

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

REIYN KEOHANE, <i>et al.</i> ,	:	
	:	
<i>Plaintiffs,</i>	:	
	:	
v.	:	Case No. 4:24-cv-434-AW-MAF
	:	
RICHARD COMERFORD, <i>et al.</i> ,	:	
	:	
<i>Defendants.</i>	:	

PLAINTIFFS' CLOSING REPLY

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Plaintiffs have more than met the burden articulated by this Court in its ruling on summary judgment. Indeed, Defendants' Closing Brief admits key facts. After two years of litigation, Defendants finally acknowledged that the Florida Department of Corrections ("FDC") has a blanket ban on social transition accommodations for the treatment of gender dysphoria. Defendants' Closing Brief ("Response") at 25–26, Dkt. 220. They admit that FDC's healthcare providers expected patient mental health to decompensate from the withdrawal of accommodations, *id.* at 34, but FDC went ahead with the policy anyway. And they admit that some patients did experience "worsening symptoms" due to loss of accommodations, *id.* at 35, yet FDC continues to maintain the blanket policy.

None of Defendants' arguments defeat Plaintiffs' claim that FDC is acting with deliberate indifference to the serious medical needs of class members. Defendants whitewash the suffering FDC's withdrawal of treatment has caused the Plaintiffs and others, ignoring the ample evidence demonstrating the seriousness of the harm. Their attempt to conjure a professional dispute in the medical field about social transition has no support in the trial record and, in any case, would not negate the deliberate indifference of denying care even their own healthcare providers agree some class members need. And they invent new legal standards that, if actually the law, would make the Eighth Amendment's protection of medically necessary care a dead letter.

As for relief, Defendants misconstrue the nature of Plaintiffs injunctive claims, arguing that Plaintiffs have not shown that all class members are entitled to social transition accommodations. But Plaintiffs have never requested this. They simply seek an order enjoining FDC from maintaining its blanket ban on social transition accommodations to allow mental health professionals to resume assessing the individual medical needs of patients and providing the care if deemed necessary.

Whatever FDC knew about the harms of denying this treatment in September 2024, after two years under the policy, after FDC officials were shown psychological assessments and other medical records from their own mental health providers documenting that some patients experienced significant mental health benefits from accommodations and significant decompensation without them, after they were shown a psychological autopsy finding that an inmate chose to die by suicide in part because of the loss of social transition accommodations, and after witnessing three days of testimony at trial—including Plaintiffs’ testimony describing their distress from losing accommodations and that they resort to making their own undergarments and risk discipline because they simply cannot bear to wear the undergarments given to them by FDC—FDC now clearly knows that withholding this care is causing serious harm. FDC’s refusal to even consider class members’ individual medical need for this treatment in the face of this knowledge is the very essence of deliberate indifference to a serious medical need that the Eighth Amendment does not permit.

Argument

I. Defendants’ assertion that the harms of the denial of social transition accommodations are not sufficiently serious to constitute constitutionally inadequate care has no basis in fact or law.

Defendants concede that some class members have experienced distress due to the denial of social transition accommodations, but argue that this does not rise to the level of serious harm for purposes of the Eighth Amendment. Response at 28. But FDC’s own healthcare providers anticipated severe harm from the withdrawal of accommodations, and a mountain of evidence—including from FDC’s own healthcare providers—shows that accommodations are an essential treatment for some class members. The loss of accommodations has, in fact, caused serious harm including depression, self-harm, and suicidal ideation, and it contributed to the actual suicide of one class member. *See* Plaintiffs’ Closing Brief (“Pls.’ Brief”), Section II(A)(1), Dkt. 217 (discussing the evidence).

If these harms are not “serious,” it is hard to imagine what mental health harms could ever be “serious” enough to trigger Eighth Amendment protection. *See Keohane v. Fla. Dep’t of Corr.*, 952 F.3d 1257, 1264 (11th Cir. 2020) (*Keohane I*) (implicitly acknowledging that “a substantial risk of self-harm or severe psychological pain” constitutes the type of harm that could constitute the denial of constitutionally adequate care).

Defendants also argue that there is no substantial risk of serious harm because Dr. Evans “framed her prognoses in probabilistic terms,” such as self-harm ideation and other symptoms “‘would likely continue or worsen’ without accommodations.” Response at 29 (quoting Dr. Evans). This is preposterous. Certainty of future harm is not the standard, but rather “substantial *risk* of serious harm.” *Wade v. McDade*, 106 F.4th 1251, 1255 (11th Cir. 2024) (emphasis added). Any assessment of risk is inherently probabilistic. Moreover, here, the serious risk was also anticipated by FDC’s own healthcare providers, and actual harm has been documented. *See* Pls.’ Brief, Section II(A)(1).¹

II. Defendants’ assertion that Plaintiffs must show “widespread” serious harm departs from well-established Eighth Amendment jurisprudence.

