

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF WISCONSIN

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ALINA BOYDEN and  
SHANNON ANDREWS,

Plaintiffs,

Case No. 17-cv-264

v.

STATE OF WISCONSIN DEPARTMENT  
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

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**PLAINTIFFS' BRIEF IN SUPPORT OF MOTION *IN LIMINE* TO EXCLUDE  
EVIDENCE OR TESTIMONY FROM DR. LAWRENCE S. MAYER**

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Plaintiffs, Alina Boyden and Shannon Andrews, (collectively "Plaintiffs"), through their undersigned attorneys, submit this brief in support of their Motion *in Limine* to preclude Defendants, along with their witnesses and/or counsel, from directly or indirectly offering the testimony of, or documents generated by Dr. Lawrence S. Mayer at trial or any subsequent stage of this case pursuant to Federal Rules of Evidence 702 and 403.

**INTRODUCTION**

Plaintiffs are transgender women, meaning the gender assigned to them at birth does not reflect their core understanding of their gender, or gender identity, as women. (Dkt. # 96, Plaintiffs' Proposed Findings of Fact ¶¶ 5, 24). Plaintiffs have been diagnosed with gender dysphoria, a medical condition characterized by severe distress due to an incongruence between their sex assigned at birth and their

gender identity. (Dkt. # 96, ¶¶ 8, 13). Plaintiffs have been prescribed hormone therapy and gender confirmation surgery (“GCS”) to treat their gender dysphoria. (Dkt. # 96, ¶¶ 18, 31).

Plaintiffs filed suit on April 7, 2017, asserting discrimination claims under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, *et seq.*, the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution, U.S. Const. amend. xiv, § 1, and the Patient Protection and Affordable Care Act, § 1557, 42 U.S.C. § 18116, based on Defendants’ adoption and enforcement of a categorical exclusion of coverage for “procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment” across all state employee health insurance plans. (Dkt. # 96, ¶ 43).

In connection with this suit, Defendants retained Dr. Lawrence S. Mayer to opine “on the efficacy, safety, and optimality of hormonal and surgical interventions for the treatment of gender dysphoria.” (Dkt. # 90, Expert Report of Dr. Lawrence S. Mayer (“Mayer Report”), p. 1). In his Report, Dr. Mayer—who is not licensed to practice medicine and, in fact, has never treated patients (other than as a student)—asserts that “[m]edical and surgical treatments have not been demonstrated to be safe and effective for gender dysphoria.” (Dkt. # 112, Mayer Dep. at 7:5-6; Dkt. # 90, Summary of Opinions, ¶ 6).

As an initial matter, Dr. Mayer’s testimony is irrelevant to this case. Whether medical and surgical treatments have been definitively proven to be safe and effective treatment for all people with gender dysphoria is not at issue in this

case. Safety and efficacy of the treatment played no role in Defendants' decision to exclude coverage for such treatment, and many other medical treatments are covered which do not have "definitive proof" of their safety and efficacy. Therefore, Dr. Mayer's testimony should be excluded under Fed. R. Evid. 702 and 403, as its limited probative value is outweighed by the danger of confusing the issues and misleading the jury to believe that they must find definitive proof of safety and efficacy of the denied treatment in order to find for Plaintiffs.

Even if Dr. Mayer's testimony were relevant to this matter, it should be excluded under Fed. R. Evid. 702, which requires expert witnesses to be sufficiently *qualified* and their testimony to be *reliable*. Dr. Mayer's qualifications and methodology fail this requirement. Dr. Mayer offers scant explanation and dubious support for the opinions presented in his Report, instead relying heavily on his own published work, which has been almost universally denounced within the scientific community. Further, Dr. Mayer expresses several clinical opinions, which are outside the scope of his qualifications. Dr. Mayer's testimony fails to meet the requirements for admissibility set forth in Fed. R. Evid. 702 and, as such, should be excluded from consideration in this matter.

### **ARGUMENT**

#### **I. Fed. R. Evid. 702 Permits Admission Only of Relevant, Reliable Expert Testimony.**

Under Fed. R. Evid. 702, expert witness testimony may be admitted only if:

a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; b) the testimony is based on sufficient facts or data; c) the testimony is the product of reliable principles and methods; and d) the expert has reliably applied the principles and methods to the facts of the case.

