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

| | | |
|---|---|---|
| REIYN KEOHANE, *et al.*, | : | |
| | : | |
| *Plaintiffs*, | : | |
| | : | |
| v. | : | Case No. 4:24-cv-434-AW-MAF |
| | : | |
| RICHARD COMERFORD, in his official capacity as Secretary of the Florida Department of Corrections; *et al.*, | : | |
| | : | |
| *Defendants.* | : | |

**PLAINTIFFS' CLOSING BRIEF**

## Table of Contents

# TABLE OF AUTHORITIES

**Page(s)**

**Cases**

**Other Authorities**

As demonstrated at trial, on September 30, 2024, the Florida Department of Corrections ("FDC") implemented a policy that withdrew accommodations that enable social transition ("social transition accommodations") from individuals with gender dysphoria and prohibited such accommodations going forward, regardless of patient need. FDC implemented and continues to maintain this policy despite its knowledge that prior to the policy change, social transition accommodations significantly alleviated gender dysphoria and improved the mental health of Plaintiffs and other class members, and that the loss of these accommodations has caused them to suffer significant deterioration of their mental health. This treatment was recommended to these patients by FDC's psychologists, and its positive impact on patients' mental health, as well as the damaging impact of its withdrawal, was recognized by FDC's health care providers and documented in FDC medical records. This evidence, which FDC does not dispute, along with additional evidence presented at trial, establishes deliberate indifference to a serious medical need in violation of the Eighth Amendment.

FDC's stated rationale for withdrawing and denying this care despite its demonstrated benefit to patients—and over concerns voiced by the leadership of FDC's contracted health care provider, Centurion of Florida, LLC ("Centurion")—is that FDC health care officials Dr. Danny Martinez and Dr. Suzonne Kline reviewed the scientific literature and found that the research supporting social

transition as a treatment for gender dysphoria is "low quality" evidence. This explanation does not negate FDC's deliberate indifference in maintaining the policy given that FDC knows that it is subjecting some patients to the denial of medically necessary care that is causing substantial harm. Moreover, FDC's stated rationale simply cannot be believed. "Low quality" evidence is a term of art in scientific research, and both sides agree that many medical treatments, including the hormone therapy that FDC provides to patients with gender dysphoria, rest on "low quality" evidence. This is simply not a plausible reason for withdrawing care that FDC's health care providers have found to help alleviate what both sides agree is a serious medical condition.

Additionally, the political circumstances leading up to the policy change; the cross examination of the authors of the policy regarding their purportedly comprehensive literature review (where Dr. Martinez said he spent hundreds of hours reviewing hundreds of studies but did not take down *any* notes); and Dr. Martinez's failure to even consider the input of FDC's own health care providers, further betray their purported literature review as a charade.

FDC, citing *Gibson v. Collier*, 920 F.3d 212 (5th Cir. 2019), has argued that it can categorically deny this care without regard to individual patient need because, it asserts, there is a debate within the medical field about the efficacy of social transition for the treatment of gender dysphoria. *Gibson* has no bearing on cases like

this one where there is no dispute between FDC's own health care providers and Plaintiffs regarding their need for this care. FDC's psychologists recommended social transition accommodations to Plaintiffs and other class members, and they observed actual benefits from the treatment and actual harm when it was withdrawn. *Gibson* is also at odds with Eleventh Circuit authority. But even if *Gibson* were applicable, the evidence at trial showed no divide in the medical field as to the efficacy of social transition as a treatment for gender dysphoria. To the contrary, the undisputed evidence showed that this treatment is widely accepted in the medical community and supported by the major medical and mental health professional associations.

None of the evidence presented by FDC demonstrated a "robust and substantial good faith disagreement dividing respected members of the expert medical community." *Gibson*, 920 F.3d at 220. FDC's evidence merely demonstrates that, as with all medical or mental health treatments, some individual practitioners hold views that diverge from well-accepted practice. Even under *Gibson*, that is not a basis to withhold a particular treatment from all incarcerated people regardless of their individual need for it. Such a rule would eviscerate the Eighth Amendment's protection against the denial of medically necessary care.

Absent a declaration that FDC's ban on social transition accommodations is unconstitutional and an injunction against its enforcement, Plaintiffs and other class

members will continue to be denied medically necessary care, causing them to experience substantial harm to their mental health.

## Legal Standard

The Eighth Amendment's prohibition on cruel and unusual punishments extends to the failure to provide minimally adequate health care to incarcerated people and to conditions of confinement that "involve the wanton and unnecessary infliction of pain." *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981); *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

Corrections officials violate the Eighth Amendment when they display "deliberate indifference to serious medical needs of prisoners." *Estelle*, 429 U.S. at 104. Deliberate indifference is established by showing that plaintiff has an "objectively serious" medical need, *Wade v. McDade*, 106 F.4th 1251, 1255 (11th Cir. 2024) (en banc), and that defendants were "subjectively aware" that their "conduct—[their] actions or inactions—put the plaintiff at substantial risk of serious harm." *Id.* at 1258.

Under the subjective prong, "acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk." *Farmer v. Brennan*, 511 U.S. 825, 836 (1994). Though "Eighth Amendment liability requires consciousness of a risk," *id.* at 840, "an Eighth Amendment claimant need not show that a prison official acted or failed

to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm." *id.* at 842. In an injunctive relief case, prison officials' knowledge of the risk is not at issue, as the litigation itself puts them on notice. *Id.* at 846 n.9 ("If . . . the evidence before a district court establishes that an inmate faces an objectively intolerable risk of serious injury, the defendants could not plausibly persist in claiming lack of awareness").

Medical treatment that is so inadequate as to "shock the conscience" or constitute a "refusal to provide essential care" violates the Eighth Amendment. *Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986) (citations omitted); *see also Harris v. Thigpen*, 941 F.2d 1495, 1505 (11th Cir. 1991).

Medically necessary care includes care for mental health conditions. *See*, *e.g.*, *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990). Medically necessary care also includes supplies and devices. *See*, *e.g.*, *Miller v. King*, 384 F.3d 1248, 1261–62 (11th Cir. 2004) (orthopedic shoes), *vacated and superseded on other grounds*, 449 F.3d 1149 (11th Cir. 2006); *Bradley v. Puckett*, 157 F.3d 1022, 1024–26 (5th Cir. 1998) (shower chair). And medically necessary care includes treatment that alleviates symptoms; it is not limited to treatment that fully cures a condition. *Washington v. Dugger*, 860 F.2d 1018, 1021 (11th Cir. 1988).

## Argument

### I. FDC's policy change on September 30, 2024, effected a categorical ban on social transition accommodations.

When FDC rescinded Procedure 403.012 and replaced it with Health Services Bulletin 15.05.23 (the "HSB"), it categorically banned social transition accommodations for individuals with gender dysphoria, regardless of a patient's medical need for them.

The HSB does not include social transition accommodations among the treatment options for gender dysphoria. *See* Ex. 50 (HSB) at 4–5.[1] Social transition accommodations were previously permitted pursuant to the prior Procedure, which provided for exceptions from FDC's otherwise gender-specific rules regarding grooming, clothing, and canteen. *See* Ex. 2 (2019 Procedure 403.012) at 6; Ex. 148 (2017 Procedure 403.012) at 6. The HSB's silence on social transition accommodations means that FDC's grooming, clothing, and canteen rules for men's facilities apply to transgender women, and the grooming, clothing, and canteen rules for women's facilities apply to transgender men. And although the HSB indicates hormone therapy is available with a variance, it allows no variances for social transition accommodations. *See* Ex. 50 (HSB) at 6–8.

[1] Citations to "Ex." refer to exhibits on the parties' "Master Exhibit List: Joint Exhibits" (Dkt. No. 207).

FDC documents given to staff and inmates during the roll-out of the new policy made clear that FDC no longer permitted social transition accommodations. The "HSB 15.05.23 Action Plan" for the roll-out of the policy states that inmates "will be advised that the alternate canteen and quarterly order menus will be rescinded, and they will have to comply with the grooming standard in accordance with their biological sex." Ex. 104 (HSB 15.05.23 Action Plan); *see also* Ex. 106 (FAQ re Gender Dysphoria) (FAQs for staff explaining that social transition accommodations will no longer be available); Ex. 8 (Script Regarding Undergarments, Hair, and Alternate Canteen Items) (given to inmates on September 30, 2024; mandated that they exchange their undergarments for those authorized at their institution, bring their hair into compliance with the requirements of Rule 33-602.101, F.A.C., Care of Inmates paragraph (4), and consume or mail home alternate canteen items within 30 days or face discipline).

After the HSB went into effect, FDC revoked all accommodations passes from gender dysphoric patients, with no assessment of individual need. Kline Desig. 226:10–227:1.[2] It is undisputed that no individuals in FDC custody currently receive

[2] Deposition designations are available at Joint Pretrial Stipulation Ex. E, Dkt. No. 182–5. The transcript excerpts themselves are available at Dkt. No. 202.

social transition accommodations. Tr.[3] 203:18–21 (Boothe); Tr. 315:21–24 (Keohane); Tr. 372:6–11 (Lay); Tr. 404:15–23 (Watkins-Ferrell).

Additionally, the documents necessary to provide social transition accommodations no longer exist. The gender dysphoria evaluation template no longer contains a section in which psychologists can recommend accommodations. Tr. 460:25–461:8 (Joshi); Martinez Desig. 159:8–21. And Form DC4-634G—the accommodations pass—no longer exists.[4] Martinez Desig. 204:6–24.

As the evidence made clear, FDC's officials—including the Chief of Mental Health, the Chief of Medical Services, and the Chief of Security—understand that social transition accommodations are no longer available since the policy change. *See* Kline Desig. 224:19–225:2, 226:10–14; Tr. 747:3–25 (Kline); Martinez 30(b)(6) Desig. 160:1–8, 161:9–162:24; Martinez Desig. 159:8–21; Tr. 671:13–672:4 (Martinez); Harrell Desig. 79:22–80:20; *see also* Wasserman Desig. 110:24–112:1; Weiss Desig. 143:10–144:19.