Defendants make a strawman argument that Plaintiffs have failed to demonstrate the need for class-wide relief because they have failed to show the denial of social transition accommodations resulted in “widespread” serious harm.

¹ Defendants’ reliance on *Keohane I* to support their argument that there is not a substantial risk of serious harm, Response at 28–29, is misplaced. There, the court said that FDC providers determined at that time that compliance with FDC’s male grooming policies did not place Ms. Keohane at a substantial risk of serious harm. *Id.* at 28–29. But a near decade-old factual finding about one person has no bearing on whether there is a present substantial risk of harm for her, much less for other members of the class. *See* Order Den. Pl.’s Mot. for Prelim. Inj., Dkt. 55 at 17 (this Court recognized that Keohane’s medical needs could have changed since *Keohane I*).

Response at 34. This is an invented requirement. Again, the Eighth Amendment standard is whether defendants' conduct puts class members at *substantial risk* of serious harm. *Wade*, 106 F.4th at 1255.

Plaintiffs have demonstrated that the denial of social transition accommodations puts *all* class members at substantial risk of serious harm. The Court defined the class as “all persons who are or will be incarcerated in the custody of the FDC who have been diagnosed with gender dysphoria and who, absent HSB 15.05.23, would be provided social accommodations to treat their gender dysphoria if deemed medically necessary for them.” Class Certification Order at 13, Dkt. 125. And the evidence showed—indeed FDC’s own healthcare providers recognized—that for some patients with gender dysphoria, social transition accommodations are necessary. *See* Pls.’ Brief, Section II(A)(1). Thus, by banning this care without considering individual patient need and prohibiting healthcare providers from providing it even when they deem it necessary, Defendants are putting all class members at risk of being denied medically necessary care.

Defendants make much of testimony stating that the policy caused less harm to patients than FDC’s healthcare providers feared. That, of course, is not the Eighth Amendment standard, and only underscores FDC’s reckless indifference to the harm

they expected to cause.² FDC’s “better than expected” argument is cold comfort for Sheila Diamond, who talked to her therapist about ways to die because of the distress she felt from losing accommodations, *see* Ex. 11 (Diamond Medical Record) at 2, for Reilyn Keohane, who was put on suicide observation after FDC confiscated her bra, Tr. 313:5–314:15 (Keohane), or for the class member who died by suicide.

Although Plaintiffs’ claim does not turn on the number or percentage of class members who have suffered actual harm as a result of the policy, it is worth noting that Defendants’ reliance on the testimony of Drs. Kline and Lay to say that harm was not widespread is misplaced. Dr. Lay testified that he did not know whether it was a majority or minority of the class that experienced harmful effects on their mental health from the loss of social transition accommodations. Response at 34. And Drs. Kline and Lay both said they were not aware of the actual examples of FDC’s healthcare providers documenting the positive mental health impact of social transition accommodations and the harms from the withdrawal of that care that were presented to the Court. Tr. 768:3–6 (Kline) (reports did not make their way up to

² Rescinding a policy that the healthcare providers agreed was working well and did not have any issues, Tr. 416:23–25 (Watkins-Ferrell), to implement a new policy that was anticipated to cause a “wave of decompensation,” and then calling it “far more successful” than anticipated when the mental health decompensation is less frequent and severe than you expected, Response at 34–35, is so ludicrous that it would be funny if the harm was not so serious.

her)³; Tr. 360:8–361:10 (Lay) (he didn’t know whether clinicians observed benefits from accommodations because he had “little involvement” in the mental health side).

III. Plaintiffs’ co-occurring mental health conditions do not diminish the seriousness of the harm they have endured from the denial of accommodations, and do not shield FDC from liability under the Eighth Amendment.

Defendants try to defend the denial of social transition accommodations by arguing that the causal connection between the distress that Plaintiffs and other class members have experienced and the loss of accommodations is unclear due to the presence of other mental health conditions and life circumstances. Response at 29–34. This argument is baseless.

It is absolutely true that Plaintiffs have not lived lives free from the pain of a variety of mental health conditions and other life stressors. Each has gender dysphoria. The fact that each has other things that distress them does not mean that they and their healthcare providers, and Dr. Evans, cannot identify the distress attributable to gender dysphoria; nor does it render treatment for their gender dysphoria unnecessary or ineffective. Plaintiffs’ co-occurring mental health conditions and life challenges do not give FDC license to compound their suffering by denying medically necessary care.

³ Whether or not Dr. Kline was aware of those documents at the time they were created, she and FDC are fully aware of them now, yet the policy remains in place.