In assessing the admissibility of expert testimony, courts act as an “evidentiary gatekeeper,” ensuring that the testimony is both reliable and relevant. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 597 (1993). District courts “must evaluate: (1) the proffered expert’s *qualifications*; (2) the *reliability* of the expert’s methodology; and (3) the *relevance* of the expert’s testimony.” *Gopalratnam v. Hewlett-Packard Co.*, 877 F.3d 771, 779 (7th Cir. 2017) (emphasis added). The party offering the expert testimony has the burden of establishing that the proffered testimony satisfies Fed. R. Evid. 702. *Real Estate Value Co. v. USAir, Inc.*, 979 F. Supp. 731, 743-44 (N.D. Ill. 1997).

**II. Dr. Mayer’s Opinion on the Safety and Efficacy of Medical and Surgical Treatments for Gender Dysphoria Fails the “Helpfulness Test” Because It Does Not Assist the Jury in Determining a Fact in Issue and Is Likely to Mislead or Confuse the Jury.**

First, under Fed. R. Evid. 702(a), testimony is permissible only if the expert’s “scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.” Dr. Mayer’s opinion fails this element of Fed. R. Evid. 702. His testimony will not assist the jury in determining a fact at issue because the methodological strength of studies which show that gender confirmation treatments are safe and effective in treating gender

dysphoria is not in issue in this case. Further, even if Dr. Mayer's opinion had some probative value, it would be outweighed by the risk of confusing the issues and misleading the jury to believe that they must decide whether gender confirmation surgery is medically safe and effective. For these reasons, Dr. Mayer's testimony should be excluded under Fed. R. Evid. 702 and 403.

**A. Dr. Mayer's Opinion Does Not Assist the Jury in Determining a Fact in Issue Because the Safety and Efficacy of Treatments for Gender Dysphoria is Not in Issue in This Case.**

Dr. Mayer's report fails the first element of Fed. R. Evid. 702 because it will not "help the trier of fact understand the evidence or to determine a fact in issue." Fed. R. Evid. 702(a). The "helpfulness factor" has two elements: 1) does the testimony help the jury understand an issue which is outside of a layperson's general knowledge; and 2) is that issue relevant to the case, *i.e.* is it "a fact in issue"? *See United States v. Curry*, 977 F.2d 1042, 1051-52 (7th Cir. 1992).

Dr. Mayer's testimony fails because it is irrelevant. His opinion that medical and surgical treatments for gender dysphoria have not yet been definitively proven to be safe and effective, is not a fact at issue in this case. Rather, the issue is whether Defendants discriminated against Plaintiffs by excluding coverage for their gender confirmation treatment. Plaintiffs need not show that these treatments have been definitively proven to be safe and effective in order to prevail on their claims. Definitive proof of safety and effectiveness of treatment is impossible, and "definitive proof" is not the standard by which medical treatment or insurance coverage is evaluated; if it were, many treatments would never be covered at all.

(See Dkt. # 106, Expert Witness Report of Loren S. Schechter, M.D., p. 19). It is undisputed that qualified treatment providers have prescribed Plaintiffs gender confirmation surgery and hormone therapy to treat their gender dysphoria. (Dkt. # 96, ¶¶ 8, 13). Dr. Mayer does not (and cannot) opine that this treatment is *ineffective* or *unsafe*. He also acknowledges that he cannot opine as to whether such treatments (or, indeed *any* treatment) would be effective for individual patients or medically necessary for individual patients. (Dkt. # 112 at 72:8-19; 23:3-8; 64:1-3; 65:5-8). In short, his opinion has absolutely no bearing on whether Defendants' decision to issue a blanket exclusion of all medical and surgical treatment for gender dysphoria was discriminatory.

Further, Dr. Mayer's opinion is irrelevant because the safety and efficacy of gender confirmation surgeries was not considered as part of GIB's decision to reinstate the exclusion for these treatments. (Dkt. # 96, ¶ 111). As explained fully in Plaintiff's Brief in Support of Their Motion for Partial Summary Judgment, Defendants' arguments regarding the costs of gender confirmation treatment are mere *post hoc* justifications created in response to litigation and did not actually motivate Defendants' decision to reinstate the exclusion and therefore are not a legally valid defense to any of Plaintiffs' claims. (Dkt. # 97, pp. 29-31 (*post-hoc* rationalizations do not satisfy heightened equal protection scrutiny); *see also Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 199 (1991) ("Whether an employment practice involves disparate treatment [under Title VII] through explicit facial discrimination

does not depend on why the employer discriminates but rather on the explicit terms of the discrimination”).<sup>1</sup> GIB members did not consider safety and efficacy of these treatments when they voted to reinstate the exclusion. (Dkt. # 113, Plaintiffs’ Response to Defendants’ Proposed Findings of Fact, ¶ 67). They did not discuss safety and efficacy prior to voting on the exclusion. *Id.* They did not have Dr. Mayer’s report when they made their decision. The lack of “definitive proof” that gender confirmation surgery is safe and effective played absolutely no role in Defendants’ decision to reinstate the coverage exclusion which is the subject of this case and therefore has no bearing on any “fact in issue” which the jury must decide. Because Dr. Mayer’s testimony fails the “helpfulness” test of Rule 702(a), it should be excluded.