Defendants do not dispute that the current policy does not permit social transition accommodations. They nevertheless suggest that there is no ban because

[3] "Tr." refers to Bench Trial Transcript Volumes 1–4. *See* Notice of Filing of Official Bench Trial Transcript, Dkt. Nos. 213–216.

[4] FDC only allows medical passes for bras for those with breast development requiring physical support, not as social transition accommodations. *See* Tr. 376:7–19 (Lay); Ex. 106 (FAQ re Gender Dysphoria) at 2; *see also* Ex. 94 (Email Correspondence) at 1–2; Martinez Desig. 206:22–208:6.

if mental health providers believe that patients need social transition accommodations, they could bring that to the attention of Dr. Kline and they "would have a discussion about it." Tr. 736:13–23 (Kline). This is nonsense. FDC has told these same mental health providers that social transition accommodations can no longer be provided. Tr. 747:19–22 (Kline); Tr. 371:25–372:2 (Lay); Tr. 404:15–405:8 (Watkins-Ferrell); Tr. 459:25–461:8 (Joshi). Centurion psychologists therefore no longer assess patients for their need for social transition accommodations. Tr. 460:19–24 (Joshi). Dr. Aloka Joshi, a psychologist who conducted many of the gender dysphoria evaluations, testified that she would continue to recommend social transition accommodations for some patients but cannot do so because they are no longer available. Tr. 460:12–18 (Joshi). Centurion's Statewide Medical Director, Dr. John Lay, testified that even if Centurion providers believed social accommodations were medically necessary, there is no process to approve a patient to receive them. Tr. 375:16–376:6 (Lay).

The evidence, thus, overwhelmingly demonstrated that FDC has implemented a blanket policy prohibiting social transition accommodations as treatment for gender dysphoria, regardless of patient need.

## II. The categorical withdrawal of social transition accommodations constitutes deliberate indifference to a serious medical need.

### A. FDC is aware that by denying social transition accommodations to Plaintiffs and other class members, it is denying them medically necessary care and subjecting them to serious harm or the risk of serious harm.

1. FDC's health care providers recognized and documented the mental health benefits of social transition accommodations, and the negative mental health impacts of withdrawing them.

Plaintiffs and other class members were diagnosed with gender dysphoria by FDC health care providers. Joint Pretrial Stipulation ("Stip.") 10–11, Dkt. No. 182. It is undisputed that gender dysphoria is a serious medical condition that can result in significant mental health distress. Kline Desig. 286:25–287:23; Tr. 738:7–11 (Kline); Martinez 30(b)(6) Desig. 50:6–8, 51:2–5; Tr. 652:19–24 (Martinez).

FDC prescribed hormone therapy for Plaintiffs and other class members after a psychologist evaluated them and determined that this treatment was medically necessary to help alleviate their gender dysphoria. The Gender Dysphoria Review Team ("GDRT")—which included FDC's Chief of Mental Health and its Chief of Medical Services—approved these treatment recommendations. Kline Desig. 49:6–12; Tr. 740:3–16 (Kline). Similarly, before the new policy, FDC provided social transition accommodations to patients if a psychologist determined that providing such accommodations would likely help alleviate their gender dysphoria, and the GDRT approved the treatment. Kline Desig. 28:14–24; Tr. 738:24–740:2 (Kline). The prior policy initially permitted social transition accommodations when deemed

medically necessary for a patient by FDC's health care providers. Ex. 148 (2017 Procedure 403.012) at 6. The updated version of the policy did not expressly require a medical necessity determination, Ex. 2 (2019 Procedure 403.012) at 6, but, as noted, these accommodations were only provided when recommended by a psychologist.

FDC's Chief of Mental Health, Dr. Suzonne Kline, recognized that the purpose of both hormone therapy and social transition is to alleviate gender dysphoria by helping the patient align their presentation with their gender identity. Tr. 740:17–24 (Kline); *see also* Tr. 23:20–24:7 (Karasic) (agreeing that this is how gender dysphoria treatment works). Dr. Kline, as well as FDC Chief of Medical Services, Dr. Danny Martinez, recognized that in the community, social transition is a standard part of treatment for gender dysphoria. Martinez 30(b)(6) Desig. 60:6–18; Tr. 652:25–653:5 (Martinez); Kline Desig. 50:15–25.

FDC provided this treatment for gender dysphoria—hormone therapy and social transition accommodations when recommended by FDC's psychologists—from July 13, 2017, until September 30, 2024, when FDC categorically prohibited social transition accommodations. Ex. 148 (2017 Procedure 403.012); Ex. 2 (2019 Procedure 403.012); Ex. 50 (HSB); Ex. 106 (FAQ re Gender Dysphoria).

The undisputed evidence from FDC's own health care providers showed that, for some patients, the provision of social transition accommodations substantially

reduced their gender dysphoria and, in some cases, also co-occurring mental health symptoms. It further showed that the removal of these accommodations, for some patients, resulted in mental health decompensation, including worsening gender dysphoria.

Dr. Joshi and Dr. Zuniga, both psychologists, conducted most of the evaluations of individuals with gender dysphoria, both before and after the policy change. Tr. 423:8–13 (Watkins-Ferrell). These evaluations included a medical records review, psychological testing, and consultation with patients' on-site mental health providers. Tr. 455:2–456:5 (Joshi). Dr. Joshi testified that for some patients, social transition accommodations can be necessary to alleviate their gender dysphoria, and she would continue to recommend them for patients if she could. Tr. 459:6–19, 460:12–14 (Joshi).

For example, Dr. Joshi wrote in Plaintiff Sheila Diamond's evaluation that her "test scores are indicative of depression, anxiety, and suicidal ideation, which are likely due to her inability to feminize," and that "[i]t is likely that her symptoms will improve if she is approved for accommodations to feminize during her incarceration." Ex. 12 (Diamond Medical Record) at 11. She also wrote that if Ms. Diamond "is not allowed all available accommodations for transgender individuals during her incarceration, her mental health may further decompensate, leading to

additional distress and/or mental health symptoms (i.e., depression, anxiety, and suicide ideation/attempt)." *Id.* at 13.

Similarly, Dr. Joshi wrote in Plaintiff Karter Jackson's evaluation that his "mental health prognosis is likely to improve once allowed to express his gender identity," and recommended that he receive social transition accommodations. Ex. 30 (Jackson Medical Record) at 15–16.

Dr. Kline knew that it was the professional opinion of psychologists who evaluated patients that their gender dysphoria would likely improve if they were permitted social transition accommodations, and that they had documented this. Kline Desig. 255:4–23; Tr. 748:1–12 (Kline). And she herself acknowledged that social transition could help alleviate gender dysphoria for people in prison. Kline Desig. 52:18–53:16, 92:16–25.

FDC's psychologists not only anticipated that social transition accommodations would improve symptoms of gender dysphoria, they documented actual mental health improvement. For one patient, Dr. Joshi wrote that since approval for accommodations, the patient's "records indicate a decrease in psychological emergencies and staff referrals." Ex. 9 (Redacted Medical Record) at 4. She further noted that the patient's on-site mental health provider reported that her "'mental health has improved substantially' following approval for gender-affirming accommodations." *Id.*

An evaluation by Dr. Zuniga similarly documented that another patient had a significant reduction in disciplinary reports "after being approved for gender dysphoria related accommodations" (69 in the 16 years before approval of accommodations—an average of more than four per year—and just 3 during the five years since approval). Ex. 33 (Redacted Medical Record) at 1. The evaluation also noted that the patient had multiple Crisis Stabilization Unit ("CSU") and Transitional Care Unit ("TCU")[5] admissions per year prior to being approved for accommodations related to her gender dysphoria, but none since. *Id.* Dr. Martinez considers significant reductions in disciplinary reports ("DRs") to be evidence that treatment is benefiting a patient and supports a determination of medical necessity. Martinez Desig. 162:25–164:20 (describing significant reduction of DRs as indicator that continuing hormone therapy is medically necessary for a patient); *see also* Tr. 692:9–20 (Martinez).

Dr. Joshi testified that she had concerns about the impact of the loss of social transition accommodations on patient mental health, as some patients relied on them to alleviate their gender dysphoria. Tr. 463:6–20 (Joshi). Plaintiff Sheila Diamond is one of the patients she was specifically concerned about. Tr. 468:11–15 (Joshi).

Centurion leadership also had concerns about the removal of social transition accommodations, anticipating "a lot of serious decompensation," Tr. 389:10–390:5

[5] The CSU and TCU are higher levels of mental health care. Tr. 708:21–24 (Kline).

(Lay); *see also* Tr. 417:20-418:7 (Watkins-Ferrell). When Centurion provided its feedback on the new HSB to Dr. Kline, the Director of Health Services (Clayton Weiss), and others, it tried to get social transition accommodations included. Tr. 411:14–19 (Watkins-Ferrell); Tr. 367:12–371:19 (Lay).

When getting ready to implement the new policy, FDC and Centurion brought in more mental health staff to prepare for a rise in mental health crises, including patients becoming suicidal. Tr. 420:7–422:17 (Watkins-Ferrell); Tr. 383:6–384:2 (Lay); Tr. 647:23–648:8 (Martinez); Tr. 726:12–727:4 (Kline).

These concerns were warranted. While the impact was not as severe as what FDC and Centurion had prepared for, some patients did experience significant mental health decompensation as a result of the loss of their social transition accommodations. Centurion's Statewide Medical Director, Dr. John Lay, said that some patients did okay, but for some, their gender dysphoria symptoms increased; he could not say which group was larger. Tr. 386:7–20 (Lay).[6]

[6] Dr. Lay acknowledged that this was his testimony at his deposition and did not say that he misspoke or that it was otherwise inaccurate. Tr. 386:7–20 (Lay). At trial, Dr. Lay suggested the harm to patients was less than anticipated but acknowledged that he was not saying that more alarming impacts like patients having to go into Self Harm Observation Status unit ("SHOS"), self-harming, or being suicidal didn't happen, just that he was not personally aware of it. Tr. 393:13–19, 394:2–14 (Lay). And as discussed below, there were patients who had to go to TCU or the SHOS and patient's medical records documenting suicidal ideation due to the loss of accommodations, and the loss of social accommodations was a contributing factor to one suicide. *See infra* at 17-18, 21-22.