There is ample evidence of the direct impact of the denial of accommodations on Plaintiffs and other class members' mental health. Plaintiffs did not simply "reason[] backward from the existence of post-HSB distress." Response at 30. For example, Dr. Evans' testified that some Plaintiffs' symptoms of gender dysphoria became more intense after the loss of accommodations, Tr. 495:1–5 (Evans), and that the distress of gender dysphoria is a specific type of distress that relates to the body and gender. Tr. 580:14–17 (Evans). Plaintiffs themselves testified extensively to the distress they have experienced as a direct result of the denial of social transition accommodations, even as they acknowledge that they have other sources of distress in their lives. *See* Pls.' Brief at 25–29. For example, Ms. Keohane explained how being forced to have a short, masculine hair style and not being able to wear makeup to cover up her five o'clock shadow are a major cause of her gender dysphoria, Tr. 310:12–311:24 (Keohane), and how she has resumed self-isolation because she does not want anyone to look at her. Tr. 309:25–310:11 (Keohane). When her bras were confiscated, she had a psychological emergency and was put on suicide observation, Tr. 313:5–314:15 (Keohane), and when her makeshift bra was confiscated the morning of trial, she cut herself to cope. Tr. 301:25–302:16, 308:13–309:3 (Keohane).

Each Plaintiff testified that the loss of their undergarments exacerbates their gender dysphoria and is so distressing and intolerable that they risk disciplinary

reports and confinement by using makeshift bras, underpants, and boxers. Tr. 206:3–207:7 (Boothe); Tr. 253:5–11 (Mendoza); Tr. 315:5–7 (Keohane).

FDC’s own healthcare providers also recognized the connection, documenting mental health deterioration directly associated with the loss of accommodations. For example, one class member’s medical record stated that the patient was “‘crying a lot more recently’ due to the new 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.” Ex. 10 (Redacted Medical Record) at 3. When asked about this patient at trial, Dr. Joshi said she believed “that the loss of social accommodations ha[d] caused a decompensation of [the patient’s] mental health” and that “restoring social transition accommodations that she had previously had could alleviate her mental health symptoms.” Tr. 468:17–470:17 (Joshi). Another patient’s mental health provider “reported belief that Inmate [redacted] ‘mental health has improved substantially’ following approval for gender-affirming accommodations,” citing no “inpatient admissions, self-harm ideation, or psych emergencies/staff referrals.” Ex. 9 (Redacted Medical Record) at 4. When asked about this patient at trial, Dr. Joshi expressed her belief that for this patient, “social transition accommodations that she previously had could help improve her mental health.” Tr. 470:20–471:21 (Joshi).

If this was not enough, FDC itself determined that the loss of accommodations was a contributing factor in one class member's suicide. Kline Desig. 272:1–23; Wasserman Desig. 112:15–113:1.

Defendants point to Plaintiffs' "competing causes of distress" to try to disprove FDC's withdrawal of social transition accommodations as a cause of mental health deterioration. Response at 31–32. They argue the "clearest example" is that Plaintiff Mendoza testified that her suicide attempts stopped after she began receiving accommodations and hormone therapy for her gender dysphoria, but she became suicidal again after losing her mother, thereby "undermin[ing] Plaintiffs proposed causal connection" between Mendoza's distress and the absence of accommodations. *Id.* at 31. Defendants also point to Ms. Mendoza's persistent depressive disorder. *Id.* at 31–32. But Plaintiffs have never argued that social transition accommodations can cure everything that ails them. They simply ask that they not be denied care that is known to help their gender dysphoria. That Ms. Mendoza experienced suicidal thoughts as a result of her grief *from losing her mother* does not negate the huge positive impact of social transition accommodations on her mental health. Taken to its logical conclusion, Defendants' argument would foreclose Eighth Amendment relief for the denial of mental health treatments for any person with more than one mental health condition or who experienced any distressing life events.

Defendants say that the fact that Ms. Keohane had suicide attempts and self-harm while receiving accommodations shows “that social accommodations do not constitute the panacea of treatment presented by Plaintiffs.” Response at 34. Again, Defendants attempt to rebut an argument that Plaintiffs have never made. Dr. Evans testified that, because Ms. Keohane has significant distress related to her genitals, she will likely continue to experience gender dysphoria related to her genitals absent surgery. Tr. 546:14–23 (Evans). She also testified about the substantial impact social transition accommodations had on alleviating Ms. Keohane’s distress and other co-occurring conditions, and the additional self-harm and suicidality she experienced directly related to losing accommodations. Pls.’ Brief at 21–22 (citing Dr. Evans’ testimony). Ms. Keohane has distress directly traceable to FDC’s conduct, which her other conditions do not obfuscate.

Similarly, it can hardly be a defense for FDC that Nelson Boothe was grief stricken following the deaths of two family members. Response at 32. And Dr. Evans freely acknowledges that Mr. Boothe would still experience symptoms of depression and anxiety even if he were to receive social transition accommodations. *Id.* at 33 (citing Tr. 600:2–10). But Mr. Boothe testified that FDC’s prohibition on accommodations made his gender dysphoria the worst it has ever been, and has caused him to make his own underwear, at risk of discipline, because he cannot bear to wear women’s underpants. Tr. 206:3–207:7, 207:17–19 (Boothe). Plaintiff’s

contention is simply that accommodations would help his gender dysphoria, not cure everything that ails him.