**B. Dr. Mayer’s Opinion Should Be Excluded Under Rule 702 and 403 Because it Is Likely to Confuse the Issues or Mislead the Jury.**

Even if Dr. Mayer’s opinion had some relevance to the issues in this case, his testimony should be excluded because any scant probative value it could have is outweighed by the danger of misleading the jury into believing that it must decide whether medical and surgical treatment for gender dysphoria has been definitively

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<sup>1</sup> This Court has already determined in this case that “facial discrimination is a flavor of disparate treatment – one in which the burden-shifting framework of *McDonnell Douglas* is inappropriate.” (Dkt. # 67, Opinion and Order on Defendants’ Motion to Dismiss, p. 17, n.13) (citing *See Reidt v. Cty. of Trempealeau*, 975 F.2d 1336, 1340–41 (7th Cir. 1992); *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973)). Because *McDonnell Douglas* burden-shifting is inappropriate on Plaintiffs’ Title VII claim, Defendants’ purported legitimate non-discriminatory reason for reinstating the exclusion is irrelevant.

Because the ACA’s non-discrimination provisions incorporate the standards of other non-discrimination statutes, *see Prescott v. Rady Children’s Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098 (S.D. Cal. 2017), *post-hoc* non-discriminatory justifications are also irrelevant to Plaintiffs’ section 1557 claims.

proven to be safe and effective. However, as explained above, this is not an issue that the jury must decide in this case.

Under Fed. R. Evid. 403, even relevant evidence may be excluded “if its probative value is substantially outweighed by a danger of . . . confusing the issues [or] misleading the jury.” The court’s role in excluding evidence that has a danger of confusing the issues or misleading the jury is especially important in evaluating the testimony of expert witnesses “due to the fact that ‘[e]xpert evidence can be both powerful and quite misleading because of the difficulty in evaluating it. *Gopalratnam*, 877 F.3d at 778-79 (internal citations removed). Courts have therefore included Fed. R. Evid. 403 considerations into the Fed. R. Evid. 702 analysis of expert witness admissibility. *See United States v. Curry*, 977 F.2d 1042, 1051 (7th Cir. 1992).

Evidence poses a danger of confusing the issues or misleading the jury when it could lead the jury to a mistaken inference. For example, courts have excluded evidence under Fed. R. Evid. 403 in the following instances: evidence regarding competency evaluations when the defendant’s competency to stand trial was not at issue, *see United States v. Wolling*, 223 F. App’x 610, 612-13 (9th Cir. 2007); an expert psychologist’s testimony regarding the defendant’s personal philosophy and view of the justice system, as it could mislead the jury into believing his philosophy “amounts to a form of temporary insanity or ameliorates the offense,” *see United States v. Ahrendt*, 560 F.3d 69, 76 (1st Cir. 2009); and evidence of a demand letter which referred to unpleaded allegations, as it would “serve to confuse and mislead

the jury about the nature of the claims in [the] case,” *see Coquina Invs. v. Rothstein*, No. 10-60786-Civ, 2012 U.S. Dist. LEXIS 139947, at \*54-55 (S.D. Fla. Sep. 28, 2012). In sum, courts must look to the fit or “helpfulness factor” between the proposed evidence and the facts at issue, and exclude evidence which does not have sufficient relevance to outweigh the danger of confusing or misleading the jury. *See Curry*, 977 F.2d at 1051.

Dr. Mayer’s ultimate opinion is that “[t]here is little evidence that medical and surgical interventions reduce the incidence and prevalence of gender dysphoria.” (Dkt. # 90, Conclusion, p. 10). Because Dr. Mayer is unqualified to testify regarding the clinical treatment of individuals with gender dysphoria (*see* Section IV, below), his testimony will necessarily instead focus on his critique of the multitude of studies which show that these interventions *are* safe and effective. (*See, e.g.*, Dkt. # 119, Supplemental Expert Witness Report of Stephanie Budge, Ph.D., pp. 6-9). Dr. Mayer’s testimony on this issue will inevitably lead to a mini-trial regarding the dependability and scientific rigor of these individual studies. Such testimony would pose a significant danger that the jury will be misled into believing that they must decide whether these treatments have been definitively proven to be safe and effective for every person with gender dysphoria. Yet that is not an issue in this case.