Patient medical records also documented the decompensation of some patients' mental health. For example, Dr. Joshi documented that one patient's mental health decompensation from the loss of accommodations included increased depression and anxiety. Ex. 10 (Redacted Medical Record) at 3. She noted that the patient "has been 'crying a lot more recently' due to the policy changes for transgender individuals" and "reported suicidal ideation with a plan to overdose on psychotropic medications at the end of September 2024 and mid-October 2024." *Id.*; Tr. 469:15–470:2 (Joshi). Dr. Joshi believed that restoring accommodations could alleviate the patient's mental health symptoms. Tr. 468:17–470:17 (Joshi).

In another case, Dr. Joshi wrote that a patient who had experienced improvement in mental health after receiving accommodations reported that "losing access to all gender-affirming accommodations causes her to 'feel more depressed and do the old stuff I was doing, like not doing treatment, not caring anymore, and cutting." Ex. 9 (Redacted Medical Record) at 5. Dr. Joshi felt that social transition accommodations that she previously had could help improve her mental health. Tr. 471:17–21 (Joshi). *See also* Ex. 33 (Redacted Medical Record) at 3 ("since the change in policy" patient experienced "increased symptomology including anhedonia, feeling down, hopelessness, disturbance of appetite, disturbance of sleep, low energy, excessive worrying, anxiety, chest palpitations, increased psychomotor agitation, and increased irritability").

Plaintiff Sheila Diamond's mental health provider documented in her medical records in May 2025 that she was experiencing depression and expressed suicidality with a "plan" due to the denial of accommodations. *See* Ex. 11 (Diamond Medical Record) at 2–3; *id.* at 2 ("Pt stated 'I worry I'm never going to get my accomidations [sic]. It's like why am I living? I was talking with one of the girls and she taught my [sic] to cut here, here, and here and I can bleed out in 2 minutes."; "without those accommidations [sic] I want to die").

The medical records of another patient document that she was transferred to the TCU after accommodations were rescinded. The record states: "Since the removal of GD accommodations, IMP has struggled with adapting to the demands of prison. For example, IMP described that going through the experience of having grown hair shaved involuntarily triggered an adverse reaction subsequently resulting in the TCU transfer and admission." Ex. 107 (Medical Record) at 5; *see also* Kline Desig. 250:19–253:25.

In one tragic case, FDC identified the loss of social transition accommodations as a contributing factor in the suicide of a transgender woman shortly after the policy change. Kline Desig. 272:1–23; Tr. 750:17–24 (Kline); Wasserman Desig. 112:15–113:1. Dr. Joshi testified that it did not surprise her that loss of social transition accommodations contributed to this individual taking her own life because some patients experienced increased depression, anxiety, and

gender dysphoria after they lost their social transition accommodations. Tr. 472:14–24 (Joshi).

Even FDC's expert witness, Dr. Kristopher Kaliebe, acknowledged that some of the Plaintiffs experienced mental health decompensation—worsening of mental health—after the loss of their social transition accommodations. Tr. 858:7–11 (Kaliebe).

This evidence from FDC's own health care providers demonstrated that the policy banning social transition accommodations is denying Plaintiffs and other class members medically necessary care and subjecting them to serious harm to their mental health. As discussed below, additional evidence supporting this conclusion comes from the testimony of Plaintiffs' expert who evaluated them, Dr. Jennifer Evans, and the testimony of the three Plaintiffs who testified.

2. Testimony from Dr. Evans and Plaintiffs provides further evidence that FDC is denying them medically necessary care and causing them to suffer.

*Testimony of Dr. Evans*

Dr. Jennifer Evans[7] conducted psychological evaluations of the five Plaintiffs, which involved clinical interviews and a review of their medical records. Tr. 483:13–

[7] Dr. Evans is a clinical psychologist licensed in the state of Florida. Tr. 476:8–10, 477:3–6 (Evans). She has extensive experience treating patients who have gender

22 (Evans). Her clinical interviews, which lasted an average of four hours each, followed her typical protocols for psychological evaluations, including standard questions related to the patient's history, as well as making behavioral observations of Plaintiffs, such as their appearance, behavior, affect, and mood. Tr. 484:15–21, 485:16–18, 486:9–21 (Evans). Her review of Plaintiffs' medical records—thousands of pages in all—took her 180 hours. Tr. 484:25–485:4 (Evans). Through her clinical interviews and medical records reviews, Dr. Evans gathered information about each Plaintiff's history, including their family, social, educational, employment, legal, medical, mental health, substance abuse, and trauma history; any history of assessments the individual has had; and specific information about gender dysphoria, including gender history, gender dysphoria symptoms, and any diagnostic history as it relates to gender dysphoria. Tr. 486:25–487:16 (Evans). Her reports summarized the information she gathered from her clinical interviews and review of medical records and provided diagnostic impressions, as well as a prognosis and discussion of treatment needs. Tr. 487:15–16 (Evans).

Dr. Evans' testimony provided a full picture of Plaintiffs' gender dysphoria and other mental health symptoms. She discussed the fact that all five Plaintiffs have experienced gender incongruence since childhood or adolescence. Tr. 489:20–23,

---

dysphoria, as well as conducting mental health evaluations. Tr. 478:19–480:7, 481:14–17 (Evans).

499:3–21, 508:18–24, 512:13–21, 515:22–516:2 (Evans). They also experienced symptoms of gender dysphoria from a young age. For example, as a child, Nelson Boothe would avoid looking in the mirror and avoid showering due to his gender dysphoria, and he would "hurt[] his body and hurt[] his flesh," such as banging his head as a child, when feeling gender dysphoric. Tr. 512:13–21, 513:18–20 (Evans). Reiyn Keohane isolated herself and stopped going to school because of her gender dysphoria. Tr. 499:22–500:5 (Evans). Sheila Diamond attempted to castrate herself as a young child by copying what she saw people do to remove puppies' tails. Tr. 489:20–490:5 (Evans).

The distress of gender dysphoria has continued into adulthood for the Plaintiffs. For example, because of his gender dysphoria, Karter Jackson showers at 3:30 a.m. to avoid contact with other people. Tr. 509:5–14 (Evans). And he was so dysphoric about his chest that he contemplated performing a double mastectomy on himself after being unable to get a chest binder. Tr. 509:15–510:1 (Evans). Sasha Mendoza has had several suicide attempts because she was not able to live as a girl, as documented in her medical records. Tr. 516:3–13 (Evans).

Dr. Evans also testified about her assessment of the impact on Plaintiffs of having access to social transition accommodations, and of having those accommodations taken away. She concluded based on her clinical interviews and review of the Plaintiffs' medical records that for each of them, the provision of social

transition accommodations significantly decreased their gender dysphoria as well as some of their co-occurring mental health symptoms. Further, the withdrawal of these accommodations seriously exacerbated their gender dysphoria and some of their other mental health symptoms, just as FDC's health care providers had documented for several other class members.

For example, Dr. Evans testified that Sheila Diamond experienced less gender dysphoria and anxiety when she had accommodations—even before being treated with hormone therapy, and that the loss of accommodations "has exacerbated her symptoms of gender dysphoria as well as symptoms of depression, suicidal ideations[,] thoughts of self-castration and anxiety." Tr. 494:4–495:24, 497:3–7 (Evans).

For Reiyn Keohane, the provision of social transition accommodations reduced her symptoms of gender dysphoria as well as anxiety and depression, and the loss of those accommodations caused all of her symptoms to increase significantly, including bulimia and self-harm. Tr. 500:20–23, 502:12–21 (Evans). Dr. Evans noted that Ms. Keohane's therapist documented a pronounced increase in symptoms of anxiety as a result of changes in gender dysphoria policy regarding female underwear. Tr. 503:11–504:5 (Evans). She further noted that Ms. Keohane experienced a documented mental health crisis after the confiscation of her bras, which had special significance to her as the last remaining vestige of being able to

socially transition. *See* Tr. 502:12–503:13 (Evans). Ms. Keohane engaged in cutting her arm and became suicidal, causing her to be admitted to the SHOS. *Id.*

Dr. Evans testified that when Karter Jackson was provided social transition accommodations, his gender dysphoria improved, he had a decrease in anxiety symptoms, and there was a noticeable decrease in the frequency of his psych emergencies. Tr. 510:12–20 (Evans). When he lost his accommodations, his gender dysphoria, anxiety, and depression increased. Tr. 511:4–8 (Evans).

For Sasha Mendoza, Dr. Evans testified that her gender dysphoria decreased when she had social transition accommodations, as did her depression, anxiety, and suicidal ideation; when accommodations were rescinded, these symptoms all increased. Tr. 516:23–517:15 (Evans).

For Nelson Boothe, the inability to have social transition accommodations caused him to experience an increase in gender dysphoria, depression, anxiety, and panic attacks. Tr. 514:14–19 (Evans).

Based on the significant positive impacts of receiving social transition accommodations, and significant negative impacts following their withdrawal, Dr. Evans concluded that this intervention is medically necessary for each Plaintiff, by which she meant that "providing them is necessary to alleviate [their] gender dysphoria and co-occurring conditions, and withholding them will put [them] at significant risk of [their] mental health seriously deteriorating, causing [them]

serious harm." Tr. 497:11–17, 506:19–22, 511:19–21, 515:7–9, 518:2–4 (Evans). Dr. Evans did not opine that the restoration of accommodations would completely eliminate gender dysphoria for all of the Plaintiffs. Tr. 500:24–501:10, 546:21–23 (Evans). Nor did she opine that restoring accommodations would completely resolve all of their other mental health symptoms such as depression, anxiety, and suicidality, as those symptoms were not necessarily solely attributable to gender dysphoria, although gender dysphoria exacerbates them.[8] Rather, she testified that this intervention significantly alleviated Plaintiffs' gender dysphoria and other mental health symptoms, while stripping them of this care has caused significant worsening of symptoms.