Defendants point out that some Plaintiffs did not experience *every* potential adverse mental health symptom after the withdrawal of social transition accommodations to suggest a disconnect between accommodations and patient mental health. For example, Defendants note that Plaintiff Mendoza experienced her last panic attack in July 2024 (shortly after her mother passed away and before accommodations were withdrawn), and Plaintiff Boothe was placed on Self-Harm Observation Status after the “tragic double loss” of two family members, but did not have suicidal ideation or self-injury since the loss of accommodations. Response at 31–32. That Plaintiffs Mendoza and Boothe experienced those serious harms in the midst of extreme grief but not in response to the loss of accommodations does not make the distress and worsening of mental health symptoms they experienced due to the loss of accommodations any less serious. Ms. Mendoza and Mr. Boothe testified in detail about the serious harms they have experienced and continue to experience due to the loss of accommodations, including intensification of their gender dysphoria as well as depression, anxiety, and suicidal thoughts. Tr. 204:7–22 (Boothe); Tr. 253:12–17 (Mendoza). Defendants have not questioned the veracity of their testimony or shown that those harms are not serious. Pls.’ Brief at 23–29.

IV. That FDC took steps to try to mitigate the distress it anticipated would be caused by its own actions does not rescue it from Eighth Amendment liability.

Defendants argue that even if “FDC knew of a substantial risk” to class members posed by withdrawing social transition accommodations, it was not deliberately indifferent because FDC put in place measures to increase mental health supports for inmates who suffered as a result of its action. Response at 39–40. Defendants argue that this constitutes a reasonable response to the risk, thereby precluding a finding of deliberate indifference. *Id.* at 39 (citing *Farmer v. Brennan*, 511 U.S. 825, 844 (1994)). But *Farmer* did not involve prison officials taking action that they knew would subject inmates to a substantial risk of serious harm, and does not support Defendants’ astonishing argument that taking steps to mitigate harm the department knew would result from its own actions means that it did not act with deliberate indifference to the harm it knowingly caused.⁴ This is akin to saying that it would not violate the Eighth Amendment for a prison to prohibit heart medication as long as it increased the number of doctors and defibrillators to treat resulting heart attacks.

⁴ The same is true of *Swain v. Junior*, 961 F.3d 1276 (11th Cir. 2020) (challenge to inadequate response to COVID-19 pandemic); *Rasho v. Jeffreys*, 22 F.4th 703 (7th Cir. 2022) (challenge to systemically inadequate prison healthcare); and *Wade*, 106 F.4th 1251 (challenge to failure to provide seizure medication).

Even if one could give credence to Defendants’ argument that the Eighth Amendment permits prisons to knowingly subject patients to distress as long as they subsequently alleviate the distress they caused, as discussed above and in Plaintiffs’ Closing Brief, the evidence showed that Defendants have not alleviated the distress they caused Plaintiffs and at least some other members of the class. FDC knows this, and still maintains its ban on social transition accommodations.

V. The fact that FDC provides other treatment for gender dysphoria does not mean that the care provided is constitutionally adequate.

Defendants argue that there is no constitutional violation because FDC provides other treatment for gender dysphoria. They say this “defeat[s] a claim of wholesale or cursory non-treatment.” Response at 23. Plaintiffs do not claim “non-treatment”; they claim constitutionally inadequate treatment. As this Court has noted, “even when there is some treatment, there can be an Eighth Amendment violation,” Summary Judgment Order at 16, Dkt. 200, *e.g.*, when care is grossly inadequate or shocks the conscience, *id.* at 15.

Many medical conditions require more than one treatment for adequate care. For example, a broken bone may require a cast to set the bone and pain medication to relieve the pain. A prison could not refute a deliberate indifference claim challenging a blanket ban on casts (or pain medication) for broken bones by pointing to the fact that they are providing pain medication (or casts). It is absurd to suggest that a recognized treatment that a patient needs can be categorically banned just

because other treatments address aspects of the medical problem. Under Defendants’ theory, prisons could categorically ban countless medically necessary treatments, including psychiatric medications for bipolar disorder, schizophrenia, and other conditions if they provide psychotherapy and crisis intervention. Response at 23. But that is not the law. Abundant evidence at trial—including from FDC’s own healthcare providers—showed that for some patients, their gender dysphoria cannot be adequately treated without social transition accommodations, as this treatment resulted in significant improvement in their mental health while the denial of accommodations caused significant mental health deterioration, including depression, self-harm, and suicidal ideation. *See* Pls.’ Brief, Section II(A)(1). Dr. Joshi, a psychologist who conducted many of FDC’s evaluations of patients with gender dysphoria, recognizes that social transition accommodations can be necessary for some patients, Tr. 459:6–19 (Joshi), and testified that she would continue to recommend them for patients if she could. Tr. 460:12–14 (Joshi).⁵

FDC knows all of this and yet continues to prohibit its healthcare providers from recommending care that they deem necessary for individual patients. This is

⁵ Thus, contrary to Defendants’ suggestion, this is not a matter of FDC choosing an “alternative course[] of medical treatment” that adequately addresses all patients’ gender dysphoria. Response at 7. For some class members, their condition cannot be adequately treated without this intervention.

the definition of grossly inadequate care, indifference to the needs of patients, and a course of conduct that shocks the conscience.

