We'll read.

(Witness excused.)

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

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CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF DUVAL)

I, Kelly G. Broomfield, the undersigned authority, certify that MONICA MORTENSEN, D.O., personally appeared before me on September 28, 2023, and was duly sworn.

WITNESS my hand and official seal this 8th day of October, 2023.

Kelly G. Broomfield, Stenographic Reporter
Notary Public - State of Florida
My Commission expires: September 30, 2025
My Commission No. HH 164930

REPORTER'S CERTIFICATE

STATE OF FLORIDA)

COUNTY OF DUVAL)

I, Kelly G. Broomfield, Stenographic Reporter, certify that I was authorized to and did stenographically report the deposition of MONICA MORTENSEN, D.O.; that a review of the transcript was requested; and that the transcript, Volume 2, pages 182-262, is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 8th day of October, 2023.

Kelly G. Broomfield, FPR
Stenographic Reporter
LEXITAS

October 8, 2023

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

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

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

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Respectfully,

Kelly G. Broomfield, FPR
LEXITAS
Reference Job No. 329487

I do hereby waive my signature.

_____ DATE _____
MONICA MORTENSEN, D.O.

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

PAGE NUMBER	LINE NUMBER	SUGGESTION/REASON

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

DATE MONICA MORTENSEN, D.O.

Email completed Errata to fl.production@lexitaslegal.com

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E