*Testimony of Plaintiffs Nelson Boothe, Sasha Mendoza, and Reiyn Keohane*

Plaintiffs Nelson Boothe, Sasha Mendoza, and Reiyn Keohane gave powerful, first-hand testimony as to what their lives were like when they could socially transition and what their experience has been since accommodations that enabled them to socially transition were taken away. Their heartfelt testimony illustrates why

[8] As noted in FDC medical records, in some cases, symptoms of depression and anxiety may stem from gender dysphoria. In Sheila Diamond's case, Dr. Joshi determined that a diagnosis of depression or anxiety was not warranted at that time because they are "likely due to her inability to feminize" and "it was likely that her symptoms will improve if she [is] approved for accommodations to feminize during her incarceration." Tr. 493:15–25 (Evans); Ex. 12 (Diamond Medical Record) at 11; *see also* Ex. 9 (Redacted Medical Record) at 2 (patient's "symptoms of depression were 'mostly related to her gender identity' issues").

social transition accommodations are not merely "pleasing," as FDC and its expert witness suggest, but critical to alleviating their gender dysphoria and maintaining their overall mental health.

Reiyn Keohane and Nelson Boothe had socially transitioned prior to incarceration and had been living their lives consistently with their gender identities. Tr. 288:2–14, 292:11–12, 293:11–12 (Keohane); Tr. 193:9–194:4 (Boothe). Sasha Mendoza did so in contexts where she felt she could. Tr. 221:18–223:20 (Mendoza). They all viewed themselves, and presented themselves, as Reiyn, Nelson, and Sasha, and continue to do so today. They have all received hormone therapy for years, and their physical features have developed to align with their gender identity. *See, e.g.*, Tr. 196:9–22, 203:12–14 (Boothe) (describing experiencing the changes other boys experience during puberty such as voice change and body hair growth, and having facial hair); Tr. 298:20–299:4 (Keohane) (describing development of breasts and more feminine body shape); Tr. 241:17–25 (Mendoza). Before FDC's policy change, Ms. Keohane and Ms. Mendoza were able to socially transition in prison—dressing and grooming consistently with their gender identity. Tr. 300:9–11 (Keohane); Tr. 238:11–20, 239:7–19 (Mendoza). Before coming into FDC custody in September 2024, Mr. Boothe had been able to dress and groom consistently with his gender identity while in county jail. Tr. 198:10–25, 200:8–10 (Boothe).

Ms. Keohane testified about the great relief she experienced in being able to socially transition, both prior to incarceration and then when permitted to do so by FDC. She described socially transitioning as a teenager as reducing the feelings of disgust and self-loathing—as well as depression and anxiety—that she previously felt due to her body. She felt like a "big pimple," such that she "didn't want to meet people looking like that" and "wanted to isolate" and "not exist at all." Tr. 293:16–294:19 (Keohane). When she finally received social transition accommodations from FDC, after going 6 years without them, she described feeling able to leave her bunk where she had been isolating herself, being able to participate in educational programs, and getting along socially with others. Tr. 298:14–17, 300:9–302:23 (Keohane). She felt that she could "wake up in the morning and look in the mirror" and instead of seeing someone "that's stuck in between" with short hair, facial hair, and a masculine appearance, "I could see myself as myself." Tr. 301:5–10. Instead of starting the day with "a twist in [her] gut," she felt good and ready to go out and do things. Tr. 301:10–14. Social transition accommodations made her gender dysphoria "manageable instead of something that was overwhelming" and something "where I really couldn't even function." Tr. 302:17–23 (Keohane).

Prior to being able to socially transition in prison, Ms. Mendoza had several suicide attempts due to her "struggle to live as a woman trapped inside of a man's body." Tr. 232:1–18 (Mendoza). After getting approved for social transition

accommodations, it felt "like a weight taken off [her]" and "[she] was able to actually live, not just exist." Tr. 238:11–20 (Mendoza).

The loss of social transition accommodations in late 2024 had a profound impact on Ms. Keohane and Ms. Mendoza. Ms. Keohane is cutting herself as a coping mechanism. Tr. 301:25–302:16 (Keohane). She is also binging and purging as her bulimia symptoms have increased. Tr. 309:16–24 (Keohane). And she has resumed self-isolation because she does not want anyone to look at her or "have the memory of seeing me like this because I feel so disgusting." Tr. 309:25–310:11 (Keohane). She described the experience of feeling a twist in her stomach after catching a glimpse of her reflection in a pane of glass, which made her depressed. Tr. 311:1–9 (Keohane). She has been forced to have her long hair cut to a very short, masculine hair style, Tr. 310:12–25 (Keohane), and she described how not being able to wear foundation to cover up her five o'clock shadow is distressing because "the feeling of facial hair and the appearance of facial hair are a major cause of dysphoria" for her. Tr. 311:10–24 (Keohane).

When Ms. Keohane's bras were eventually confiscated—for reasons unknown to her, FDC did not confiscate these at the same time as her other accommodations—she had a psychological emergency and was put on suicide observation and then the CSU. Tr. 313:5–314:15 (Keohane). She explained that the loss of her bras caused such distress because "I had lost everything else where I could even feel remotely

feminine . . . , but I still had these bras . . . . When they took the bras, I had nothing." Tr. 314:1–15 (Keohane).

On the day Ms. Keohane testified at trial, after an ACE bandage she had been wearing as a makeshift bra was taken from her after a search, she cut herself and required medical attention. Tr. 308:13–309:3 (Keohane). She was already feeling distress about having to come to court and have people see her with facial hair because she had not been permitted to shave for the week before trial. Tr. 310:1–11 (Keohane).

For Ms. Mendoza, in the wake of losing her social transition accommodations, she sometimes asks herself, "what's the use to even keep on." Tr. 253:12–17 (Mendoza). She has a life sentence and feels that if she has to spend the rest of her life this way, "it would continue to be torture." Tr. 255:8–12 (Mendoza).

Mr. Boothe testified that following the loss of his male underwear, clothing, and personal care items, he experienced more anxiety attacks, more depression waves, and his gender dysphoria was "at its all-time high" and "still is." Tr. 201:7–204:22, 207:17–19 (Boothe). For him, being forced to wear women's panties is "like being forced to detransition" and wearing them would be "mentally devastating." Tr. 207:11–16 (Boothe).

Each of these Plaintiffs testified that the loss of their undergarments[9] is so distressing and intolerable that they risk disciplinary reports ("DRs") and confinement by making or otherwise obtaining makeshift boxers, bras, and panties. FDC treats such items as contraband. As Mr. Boothe explained, "my mental health is important to me, if that means that I have to risk a CC or a DR or confinement in order to manage and control my [gender dysphoria symptoms], it's worth it to me." Tr. 205:12–207:7 (Boothe). Ms. Mendoza similarly explained, "so you decide which one's the worse of the punishments, and to me the confinement is less of the punishment." Tr. 252:14–243:11 (Mendoza); *see also* Tr. 314:23–315:20 (Keohane) (without the makeshift undergarments, "I can't function").

These Plaintiffs shared this very private and painful information—even, as Ms. Keohane noted, enduring the distress of being in front of a lot of people while forced to appear like a man—because, as she put it, "it is more important for me to

[9] Ms. Keohane explained why the ability to wear women's underwear had such a significant positive impact on her gender dysphoria in addition to this being an important aspect of social transition. She feels significant dysphoria related to her genitals, and when she wears women's panties, it prevents movement so she can put them out of her mind most of the day, but when required to wear boxers, those parts move around and make her aware of them, causing disgust and self-loathing. Tr. 302:24–303:24 (Keohane).

As for bras, apart from being part of social transition, Ms. Keohane testified that since she has breast development, she feels vulnerable without a bra because going without one draws unwanted attention. Tr. 303:25–304:17 (Keohane).

get here and talk about this," to share and explain "what I'm going through." Tr. 309:1–7, 310:1–11 (Keohane).

* * *

The devastating mental health impact on the Plaintiffs and other class members of losing social transition accommodations is not surprising given what is known about gender dysphoria and its treatment. Plaintiffs elicited expert testimony from Dr. Karasic, who has thirty-five years of experience treating thousands of gender dysphoric patients, training other health care professionals who treat this patient population, conducting research, and publishing on this topic. Tr. 12:4–25, 13:4–14:3, 14:7–15:13 (Karasic); Ex. 150 (Karasic CV). He testified that decades of clinical experience and research have shown that social transition provides significant relief to many individuals with gender dysphoria. Tr. 25:11–27:14, 29:21–30:11 (Karasic). The efficacy of this treatment is long-established and recognized by the major medical and mental health professional associations. Tr. 33:8–35:6, 37:16–20 (Karasic). It is therefore entirely predictable that denying gender dysphoric patients social transition accommodations will cause great distress, negatively impact mental health symptoms, and impair functioning. Tr. 38:5–42:12 (Karasic).

As discussed above, FDC knows the positive impact of social transition accommodations on patient mental health, and the detrimental impact of

withdrawing them. Its own health care providers have observed and documented both. *See supra* at 13-18. And even if FDC were somehow oblivious to the serious negative impacts of denying social transition accommodations to all gender dysphoric people and ignored their own health care providers' reports about the impact of withdrawing this care, this litigation has put it on actual notice that it is denying medically necessary care for a serious medical condition for individuals in its custody. *See Farmer*, 511 U.S. at 846 n.9. Continuing to deny this medically necessary care with knowledge of the serious negative impact on patient health constitutes deliberate indifference in violation of the Eighth Amendment.

3. For Plaintiffs and some other class members, other treatments—without social transition accommodations—do not adequately treat their gender dysphoria.