VI. Drs. Martinez’ and Kline’s literature review does not refute the deliberate indifference.

Defendants assert that FDC officials did not consciously disregard a known risk because Drs. Martinez and Kline based their decision to withdraw social transition accommodations on their review of the research literature, from which they “found no strong evidence indicating that social accommodations are medically necessary.” Response at 37–38.

As discussed in Plaintiffs’ Closing Brief, the evidence showed that this explanation for Defendants’ decision to withdraw accommodations cannot be credited because, among other things, FDC and its expert agree that the absence of “strong” evidence supporting treatments is commonplace in medicine, and FDC does not deny other treatments supported only by low-certainty evidence, including hormone therapy. Pls.’ Brief at 38–48.

But even if one accepts the claim that the decision in September 2024 to prohibit social transition accommodations was made based on Drs. Martinez and Kline’s literature review, *continuing to deny this care now*, given their knowledge of the harmful impact of this policy on some patients, is deliberate indifference. FDC is consciously disregarding the known harm, documented by its own healthcare providers, that withholding this care is causing some patients serious mental health

decompensation and putting others at substantial risk of serious harm. Regardless of whether Drs. Martinez and Kline knew in 2024 the harmful impact their policy would have, they know it now and yet continue to categorically deny this care.⁶ This amounts to reckless disregard for patient health and shocks the conscience.

VII. Defendants’ argument that Plaintiffs’ claim should be denied because they failed to establish a medical consensus concerning social transition as a treatment for gender dysphoria is without merit.

Defendants argue that Plaintiffs’ claim fails because they “failed to establish a medical consensus that social accommodations are appropriate and necessary.” Response at 9. This is wrong for several reasons.

First, whether there is a medical consensus about the treatment at issue is not pertinent here where the trial evidence showed that FDC’s own mental health providers i) recommended social transition accommodations for patients; ii) documented the significant benefits of this care to patient mental health; iii) documented the significant deterioration of mental health for some patients—including self-harm and suicidal ideation—that they attributed to the denial of accommodations; iv) recognize that this care is needed for some patients; and v)

⁶ Defendants say that if Centurion identified significant problems attributable to the absence of social transition accommodations, Centurion’s leadership could raise it with FDC and they could discuss it. Response at 42. But a Centurion official testified that there is no process for that, and the Multi-Disciplinary Services Teams know there is no process. Tr. 438:18–439:18 (Watkins-Ferrell). In any case, Defendants are *already aware* of the harm to patients based on patient medical records and now, the testimony of Centurion witnesses at trial.

would continue providing it if policy permitted it. These facts establish that the continued categorical denial of this care without considering individual patient need constitutes deliberate indifference to a serious medical need whether or not there is a medical consensus supporting this care.

Gibson v. Collier, 920 F.3d 212 (5th Cir. 2019), does not stand for the proposition that where a department of corrections knows that a particular treatment has significantly alleviated a serious medical condition and that the denial of that treatment is causing a significant worsening of that condition for some patients, it may nevertheless categorically deny that care regardless of patients' need for it unless Plaintiffs prove that there is a consensus in the medical community supporting that care.⁷ Even if one could stretch *Gibson* to apply in such cases, it would fly in the face of longstanding Eighth Amendment law.

⁷ Nor does *Keohane I* support such a proposition (even if the court's statement that a "difference in medical opinion between the prison's medical staff and the inmate as to the latter's . . . course of treatment [cannot] support a claim of cruel and unusual punishment," *id.* at 1274, could be read to extend to disagreement in general within the medical field about the appropriateness of a particular treatment) (citations omitted)). The *Keohane I* court made clear that failing to consider a treatment when there is an "acknowledged medical need" is "the very definition of 'deliberate indifference.'" *Id.* at 1266–67 (citation omitted).

There is no basis for Defendants' assertion that the *Keohane I* court's recognition that blanket bans on treatment for gender dysphoria that deny treatment even when medically necessary evince deliberate indifference does not apply to social transition accommodations. The opinion does not support such a carve out. The court said:

In any case, Plaintiffs have demonstrated that social transition is a well-established treatment for gender dysphoria recognized in all clinical practice guidelines for treating gender dysphoria,⁸ recognized by every major professional medical association, and acknowledged by Drs. Martinez and Kline. *See* Pls.’ Brief at 52. This is a medical consensus as contemplated in *Gibson* as it is not a topic about which there is a “robust and substantial good faith disagreement dividing respected members of the expert medical community.” *Gibson*, 920 F.3d at 220.