Dr. Mayer’s opinion is also misleading because it is undisputed that many commonly used medical treatments also lack definitive proof of safety and efficacy. Indeed, the medical evidence which supports the use of medical and surgical

treatment for gender dysphoria is “at least as good, if not better, than the evidence supporting other commonly provided medical and surgical treatments.” (Dkt. # 106, p. 19). Dr. Mayer himself acknowledged in his deposition that *many* widely-used medical treatments lack the strong scientific evidence of efficacy and safety which he seeks to apply to the treatments at issue in this case:

Q: I'm asking in general, aren't there other conditions where we provide treatment where there is not a great deal of research supporting the particular kind of treatment?

A: Yes, sir. *Probably half the treatments we do are not supported by strong scientific research.* That doesn't mean we don't strive to do more, particularly in areas so politically charged as this.

(Dkt. # 112 at 81:12-19 (emphasis added)).

In short, though Dr. Mayer opines that strong scientific research does not support a conclusion that medical and surgical treatments for gender dysphoria are safe and effective, his opinion equally applies to many other widely-accepted treatments. Dr. Mayer's opinion, at its heart, is really a condemnation of the current state of all medical research. Yet his testimony will mislead the jury into believing, incorrectly, that the scientific support for medical and surgical treatment for gender dysphoria is particularly weak as compared to other medical treatments. Dr. Mayer's testimony should be excluded because it is likely to mislead the jury into drawing an improper inference that treatment for gender dysphoria was properly excluded from the Uniform Benefits because it is untested and unproven

compared to other widely-accepted medical interventions. Fed. R. Evid. 702 and 403.

**III. Dr. Mayer's Methods Are Deeply Flawed, Rendering His Opinion Unreliable.**

Dr. Mayer's testimony should also be excluded because it fails every test of reliability. His opinions are unsubstantiated by reliable data, have been denounced by the scientific community, and have not been subjected to peer review. Even a "supremely qualified expert cannot waltz into the courtroom and render opinions unless those opinions are based upon some recognized scientific method and are reliable . . . ." *Clark v. Takata Corp.*, 192 F.3d 750, 759 n.5 (7th Cir. 1999). When determining the reliability of expert testimony, the court should evaluate the underlying principles and methodology, rather than any conclusions proffered by the expert. *Daubert*, 509 U.S. at 595; *see also Smith v. Ford Motor Co.*, 215 F.3d 713, 718 (7th Cir. 2000) ("[W]e emphasize that the court's gatekeeping function focuses on an examination of the expert's methodology").

In doing so, courts should consider "amongst other factors: '(1) whether the proffered theory can be and *has been tested*; (2) whether the theory has been *subjected to peer review*; (3) whether the theory has been *evaluated in light of potential rates of error*; and (4) whether the theory has been *accepted in the relevant scientific community*.'" *Gopalratnam*, 877 F.3d at 779 (emphasis added). Courts are not bound by these factors when analyzing the reliability of expert testimony. Rather, the test of reliability is "flexible" and "a trial court may consider one or more of the more specific factors that *Daubert* mentioned when doing so will

help determine that testimony's reliability.” *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 141 (1999). Under any test of reliability, Dr. Mayer’s opinion fails.

**A. The Mayer Report Lacks Sufficient Factual or Scientific Basis.**

The Mayer Report contains citations to only three secondary sources, which themselves are wholly inadequate and unreliable. Two of these sources are Dr. Mayer’s own work—a literature review and an amicus brief—which have been widely rejected by the scientific community. The third source, a study by the Centers for Medicare and Medicaid Services, is used out of context in support of Dr. Mayer’s conclusion that “evidence that these interventions are safe, effective, and optimal is minimal.” (Dkt. # 90, ¶ 20). Sections III.B-D address more fully the inadequacy of these citations as support for Dr. Mayer’s opinions.

Further, the Mayer Report includes several conclusory statements that appeal to “common sense,” but are not supported by any factual or scientific evidence. The U.S. Supreme Court has held that courts should exclude expert testimony “that is connected to existing data only by the *ipse dixit* of the expert.” *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997). The Mayer Report contains several such statements, for example:

There is emerging theory that gender identify is innate and immutable. Components of this theory are described in the report of Dr. Budge. *It makes no sense . . . . Beyond any doubt, sex is biological* and, as such cannot depend on cultural constructs . . . . *Not only is this definition of sex inconsistent with fundamental biology as taught in every Biology 101 course* across the country, but to say that a cultural construct ought to be the “primary factor” in the definition of a biological concept is wholly inconsistent with basic scientific principles.