FDC argues that hormone therapy and psychotherapy provided under the current policy constitute adequate treatment for gender dysphoria. That FDC provides *some* treatment for gender dysphoria[10] does not end the Eighth Amendment inquiry. Put simply, if a patient has a serious condition that cannot be adequately addressed without a particular treatment, a prison cannot deny that necessary care on the basis that it provides some other treatment. *See*, *e.g.*, *De'Lonta v. Johnson*,

[10] As discussed *infra* at 35-37, psychotherapy can be helpful in addressing co-occurring mental health conditions, but both sides' expert witnesses agree there is no research showing that psychotherapy can alleviate gender dysphoria.

708 F.3d 520, 526 (4th Cir. 2013) (that defendants "have provided De'lonta with some measure of treatment to alleviate her GID symptoms" does not mean they necessarily provided her with "*constitutionally adequate* treatment"); *Hicklin v. Precynthe*, No. 4:16-cv-1357, 2018 WL 806764, at *12 (E.D. Mo. Feb. 9, 2018) (the fact that "some treatment" was provided does not end the inquiry; the "treatment must . . . be adequate to address the prisoner's serious medical need."); *Durmer v. O'Carroll*, 991 F.2d 64, 65–69 (3d Cir. 1993) (holding summary judgment for prison doctor improper because trier of fact could find that doctor was deliberately indifferent to inmate's need for physical therapy following stroke even though inmate had received other treatments for stroke, such as a bed board, pain medication, and an orthotic device).

Here, the evidence demonstrated that treatment for gender dysphoria alleviates the distress of gender incongruence by helping the patient align their presentation with their gender identity. Tr. 21:14–22:14 (Karasic). Hormone therapy and social transition are each components of achieving that result. Tr. 21:14–22:14 (Karasic); Tr. 740:14–24 (Kline). FDC recognizes the medical need for hormone therapy to align the patient's body with their gender identity to help alleviate gender dysphoria, but consciously undermines this treatment by forcing transgender women to dress and present as men, and transgender men to dress and present as women, causing them great distress.

In sum, this is not a case of FDC choosing among alternative treatments, either of which can adequately treat gender dysphoria. For many people, both hormone therapy and social transition are necessary to alleviate this condition. The evidence showed that for Plaintiffs and at least some other class members, their gender dysphoria cannot be adequately treated without social transition accommodations, as the rescission of those accommodations has caused significant mental health deterioration even when Plaintiffs were receiving hormone therapy and psychotherapy.

4. Dr. Kaliebe's testimony does not negate that FDC is denying medically necessary care and causing significant harm.

FDC presented Dr. Kristopher Kaliebe as its expert witness. Dr. Kaliebe opined that Plaintiffs do not have a medical need for social transition accommodations,[11] which he claims is based on his review of the Plaintiffs' medical records and Dr. Evans's expert reports. Tr. 856:25–857:13 (Kaliebe). But he spent a mere 10 hours reviewing thousands of pages of medical records of the five Plaintiffs. Tr. 856:25–857:13 (Kaliebe); Tr. 484:25–485:2 (Evans). It turns out that any review of the medical records was an unnecessary exercise for him to reach his conclusions about Plaintiffs' lack of medical need for accommodations because it is his view that

[11] He also concluded, in conflict with FDC health care providers, that hormone therapy is not medically necessary for any of the Plaintiffs. Tr. 857:6–9 (Kaliebe).

social transition accommodations are *never* medically necessary to treat anyone with gender dysphoria. Tr. 857:10–17 (Kaliebe).[12]

According to Dr. Kaliebe, social transition accommodations cannot be medically necessary no matter how favorably they impact an individual's mental health. Dr. Kaliebe acknowledges that social transition may help alleviate distress, Tr. 816:22–25 (Kaliebe), and cause a "reduction in symptoms," Tr. 843:24–844:3 (Kaliebe), and agrees that there is some evidence it could improve gender dysphoria. Tr. 843:18–23 (Kaliebe). Dr. Kaliebe even acknowledged that the loss of accommodations resulted in mental health decompensation for some of the Plaintiffs. Tr. 858:7–11 (Kaliebe). He nevertheless speculates, without support, that accommodations "may be providing mostly temporary relief." Tr. 810:13–17 (Kaliebe).[13]

---

[12] He says they can never be medically necessary because, he testified, "they are based on superficial things like how you appear," Tr. 788:12–22 (Kaliebe), and "[s]omething that people can choose to do on their own" outside of prison "would not be something that's medically necessary," Tr. 842:16–20 (Kaliebe). Yet he agreed that many things people can do on their own in the community, without a doctor, can be medically necessary. Tr. 831:23–832:3 (Kaliebe) (wearing orthopedic shoes, following a special diet, sleeping on a low bunk); *see also Aldridge v. Montgomery*, 753 F.2d 970, 972–73 (11th Cir. 1985) (reversing directed verdict to officers who failed to provide ice pack and aspirin for pain caused by bleeding cut).

[13] Even if Dr. Kaliebe's baseless speculation about relief being mostly temporary were true, it can violate the Eighth Amendment to deny care that provides even temporary relief. *See Washington v. Dugger*, 860 F.2d 1018, 1021 (11th Cir. 1988).

Dr. Kaliebe attempts to diminish the positive impacts of social transition accommodations on patient mental health by describing them as merely "psychologically pleasing," not medically necessary care. Tr. 843:24–844:3 (Kaliebe). As Dr. Evans testified, however, describing social transition as psychologically pleasing "severely minimizes the gravity of the pain and the misery that people with gender dysphoria experience." Tr. 521:23–522:1 (Evans). And the evidence—including FDC's own health care providers' documented observations—shows that social transition accommodations substantially improved the mental health of some patients. The same evidence showed that the loss of accommodations caused some patients significant mental health decompensation, including depression, suicidal ideation, and admission to the SHOS and TCU. *See supra* at 13-18. These serious outcomes put the lie to his assertion that accommodations are merely "psychologically pleasing," and expose his lack of understanding as to what gender dysphoric patients actually experience.

Astonishingly, Dr. Kaliebe admitted that "even if [he] saw in the medical records that someone after receiving social transition accommodations had reduced disciplinary infractions, had gone from frequent inpatient hospital admissions for mental health crisis to no more hospital admissions and their mental health was stable and improving, [he] still wouldn't say that social transition accommodations were medically necessary." Tr. 858:12–20 (Kaliebe).

Dr. Kaliebe also testified that even though social transition accommodations could improve symptoms of gender dysphoria, they are not medically necessary because, he says, they can prolong gender dysphoria and reduce patients' participation in psychotherapy. Tr. 844:4–9 (Kaliebe). Dr. Kaliebe admitted there is no scientific evidence to support his opinion that social transition accommodations prolong gender dysphoria. Tr. 844:10–13 (Kaliebe). He also offered no scientific support for the premise underlying his speculation that gender dysphoria in adults is likely to be a temporary condition absent social transition.[14] Dr. Karasic testified that while some research on prepubertal youth has been interpreted by some to suggest that desistance of gender dysphoria in this age group is common, it is widely recognized that gender dysphoria in adults is unlikely to desist. Tr. 49:18–50:13 (Karasic).

Dr. Kaliebe further conceded that his concern about social transition accommodations prolonging gender dysphoria would be lessened in the case of patients who have had longstanding gender dysphoria. Tr. 844:14–845:5 (Kaliebe), as is the case with all of the five Plaintiffs. *See supra* at 20. His hypothesis as applied

[14] He acknowledged that the studies he cited in his report for the proposition that gender dysphoria is better considered a temporary disorder like bulimia or depression do not address gender dysphoria. Tr. 839:22–840:10 (Kaliebe). Plaintiffs note a transcription error in this portion of the transcript at Tr. 840:8–9. Where it says "Q. And so that is an article about depression and does not discuss gender dysphoria?", the words "so that" should be "Sarzetto," the author of a referenced study.

to this case is even more far-fetched where Plaintiffs have been receiving gender-affirming hormone therapy, some for many years. Stip. at 11.

Dr. Kaliebe also admitted there is no evidence supporting his assertion that allowing social transition accommodations will make patients less willing to engage in psychotherapy. Tr. 816:9–25, 845:6–11 (Kaliebe). Additionally, Dr. Kaliebe concedes there is no research demonstrating that psychotherapy can alleviate gender dysphoria. Tr. 849:24–850:2 (Kaliebe); *see also* Tr. 44:25-45:14 (Karasic). Dr. Kaliebe concedes that there are no clinical practice guidelines that recommend psychotherapy alone to address gender dysphoria. Tr. 849:20–23 (Kaliebe). Dr. Karasic explained that psychotherapy was attempted for decades to address gender dysphoria and yielded no evidence that it can alleviate this condition. Tr. 45:15–46:3 (Karasic). While psychotherapy can help address co-occurring conditions, it cannot alleviate the distress of gender dysphoria itself, which causes its own pain independent of the exacerbation of co-occurring mental health conditions that some of the Plaintiffs and class members experience. Tr. 46:1–48:14 (Karasic); *see also* Tr. 583:10–13 (Evans).

In sum, Dr. Kaliebe has opined that the mental health distress experienced by Plaintiffs and other class members from the inability to socially transition is worth the pain because he speculates that the denial of accommodation may help end their gender dysphoria or make them more receptive to psychotherapy, which he claims

(without evidence) can help alleviate gender dysphoria. Dr. Kaliebe's support of continued actual suffering in pursuit of an unproven and entirely speculative benefit is utterly discrediting.