Unsurprisingly 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. *See, e.g., Fields v. Smith*, 653 F.3d 550, 559 (7th Cir. 2011); *see also Hicklin v. Precynthe*, No. 4:16-CV-01357-NCC, 2018 WL 806764, at *11 (E.D. Mo. Feb. 9, 2018); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 247 (D. Mass. 2012).

Id. at 1267. One of the cases cited by the court specifically held that the plaintiff was likely to succeed on her Eighth Amendment claim that defendants were deliberately indifferent by failing to provide “‘gender-affirming’ canteen items.” *Hicklin*, 2018 WL 806764, at *12–13. And the issues in another of the cases cited included the denial of access to female canteen items and clothing. *Soneeya*, 851 F. Supp. 2d at 246. Relatedly, Defendants erroneously assert that the “distinction between social accommodations and other treatment for gender dysphoria distinguishes this case from” *Hicklin*. Response at 17.

⁸ Contrary to Defendants’ suggestion, the fact that the clinical practice guidelines recommending social transition to treat gender dysphoria are not “mandatory standards” does not negate that they represent the prevailing protocols for treatment. Response at 14. Plaintiffs have never characterized any medical clinical practice guidelines as “mandatory.”

Defendants baldly assert that the evidence at trial established a “genuine professional dispute over the medical necessity and appropriateness of providing social accommodations,” Response at 16, but it did no such thing. Defendants point to the fact that Dr. Kaliebe, when asked “[i]s it your opinion that a consensus exists within the medical community that social accommodations are appropriate and necessary,” responded “[n]o, I do not think there’s a consensus.” *Id.* at 9–10. But Dr. Kaliebe has barely any experience with this patient population, Tr. 823:9–23 (Kaliebe), and Defendants offered no evidence substantiating a lack of consensus. Defendants point only to the fact that Dr. Kaliebe and Drs. Martinez and Kline have a “contrary professional view.” Response at 15. Even under *Gibson*, consensus does not mean “unanimity,” and the existence of individual dissenting views does not establish a lack of consensus that permits prisons to categorically deny a treatment to anyone regardless of patient need. *Gibson*, 920 F.3 at 220.

If the fact that some individual doctors disagree with widely accepted protocols for the treatment of particular conditions were sufficient to permit prisons to categorically ban those treatments, prisons would be free to deny *any* medical treatment to patients regardless of their need for it. For almost any disorder, there are some doctors who disagree with even broadly-recommended treatments. Tr. 36:15–37:12 (Karasic). Just looking at the news, there are plenty of examples of doctors who oppose well-accepted medical treatments. *See e.g.*, Kristina Fiore, *What*

proportion of doctors are vaccine hesitant?, MedPageToday (Apr. 13, 2022)

<https://www.medpagetoday.com/special-reports/exclusives/98196>

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[<https://perma.cc/D464-8WA9>] (discussing prominent doctor who opposed

treatment of HIV with anti-retroviral drugs because he rejected that HIV causes

AIDS). Under Defendants’ erroneous reading of the law, prisons could deny all

inmates vaccines, HIV medication, and countless other treatments.

Moreover, Drs. Martinez’ and Kline’s “contrary professional view concerning the necessity and efficacy of social accommodations” rests only on the fact that after reviewing scientific literature, “[they] found no strong evidence indicating that social accommodations are medically necessary.” Response at 15. Dr. Kaliebe “likewise” opined that social transition accommodations are not supported by “the standard of evidence in order to be medically necessary.” *Id.* at 16. Defendants specifically point to the fact that the body of research supporting this care is “low certainty” or “low quality” evidence, as opposed to randomized controlled clinical trials, which are considered higher certainty evidence. *Id.* at 11–13. But the undisputed evidence showed that most medical treatments are supported by “low

certainty” evidence. Tr. 30:15–31:7 (Karasic); *see also* Tr. 833:17–23 (Kaliebe) (agreeing that many medical and mental health treatments are supported solely by low certainty evidence). The evidence also showed that FDC provides other treatments to patients that are supported only by “low certainty” evidence, Tr. 693:2–6 (Martinez), as does Dr. Kaliebe. Tr. 833:17–834:5 (Kaliebe). The fact that a treatment is supported by “low certainty” evidence does not establish a lack of medical consensus concerning the appropriateness of that treatment. If that were a sufficient basis for prisons to categorically deny a treatment, again, they would be free to deny most medical treatments that people depend on for their health.⁹

Moreover, where, as here, the evidence showed that social transition accommodations are, in fact, medically necessary for some individuals, rescinding this care that has been shown to be effective for these individuals for the purported reason that the research supporting this care is not higher certainty research is preposterous and does not overcome the deliberate indifference.