As it turns out, Dr. Kaliebe has very little basis to offer opinions at all. He has virtually no experience treating patients with gender dysphoria. Of the 10,000–20,000 patients he has seen in his career, only about 30 had gender dysphoria. Tr. 823:9–23 (Kaliebe). Of those 30, only 6–8 were adults and for most he had just one encounter and did not provide psychotherapy to any of them. Tr. 823:24–826:1 (Kaliebe). His "publications" about gender dysphoria consist of an opinion piece, letters to the editor, and an article in which he criticizes the World Professional Association for Transgender Health ("WPATH") based on his partial review of a document production from WPATH in a case in Alabama (*see infra* at 53 n.23, discussing that critique based on the WPATH production). Tr. 827:4–20 (Kaliebe). His only other publication on gender dysphoria was a U.S. Department of Health and Human Services ("HHS") report, for which he was a contributing author. The HHS report was published pursuant to a mandate of President Trump's executive order entitled "Protecting Children from Chemical and Surgical Mutilation," which predetermined that gender-affirming medical care for minors is dangerous and "a stain on our nation's history that must end." Tr. 828:1–830:11 (Kaliebe).

B. FDC's purported reliance on its review of scientific literature to justify its withdrawal of social transition accommodations does not negate its deliberate indifference, and is not credible.

FDC's health care provider, Centurion, believed that the old gender dysphoria procedure was working well and there were no issues with it.[15] Tr. 416:21–417:1 (Watkins-Ferrell); Tr. 358:4–8 (Lay). When given an opportunity to offer edits to FDC's draft HSB, Centurion tried to include language to permit the continued provision of social transition accommodations. Tr. 411:14–23, 417:2–17 (Watkins-Ferrell); Tr. 369:20–371:19 (Lay). And when it came time to implement the new HSB, FDC and Centurion knew that withdrawing social transition accommodations would create a risk for patients' mental health and prepared for "a lot of serious decompensation." Tr. 390:2 (Lay). In the end, a Centurion official said that the severity of the negative impact on patient mental health was not as bad as they anticipated it could be, but some patients suffered worsening of gender dysphoria

[15] Defendants have specifically disclaimed any security need for taking away this treatment. Tr. 742:25–743:2 (Kline); Harrell Desig. 45:13–16. Indeed, FDC officials were clear that even if a medical treatment does pose security issues, if it is deemed medically necessary, it would still be provided. Tr. 743:3–8 (Kline); Harrell Desig. 77:12–23, 79:5–8.

While Dr. Martinez mentioned two incidents of hairbrushes being used as weapons, even if security had not been disclaimed as a rationale for the policy, that would not support a decision to deny access to women's hair length standards, undergarments, and alternate canteen hygiene products. Harrell Desig. 49:14–24. Moreover, Dr. Martinez acknowledged that such weaponization of canteen items is not specific to canteen items provided as social transition accommodations. Tr. 658:4–10 (Martinez).

symptoms. Tr. 384:7–18, 385:5–10, 386:10–20 (Lay). And as discussed above, health care providers documented significant negative mental health consequences for a number of patients. *See supra* at 16-18.

Why did FDC discontinue a policy that its health care providers believed was working well, when there were no issues, and when the health care providers feared that doing so might cause significant mental health distress? FDC's answer is that Drs. Martinez and Kline purportedly engaged in a multi-year review of the scientific research and found no "strong evidence" that social transition accommodations are medically necessary. Tr. 630:11–22, 648:22–649:3 (Martinez); Tr. 718:3–722:20 (Kline). Even if this explanation can be credited, it does not negate the deliberate indifference given FDC's knowledge of the harm caused by denying social transition accommodations. But this explanation also does not make sense and is simply not credible.

1. FDC's stated rationale for its policy change is not credible.

Dr. Martinez claimed that he decided to rescind social transition accommodations based on his review of the scientific research, which he says entailed hundreds of hours reading hundreds of studies; Dr. Kline claimed she spent an astonishing 1000 hours reviewing the literature. Tr. 634:5–8, 636:7–9 (Martinez); Tr. 721:8–12 (Kline). But extensive discovery in this case did not reveal a genuine, much less thorough, effort on the part of FDC to determine whether social transition

is an effective treatment for gender dysphoria. Dr. Martinez said he searched for authors that had cited Dr. Stephen Levine, who testified for FDC in *Keohane I*. Tr. 630:11–631:5 (Martinez); *see generally Keohane v. Jones*, 328 F. Supp. 3d 1288 (N.D. Fla. 2018), *vacated sub nom. Keohane v. Fla. Dep't of Corr. Sec'y*, 952 F.3d 1257 (11th Cir. 2020) ("*Keohane I*"); *see also* Tr. 766:16–767:3 (Kline) (when researching, she started with FDC's prior litigation and Dr. Levine). Dr. Martinez did not take *any* notes during the course of a purported multi-year review of the research in which he says he spent hundreds of hours reading hundreds of studies. Tr. 675:12–18 (Martinez). Dr. Kline took some notes, but they include only seven sources, five of which were by Dr. Levine and Dr. James Cantor, both individuals who have testified against gender-affirming care in various contexts (and those sources were mainly expert declarations and trial testimony). Tr. 761:1–765:13 (Kline). Her only other two sources included in her notes were a reference in the Diagnostic and Statistical Manual of Mental Disorders (the "DSM") and an article in the Economist magazine. Dr. Kline's notes make no mention of any studies on social transition or any of the many studies and systematic reviews of the research on gender-affirming care that exist in the scientific literature. *See, e.g.*, Tr. 29:21–30:8 (Karasic).[16] The efforts of Drs. Martinez and Kline look far more like a search

[16] While Dr. Kline testified that she also had handwritten notes on her research, this should not be credited as she said she did not scan them to be produced in discovery, Tr. 759:5–15 (Kline), and no such notes were produced.

to justify abolishing social transition accommodations than a dispassionate inquiry to ascertain the appropriate treatment for gender dysphoria.

With regard to the evidence supporting social transition as treatment for gender dysphoria, Dr. Martinez criticized the evidence as "low quality." Tr. 675:19–676:17 (Martinez); Tr. 693:7–22 (Martinez) (noting that WPATH Standards of Care ("SOC") 7 and 8 recommended social transition based on low or very low quality evidence); Tr. 680:16–681:25 (Martinez) (noting that the Dopp systematic review published by the Rand Corporation said the studies on social transition were of low quality/certainty, but nevertheless concluded that it is still evidence-based treatment).[17] Yet he and Dr. Kaliebe both acknowledged that this is a term of art in scientific research (with randomized controlled trials typically being the highest quality research) and that many treatments—including hormone therapy, which FDC *does* provide to patients with gender dysphoria—are only supported by "low quality" evidence. Tr. 690:17–691:1, 693:2–6 (Martinez); Tr. 832:18–833:16 (Kaliebe). Dr. Kaliebe acknowledged that he himself provides treatments supported by only low quality evidence, and agreed that the fact that a treatment is not supported by high

[17] Dr. Martinez used the term "low validity" but acknowledged he was talking about "low certainty or low quality as it's used to [] grade evidence," and that Dopp referenced low certainty (not low validity) research. Tr. 675:22–676:17, 680:20–681:25 (Martinez). It was undisputed by both sides' experts that low quality/certainty research does not mean invalid research. Tr. 30:12–31:25 (Karasic); Tr. 833:11–834:5 (Kaliebe).

quality evidence is not itself a reason not to utilize it. Tr. 833:17–834:5 (Kaliebe). As Dr. Karasic explained, "high quality" studies for medical interventions are rare, and the vast majority of medical interventions are supported by "low quality" evidence. Tr. 30:21–31:7 (Karasic). Given that FDC provides treatments that are supported by only "low quality" evidence and much of medicine relies on "low quality" evidence, the fact that the research supporting social transition is "low quality" fails to explain FDC's decision to deny this treatment.

Dr. Martinez waffled further in his attempt to justify FDC's different approaches to hormone therapy and social transition even though both rest only on "low quality" evidence. He pointed to clinical experience: "our own observations with this patient population" showed that some gender dysphoric inmates stopped having disciplinary reports after receiving hormone therapy. Tr. 692:9–20 (Martinez). But FDC medical records show the same impact resulting from social transition accommodations. *See* Ex. 33 (Redacted Medical Record) at 1 (noting patient's dramatic reduction in disciplinary reports after being approved for social transition accommodations, and decrease in inpatient admissions); Ex. 9 (Redacted Medical Record) at 4 (noting a reduction in staff referrals after approval for social transition accommodations).

In addition, many of the studies relied upon by Dr. Martinez did not deal with social transition, but with unrelated topics such as gender-affirming surgery (Dhejne

study and Miroshnychenko study, Tr. 679:14–680:14 (Martinez)); pediatric medical transition (McMaster review, Tr. 684:12–685:5 (Martinez)); and the HHS report—also about pediatric gender-affirming treatment[18]—published in 2025, after the HSB was implemented. Tr. 678:10–679:12.[19]

Making it even harder to believe that Drs. Martinez and Kline genuinely set out to ascertain appropriate treatment protocols for gender dysphoria is the fact that, when developing the new policy, they did not consult with FDC's psychologists and mental health care providers who evaluated and treated patients with gender dysphoria. *See* Tr. 461:24–463:2 (Joshi) (psychologist who conducted many of the evaluations of this patient population and was responsible for making treatment recommendations was not consulted). And while FDC sent a draft of the HSB to Centurion to review, and Centurion responded by adding language to provide for social transition accommodations, Tr. 408:8–16 (Watkins-Ferrell); Tr. 368:2–9

[18] Moreover, this is not a source that anyone sincerely seeking to research treatment for gender dysphoria could take seriously given that, as discussed *supra* at 38, it was commissioned by HHS as part of the Executive Order that predetermined that pediatric gender-affirming care is child mutilation that must be stopped.

[19] In addition, Dr. Martinez demonstrated a lack of familiarity with the studies he purportedly spent years reviewing, for example, mischaracterizing the Dhejne Swedish study as comparing gender dysphoric people who received treatment to gender dysphoric people who did not receive treatment, which was refuted by Dr. Kaliebe and Dr. Karasic. Tr. 634:9–636:6 (Martinez); Tr. 834:6–21 (Kaliebe); Tr. 140:7–141:3 (Karasic). And his lack of familiarity with the treatment of gender dysphoria was betrayed by his characterization of "an increase in breast tissue growth" as a "side effect" of hormone therapy, as opposed to a goal of treatment. Tr. 649:21–650:7 (Martinez).