Finally, Defendants appear to suggest that because Dr. Karasic and Dr. Joshi testified that social transition accommodations “can be” medically necessary,

⁹ Defendants also suggest that studies of social transition specific to the correctional setting are required to establish the medical necessity of this treatment for incarcerated people. But Dr. Kline testified that FDC does not limit medical treatment to those that have been studied on incarcerated populations. Tr. 755:21–24 (Kline). And as Dr. Karasic explained, there is nothing about being incarcerated that would make the benefits of social transition any different. Tr. 28:24–29:20 (Karasic).

depending on the person—as opposed to that they *are* medically necessary for *all* patients with gender dysphoria—there is a lack of a consensus about the medical necessity. Response at 9–10. This makes no sense. If only care that was deemed medically necessary for every person with a condition were deemed to meet a consensus requirement for Eighth Amendment protection, huge swaths of treatment would be excluded from Eighth Amendment protection.

Ultimately, this argument is another example of Defendants asking the Court to create new requirements for bringing an Eighth Amendment deliberate indifference claim. If accepted, a requirement for medical necessity of a treatment for *every* patient with a condition would make it impossible to establish that a categorical denial of *any* particular medical treatment that they have a demonstrated need for violates the Constitution.

VIII. Defendants’ arguments about Plaintiffs’ experts are baseless.

Defendants assert that Plaintiffs’ experts lack credibility. They overlook that Plaintiffs’ claims are also established by evidence from FDC’s own medical providers. But in any case, Defendants’ assertions regarding Plaintiffs’ experts—which largely repeat the arguments made in Defendants’ motions to exclude them that were rejected by this Court—are baseless or irrelevant.

A. Dr. Karasic

Defendants argue that because Dr. Karasic’s testimony did not go to whether denying social accommodations “falls below the constitutional minimum,” his opinions should be afforded little weight. Response at 43–44. By insisting that Dr. Karasic should have applied the Eighth Amendment’s constitutional test rather than offer testimony based on accepted medical principles, Defendants misstate the purpose of expert testimony. Dr. Karasic is a psychiatrist opining on the importance of social transition in the treatment of gender dysphoria. Ex. 150 (Karasic CV). His expert opinions in this case are appropriately confined to his area of medical expertise, including explaining the clinical nature of gender dysphoria and the evidence establishing the medical necessity of social transition to alleviate this condition. Tr. 12:4–25, 13:4–14:3, 14:7–15:13 (Karasic). At trial, Dr. Karasic 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), and that to not have access to social transition would be “expected to be harmful to those[] suffering from gender dysphoria.” Tr. 38:10–13 (Karasic). And consistent with Fed. R. Evid. 702, he does not offer any

opinion on the ultimate legal question of whether FDC's actions constitute an Eighth Amendment violation.¹⁰

Defendants next suggest that Dr. Karasic's testimony is not relevant to issues before this Court because he did not testify about the named Plaintiffs' conditions or about individual treatment needs of inmates within FDC. Response at 44–45. Again, Defendants' critique is puzzling, as Dr. Karasic never purported to opine on the medical needs of any specific individual. Rather, he offered his expert opinion on gender dysphoria and its treatment, and how FDC's blanket ban puts individuals with gender dysphoria at risk of serious harm to their mental health. Tr. 25:11–27:14, 29:21–30:11, 33:8–35:6, 37:16–20, 38:5–42:12 (Karasic). Dr. Karasic's testimony is squarely relevant to understanding whether FDC's blanket ban on social accommodations violates the Eighth Amendment.

Finally, Defendants lodge the same baseless attack against WPATH and its guidelines and once again suggest that Dr. Karasic's opinions turn on the WPATH guidelines. Response. 45–46. But Dr. Karasic made clear at trial that his opinions would be the same whether or not the WPATH guidelines existed. Tr. 52:8–53:2

¹⁰ Rule 702 makes clear that, while a “qualified expert in a civil case may offer his opinion on an ‘ultimate issue’ in a case, Fed. R. Evid. 704(a), experts ‘may not testify to the legal implications of conduct.’” *Commodores Ent. Corp. v. McClary*, 879 F.3d 1114, 1128 (11th Cir. 2018) (citation omitted); *see also Cook ex rel. Est. of Tessier v. Sheriff of Monroe Cnty., Fla.*, 402 F.3d 1092 (11th Cir. 2005) (testifying experts may not offer legal conclusions).

(Karasic). As he 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, 36:6–14, 52:8–53:8 (Karasic). And as discussed in Plaintiffs' Closing Brief, there is no basis for the critique lodged against WPATH. Pls.' Brief 52–53.

B. Dr. Evans

Defendants assert that the fact that Dr. Evans could not identify examples of patients in her clinical experience for whom social transition would not be medically necessary raises concern about the independence of her medical necessity opinion. Response at 47. It does not. As Dr. Evans testified, she is a clinical psychologist, so her patients are those who need treatment. Tr. 476:9–10, 478:19–480:20 (Evans). Given that social transition is a well-recognized intervention for gender dysphoria, it is not surprising that she considers it medically necessary for each of her patients with gender dysphoria. Tr. 33:8–35:6, 37:16–20 (Karasic). One would not question a doctor who could not think of a Type 1 Diabetic for whom insulin was not medically necessary.

Next, Defendants suggest that Dr. Evans' opinions are not reliable because they relied on subjective reporting. Response at 47–48. As Dr. Evans explained at trial, she conducted clinical interviews of Plaintiffs using protocols that are typical for psychological evaluations and spent 180 hours reviewing thousands of pages of

Plaintiffs’ medical records. Tr. 484:15–21, 484:25–485:4, 485:16–18, 486:9–21 (Evans). It is undisputed that psychological evaluations typically involve clinical interviews and a review of medical records if available. FDC’s own healthcare providers follow the same protocol utilized by Dr. Evans in conducting psychological evaluations to determine the treatment needs of patients with gender dysphoria. Tr. 454:24–455:13 (Joshi) (testifying that in conducting these evaluations, she conducts a record review and a clinical interview of the patient).

Dr. Evans’ mental health assessments of Plaintiffs are not only reliable and the result of protocols used by experts in the field of psychology, but her conclusions are also consistent with the assessments of FDC’s own healthcare providers. *See e.g.* Tr. 468:11–15 (Joshi); Ex. 12 (Diamond Medical Record) at 13 (anticipating that Plaintiff Diamond may “further decompensate” without accommodations).

Defendants grasp at straws by bizarrely claiming that Dr. Evans’ opinions are unreliable because she “did not tour the higher-level mental health units” within FDC. Response at 48. Defendants provide no explanation for how touring those facilities is relevant to, or necessary for, Dr. Evans to provide her expert opinion on Plaintiffs’ need for social transition accommodations.

Defendants also critique Dr. Evans for not conducting a “representative before-and-after population analysis” or “any type of reliable, randomized review” in offering her opinions. *Id.* Dr. Evans was retained to evaluate the impact on

Plaintiffs of having access to social transition accommodations, and of the denial of those accommodations. Pls.’ Brief at 20–21. She is not offering opinions on the impact of social accommodations on the entire class, nor, as discussed above does the Eighth Amendment’s protection for medically necessary care turn on the number of people harmed by a prison’s deliberate indifference.

Finally, Defendants fault Dr. Evans for not engaging in a comparative analysis detailing “whether Plaintiffs engaged in more self-harm in the roughly comparable periods before and after the HSB.” Response at 48–49. But self-harm is not the only harm suffered by Plaintiffs due to the loss of accommodations. Moreover, given the fact that other factors can also lead to self-harming behavior, as Defendants have noted, such a quantitative analysis of self-harm would not assess the impact of the loss of accommodations.¹¹

IX. Classwide relief is necessary.

Plaintiffs’ requested relief is straightforward—they seek the removal of a blanket policy that denies class members social accommodations irrespective of medical necessity. Defendants mischaracterize the relief sought by Plaintiffs and the

¹¹ Defendants also try to make much of a single factual mistake in her report that Dr. Evans acknowledged regarding whether one of the Plaintiffs had a shower pass that was rescinded. That one factual error in five comprehensive lengthy reports (developed from over 180 hours of records review and twenty hours of clinical interviews) does not call into question the overall reliability of her reports and conclusions. Response at 48.

class as “a uniform classwide entitlement to social accommodations.” Response at 49. That is not what Plaintiffs are seeking. Plaintiffs and class members are simply asking for individualized assessments so that if their healthcare providers deem social transition accommodations medically necessary for them, they can provide it as they did prior to the HSB. Pls.’ Brief at 56–57. *See also* Plaintiffs’ Trial Memo. at 30, Dkt. 180.

A categorical ban on social transition accommodations without considering individual medical need puts all patients with gender dysphoria at risk of serious harm and thus, classwide relief is necessary to prevent that harm. Moreover, to require hundreds of members of the class to separately bring a lawsuit to demonstrate harm would undercut the very purpose of class action litigation. *See Klay v. Humana, Inc.*, 382 F.3d 1241, 1270 (11th Cir. 2004) (quoting *Upshaw v. Ga. Catalog Sales, Inc.*, 206 F.R.D. 694, 701 (M.D. Ga. 2002) (“[E]ven if sufficient incentive existed for individual claimants to pursue their claims separately, class action treatment is far superior to having the same claims litigated repeatedly, wasting valuable judicial resources.”)).

Plaintiffs’ requested relief is narrowly tailored to prevent that harm, as permanently enjoining FDC’s blanket ban of social transition accommodations would allow FDC healthcare providers to conduct individualized assessments of

Plaintiffs and class members and provide accommodations where medically necessary.

Conclusion

For the foregoing reasons, FDC's ban on social transition accommodations violates the Eighth Amendment and should be permanently enjoined.

Respectfully submitted,

Dated: September 11, 2026

/s/ Li Nowlin-Sohl

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CERTIFICATE OF COMPLIANCE

I certify that the substantive portion of this brief contains 6,973 words.

Dated: September 11, 2026

/s/ Li Nowlin-Sohl