(Lay), Dr. Martinez never even looked at Centurion's input. Martinez Desig. 114:19–115:11; Martinez 30(b)(6) Design. 155:8–156:24, 163:13–18.

For all these reasons, Defendants' narrative—that Drs. Martinez and Kline decided to withdraw social transition accommodations because their scientific literature review showed only "low quality" evidence supporting this care—is simply not credible.

2. Political influence is the more plausible explanation for the decision to prohibit social transition accommodations.

Evidence regarding events leading up to the adoption of the HSB show that the policy change had its origin in politics, not medicine.

Dr. Martinez claims to have been discussing changing the gender dysphoria policy since 2020,[20] but no work started on the policy until sometime between January and March of 2023, when two significant developments occurred. Tr. 662:4–8 (Martinez). First, in January 2023, a reporter, acting on comments from then-South Dakota Governor Kristi Noem, contacted Governor DeSantis's office to question

[20] Dr. Martinez testified that there was a draft policy by Tammy Lander around 2021 or 2022, but that was never produced in discovery and he said she did not send it to him, he just saw it in her office. Tr. 639:18–640:6, 663:10–664:21. This should not be credited.

Dr. Lay, who met at least twice a month with FDC leadership, did not recall Dr. Martinez or Dr. Kline ever expressing concerns about social transition accommodations. Tr. 358:14–360:2 (Lay).

Florida's policy on transgender inmates. The Governor's office responded: "The Governor wants conservative governors across America to work together for reform in the enactment of conservative policies." Ex. 43 (Email Correspondence).

This communication precipitated a flurry of internal conversation at FDC about its treatment of gender dysphoric inmates. FDC Chief of Staff Tim Fitzgerald reached out to Dr. Kline to discuss FDC's gender dysphoria policy. *See* Ex. 48 (Email Correspondence); Ex. 43 (Email Correspondence). As Chief of Staff, Mr. Fitzgerald's job responsibilities included facilitating policy alignment between FDC and the Governor's Office. Fitzgerald Desig. 24:19–25:9, 76:3–9.

Mr. Fitzgerald then shared with Dr. Kline the Florida Medicaid report that concluded that medical interventions for gender dysphoria do not warrant coverage, Defs.' Ex. 153 (AHCA Report) at 2–3, and asked her to work with Florida's Agency for Health Care Administration (AHCA) on FDC's policy. Kline Desig. 74:23–75:22, 77:13–19. At the time, Dr. Kline understood that Mr. Fitzgerald was asking her to conform FDC's policy to the Medicaid report. Kline Desig. 78:4–7.

Also in early 2023, the Florida legislature introduced SB 254, which prohibited state funds from being used to pay for gender-affirming medical care. *See* www.flsenate.gov/Session/Bill/2023/254. Dr. Kline testified that she learned about SB 254 from the prior director of health services, who told her they would have to

update FDC's procedure to comply with the bill. Tr. 723:15–22; *see also* Kline Desig. 63:5–25, 117:2–14; Martinez Desig. 51:7–23.

An early draft of a script about the policy change stated: "Due to recent laws enacted by the Florida legislature, the Florida Department of Corrections is required to change some of its policies regarding treatment of gender dysphoria." Ex. 6 (Draft HSB Update); Tr. 668:1–23 (Martinez). Centurion also understood that SB 254 precipitated the change from the prior Procedure to the new HSB.[21] Tr. 363:22–364:17 (Lay). Drafting of the new HSB began in approximately May 2023. Tr. 723:23–724:1 (Kline). Unsurprisingly, initial drafts of the HSB did not include any provision for hormone therapy. Martinez Desig. 49:10–22; Tr. 723:15–724:16 (Kline); *see also* Ex. 97 (Deep Dive Presentation) at 3.

Defendants appear to be asking the Court to believe that FDC had been planning to change the policy for over two years, it did not take any action in furtherance of that plan until sometime between January and March of 2023, and that timing just happened to coincide with Mr. Fitzgerald's communications with Dr. Kline and the introduction of SB 254.

[21] In fact, at time of launch, Centurion asked FDC to revise the script for informing inmates of the new policy to explain that the policy had been changed due to the change in law, not due to a "change in medical consensus" but FDC would not make the change. Tr. 378:6–380:7 (Lay).

Dr. Martinez attempts to explain the long delay by saying he was waiting for the forthcoming WPATH SOC 8, which was released in September 2022. Tr. 660:12–661:21 (Martinez). He recognized that SOC 8 supports social transition. Tr. 661:22–662:1 (Martinez). He claimed that what changed after SOC 8 was that half of the major medical groups which had previously supported the WPATH SOC dropped their support. Tr. 674:13–22 (Martinez). This is completely untrue. Dr. Kaliebe and Dr. Karasic both testified that the major medical and mental health professional associations in the U.S. continue to support WPATH SOC 8. Tr. 34:5–35:6, 56:13–57:3 (Karasic); Tr. 848:1–21 (Kaliebe).[22]

In sum, political influence offers a far more plausible explanation for FDC's decision to toss out its old policy and implement a new one that banned social transition than the "low quality" evidence explanation. To be sure, FDC's actual knowledge that its blanket ban on social transition accommodations causes serious harm is more than sufficient to establish deliberate indifference. And the absence of a credible legitimate explanation for pulling the rug out from under Plaintiffs and other class members further evidences the unnecessary and wanton infliction of pain. But the fact that FDC withdrew this treatment for non-medical reasons provides an additional reason for the Court to rule in Plaintiffs' favor. *See, e.g.*, *Ancata v. Prison*

[22] The only caveat is that the plastic surgeons association disagreed with one provision in the SOC 8 related to surgery for minors. Tr. 56:13–24 (Karasic).

*Health Servs.*, *Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) (if necessary medical treatment is denied for non-medical reasons, "a case of deliberate indifference has been made out").

C. A purported divide in the medical community does not entitle FDC to deny care that its health care providers recognize is needed.

Defendants, relying on *Gibson v. Collier*, 920 F.3d 212 (5th Cir. 2019), apparently take the position that FDC's ban on social transition accommodations withstands Eighth Amendment scrutiny because, they say, there is a dispute in the medical field about the efficacy of social transition as a treatment for gender dysphoria.

As an initial matter, there is no need to get to the question raised in *Gibson* because here, unlike in *Gibson*, there is no disagreement between FDC's health care providers and the Plaintiffs about their need for the treatment at issue. The evidence has shown that FDC health care providers recommended social transition accommodations to some class members because, in their professional judgment, they determined that such accommodations would likely help alleviate their gender dysphoria. Moreover, FDC's health care providers documented that this treatment did, in fact, significantly improve the mental health of some class members and that the withdrawal of this treatment resulted in significant mental health decompensation for some. *See supra* at 13-18.

In *Gibson*, there was no evidence that the department's health care providers agreed the care at issue there—gender-affirming surgery—was needed, or that the plaintiff was suffering harm from the denial of that treatment. *Gibson* did not say that a division in the medical field about a treatment shields the government from Eighth Amendment liability when the department of corrections' own health care providers agree that the treatment is warranted, and the department knows that withdrawal of the treatment has subjected patients to serious harm. Extending the holding of *Gibson* to cover these circumstances would conflict with settled Eighth Amendment case law.

In addition, *Gibson* is contrary to the authority of the Eleventh Circuit and other circuits that have made clear that a blanket policy that precludes a treatment that can be effective to alleviate a serious medical condition without consideration of individual need violates the Eighth Amendment. *See Keohane I*, 952 F.3d at 1266–67 ("[R]esponding to an inmate's acknowledged medical need with what amounts to a shoulder-shrugging refusal even to consider whether a particular course of treatment is appropriate is the very definition of 'deliberate indifference'—anti-medicine, if you will."); *see also Rosati v. Igbinoso*, 791 F.3d 1037 (9th Cir. 2015); *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011); *De'lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003). As the Court said in *Keohane I*, "[u]nsurprisingly to us, other courts considering similar policies erecting blanket bans on gender-dysphoria treatments—

without exception for medical necessity—have held that they evince deliberate indifference to prisoners' medical needs in violation of the Eighth Amendment." *Id.* at 1267 (citing *Fields*, 653 F.3d 550; *Hicklin*, 2018 WL 806764, at *11; and *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 247 (D. Mass. 2012)).

Other courts have rejected *Gibson's* approach, describing that case as an "outlier," *Edmo v. Corizon*, 935 F.3d 757, 795 (9th Cir. 2019), and criticizing it for misinterpreting *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014), as standing for the premise that a blanket denial of treatment does not violate the Eighth Amendment if there is a dispute in the medical field about the treatment, when *Kosilek* said just the opposite, *Edmo*, 935 F.3d at 795; *Flack v. Wisc. Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1017 (W.D. Wis. 2019).

But even if *Gibson* were deemed to apply, this case does not present the type of division in the medical field contemplated in that case. In *Gibson*, the court said the parties agreed that there was a "medical controversy over sex reassignment surgery." *Gibson*, 920 F.3d at 226. Based on that undisputed fact, the Court held that "[t]here is no intentional or wanton deprivation of care if a genuine debate exists within the medical community about the necessity or efficacy of that care." *Id.* at 220. But the court made clear that the existence of dissenting views about a treatment does not "automatically defeat[] medical consensus about whether a particular treatment is necessary," as a showing of "unanimity" is not required. *Id.* Rather, the

court explained, where "there is robust and substantial good faith disagreement dividing respected members of the expert medical community, there can be no claim under the Eighth Amendment." *Id.*

This case does not involve a "robust and substantial good faith disagreement dividing respected members of the expert medical community" regarding the efficacy of social transition as a treatment for adults with gender dysphoria. The evidence at trial showed that decades of clinical experience and scientific research have demonstrated the efficacy of social transition as a treatment for gender dysphoria and that this is widely accepted in the medical community. Tr. 25:11–27:14, 29:21–30:11, 36:1–21, 38:5–13 (Karasic). This recognition dates back to the 1950s. Tr. 37:16–20 (Karasic). All clinical practice guidelines regarding the treatment of gender dysphoria recognize social transition as a treatment for this condition. Tr. 33:8–35:6 (Karasic). The major medical professional associations, Tr. 848:1–12 (Kaliebe), including the American Medical Association, the American Psychiatric Association, and the American Psychological Association, support this care. Tr. 32:8–35:6 (Karasic). Defendants have pointed to no clinical practice guideline that does not recommend social transition as treatment for gender dysphoria, or to any major medical professional association that does not support it. FDC's own health care provider, Centurion, agrees and includes social transition in its guidelines for the treatment of gender dysphoria. Ex. 1 (Centurion Clinical

Guidelines) at 9–10; Tr. 410:10–15 (Watkins-Ferrell); Tr. 352:20–354:9 (Lay). Even Dr. Martinez and Dr. Kline acknowledge that in the community, social transition is part of the treatment for gender dysphoria. Martinez 30(b)(6) Desig. 60:6–18; Tr. 652:25–653:5 (Martinez); Kline Desig. 50:15–25 (outside of the prison context, social transition is recommended for patients with gender dysphoria); Tr. 740:25–741:8 (Kline) (social transition is a commonly accepted treatment for gender dysphoria outside of prison).

This is simply not a subject about which the medical field is divided. Tr. 37:13–15 (Karasic).

In trying to create the appearance of a medical debate where none exists, Defendants critique WPATH and its SOC 8. The attack is meritless,[23] but more

[23] Dr. Kaliebe testified on direct examination that WPATH is discredited but offered no support for that claim. Tr. 812:23–813:15 (Kaliebe). As revealed on cross examination, his characterization of WPATH relies heavily on purportedly damning revelations from documents produced by WPATH in litigation in Alabama in which he served as an expert witness. Tr. 851:25–852:2, 852:15–18 (Kaliebe). But he admits he saw only about 1 to 5 percent of the documents in the WPATH production, which were chosen for him by Alabama's counsel, and that almost all of the authors' names and some of the content was redacted. Tr. 852:17–853:14 (Kaliebe); *see also* Tr. 57:4–58:22 (Karasic). He also relied on articles by journalists about this, but he recognized that the WPATH production was sealed and only some parts had been unsealed. Tr. 851:5–10, 854:1–3 (Kaliebe).

Another source he cited in his expert report to support his characterization of WPATH is a publication called the WPATH Files. Tr. 855:7–19 (Kaliebe). This publication is a compilation of screenshots from a message board for clinicians used by WPATH members to discuss clinical issues. Tr. 60:7–62:13 (Karasic). The WPATH Files was created by an activist against transgender rights, who selected anonymous posts that have nothing to do with the development of WPATH

importantly for present purposes, it is irrelevant. As Dr. Karasic testified, the efficacy of social transition for adults with gender dysphoria has been well established by decades of clinical experience and research, and does not in any way turn on WPATH's guidelines. Tr. 33:8–35:6, 52:8–53:8 (Karasic).

FDC also tries to stir up the appearance of a debate in the medical field about the care at issue by citing publications focused on the use of hormone therapy and puberty blockers to treat minors with gender dysphoria: the Cass report (*see* Tr. 835:16–18 (Kaliebe)), the McMaster review (*see* Tr. 631:6–632:2 (Martinez)), and the HHS report on pediatric gender-affirming medical care (*see* Tr. 678:10–18 (Martinez)). It also cites an asserted dispute about the efficacy of gender-affirming surgeries, offering a profoundly erroneous interpretation of a Swedish study by Dhejne.[24] None of these sources show any divide in the medical field about social transition (or hormone therapy) for adults with gender dysphoria.

---

guidelines, in an attempt to weave together a narrative. Tr. 60:7–62:13 (Karasic). Dr. Kaliebe acknowledged that it had a lot of anonymous content where no authorship could be determined and that it cannot be determined whether those individuals had any role in the development of WPATH's guidelines. Tr. 855:7–856:9 (Kaliebe).

[24] This study is not only irrelevant here, but did not actually assess the efficacy of gender-affirming surgery. It did not compare suicide rates among gender dysphoric people who had undergone surgery with gender dysphoric people who had not. Rather, it compared suicide rates among gender dysphoric people who had received surgery with rates among the general population. Tr. 807:7–24, 834:6–21 (Kaliebe). The study author has spoken out against people suggesting her study showed that gender-affirming medical care is ineffective. Tr. 835:12–15 (Kaliebe).

Defendants have only succeeded in demonstrating that some individual doctors, such as Dr. Kaliebe, oppose *any* gender-affirming care for adults with gender dysphoria and support only psychotherapy, a treatment which has no scientific support. Tr. 794:10–22, 789:1–11, 810:21–23 (Kaliebe) (expressing concerns about "affirmation-based" approaches and people "going along with" gender dysphoric people's "view of themselves as . . . a different than their biological sex"). But even Dr. Kaliebe agrees that this is not an evidence-based approach to treatment. *See supra* at 36-37. And even if Dr. Kaliebe could be considered a respected member of the community of experts despite having no material clinical or research experience, his personal unsupported opinions do not reflect a robust disagreement dividing the medical community.[25]

At most, Defendants have shown that, as with all medical or mental health treatments, there are some individuals who disagree with well-accepted protocols.

---

[25] Dr. Martinez suggests that Dr. Stephen Levine and Dr. James Cantor favor psychotherapy as the sole treatment of gender dysphoria. Tr. 687:5–16 (Martinez). However, on cross examination, he did not know if Dr. Cantor supported social transition. Tr. 687:5–688:3, 688:25–690:5 (Martinez). And in testimony in other litigation, Dr. Levine has supported gender-affirming treatment for adults. *See, e.g.*, *Claire v. Fla. Dept. of Mgmt. Servs.*, 4:20-cv-20 (N.D. Fla.), Doc. No. 118-20 (Deposition of Dr. Stephen Levine) at 99:16–19 (Q: "Is there anyone for whom you would say hormone therapy to treat gender dysphoria is medically necessary?" A: "Yes."); *see also id.* at 31:2–21 (describing Dr. Levine's support of certain individuals obtaining various gender-affirming surgeries). But even if they could be counted along with Dr. Kaliebe as opponents of any gender-affirming care, that would not establish a robust and substantial disagreement dividing the medical community.

Even under *Gibson*, the existence of some dissenting views does not provide a basis to withhold a particular treatment from all incarcerated people without consideration of individual need. Any other conclusion would leave prisons free to categorically ban all manner of medical treatments, rendering the Eighth Amendment's protection against the denial of medically necessary care a dead letter.

## Conclusion

The evidence has shown that social transition is medically necessary for many people with gender dysphoria, that social transition improved the mental health of Plaintiffs and other class members, and that the loss of social transition accommodations has significantly harmed them. FDC cannot deny that its own providers observed that for some people, social transition accommodations provided significant mental health benefits, while their loss resulted in significant worsening of mental health symptoms.

FDC is utterly indifferent to the impact of its actions. It promulgated a policy that denies social transition accommodations to all, without any consideration for the needs and individual circumstances of patients. In doing so, it chose to ignore the clinical judgment of its own health care providers, who would continue to recommend social transition accommodations for those patients it could benefit if permitted to do so, and whose leadership urged FDC to maintain this treatment.

FDC tried to cloak its cruel decision in the mantle of an objective review of the medical literature, but this pretext cannot withstand scrutiny. It is inconceivable that FDC would subject patients to the distress of losing this treatment simply because the quality of the evidence supporting it is not stronger. Moreover, as a scientific endeavor, this research review was a farce whose outcome was predetermined.

FDC further tried to defend its indefensible policy by hiring an expert witness with virtually no experience treating patients with gender dysphoria, who contradicted FDC's own experienced health care providers (and indeed contradicted FDC's current policy on hormone therapy). Dr. Kaliebe believes that even if social transition accommodations can reduce mental health crises and hospital admissions, reduce disciplinary infractions, and cause inmates' mental health to stabilize and improve, to him, this treatment is never medically necessary and he would not support it. His testimony should be categorically rejected.

FDC's policy violates the Eighth Amendment. It reflects system-wide deliberate indifference to a serious medical need. It has caused injury to Plaintiffs and class members, and will continue to put them at substantial risk of serious harm. Plaintiffs respectfully request that this Court permanently enjoin FDC's prohibition against social transition accommodations, and direct it to conduct individualized

assessments of Plaintiffs and class members and provide social transition accommodations where medically necessary.

Respectfully submitted,

Dated: August 5, 2026 *__/s/ Daniel B. Tilley__*

Samantha J. Past (FBN 1054519)
Daniel B. Tilley (FBN 102882)
**ACLU Foundation of Florida**
4343 West Flagler Street, Suite 400
Miami, FL 33134
Tel: (786) 363-2714
spast@aclufl.org
dtilley@aclufl.org

Li Nowlin-Sohl (*pro hac vice*)
Leslie Cooper
Sruti J. Swaminathan (*pro hac vice*)
**ACLU Foundation**
125 Broad St.
New York, NY 10004
Tel: (212) 549-2584
lnowlin-sohl@aclu.org
lcooper@aclu.org
sswaminathan@aclu.org

Anthony J. Anscombe (*pro hac vice*)
George Desh (*pro hac vice*)
Sadaf Misbah (*pro hac vice*)
Sarah Norise (*pro hac vice*)
**Steptoe LLP**
227 West Monroe Street, Suite 4700
Chicago, IL 60606
Tel. (312) 577-1300
aanscombe@steptoe.com
gdesh@steptoe.com
smisbah@steptoe.com
snorise@steptoe.com

**CERTIFICATE OF COMPLIANCE**

I certify that the substantive portion of this brief contains 13,442 words.

Dated: August 5, 2026 */s/ Daniel B. Tilley*