(Dkt. # 90, ¶ 5-9) (emphasis added). Dr. Mayer offers no citations of any kind for these bold assertions. Instead, Dr. Mayer relies on his understanding of what makes “sense”—a tactic that has been rejected in this Circuit. *See Hartman v. EBSCO Industries, Inc.*, 758 F.3d 810, 818 (7th Cir. 2014) (excluding testimony from expert who based his theory on “common sense” without testing his theory, receiving peer review, or discussing error rates).

Because Dr. Mayer’s opinions lack scientific support, it is not sufficiently reliable to qualify as expert testimony.

**B. The *New Atlantis* Article Underpinning the Mayer Report Is Unreliable and at Odds with the Consensus Within the Scientific Community.**

The bulk of the “support” for Dr. Mayer’s conclusions is his own widely-rebuked article published in *The New Atlantis* (the “*New Atlantis* Article”), a non-peer-reviewed journal issued by the Ethics and Public Policy Center, a conservative Christian think-tank “dedicated to applying the Judeo-Christian moral tradition to critical areas of public policy.” (Dkt. # 90-4, Lawrence S. Mayer and Paul R. McHugh, *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, *The New Atlantis* (entire special issue) Fall (2016)); (Ex. A, *About EPPC*, Ethics & Public Policy Center, <https://eppc.org/about/>.) The *New Atlantis* Article is a summary of certain scientific and non-scientific articles Dr. Mayer reviewed regarding “mental health issues faced by LGBT populations.” (Dkt. # 90-4 at pp. 1, 6). The *New Atlantis* Article, which serves as the Mayer Report’s primary reference, is so methodologically flawed as to be completely unreliable.

Under no measure could the *New Atlantis* Article, and the methods and principles Mayer and his co-author used to produce it, be considered generally accepted within the scientific community. Courts should consider whether a technique is generally accepted as reliable in the scientific community when analyzing the reliability of an expert's methods. *Daubert*, 509 U.S. at 580-81, 594 (“Widespread acceptance can be an important factor in ruling particular evidence admissible, and ‘a known technique which has been able to attract only minimal support within the community’ may properly be viewed with skepticism.”) (internal citation omitted). In response to the *New Atlantis* Article, nearly six hundred (600) researchers and experts on LGBTQ health signed a letter denouncing it for “*mislead[ing] readers about the state of scientific research and evidence-based clinical practice guidelines addressing the health of [LGBTQ] people*” and affirming that “*the report’s conclusions do not reflect current scientific or medical consensus about sexual orientation or gender identity research findings or clinical care recommendations.*” (Ex. B, Letter from researchers and experts on *New Atlantis* report (Mar. 22, 2017), *Expert LGBTI Consensus Letter*, Vanderbilt University MedicalCenter, [https://www.vumc.org/lgbti/files/lgbti/publication\\_files/ExpertLGBTI\\_ConcensusLetter.pdf](https://www.vumc.org/lgbti/files/lgbti/publication_files/ExpertLGBTI_ConcensusLetter.pdf) (emphasis added).

Further, the *New Atlantis* Article effectively “cherry picks” data, citing to portions of studies without including the full context, as well as ignoring the existence of studies that do not support its hypotheses. Dr. Dean Hamer, geneticist and scientist emeritus at the National Institutes of Health who has studied the role

of genes in sexual orientation, described the *New Atlantis* Article as “a selective and outdated collection of references and arguments aimed at confusing rather than clarifying our understanding of sexual orientation and gender identity.” (Ex. C, Dean Hamer, *New ‘Scientific’ Study on Sexuality, Gender Is Neither New nor Scientific*, Advocate (Aug. 29, 2016), available at <https://www.advocate.com/commentary/2016/8/29/new-scientific-study-sexuality-gender-neither-new-nor-scientific>).

Similarly, Dr. Stephanie Budge has stated that “Dr. Mayer only focused on certain parts of studies that supported his point of view and excluded numerous other studies that did not support his point of view.” (Sept. 9, 2018 Budge Declaration at ¶ 5). Dr. Budge notes that Dr. Mayer relies primarily on outdated sources, while failing to consider more recent studies that contradict his theories. For example, the *New Atlantis* Article relies heavily on a 2004 report from Birmingham University (12 years prior to the *New Atlantis* Article’s publication), while ignoring the “substantial body of literature” published more recently. (Sept. 9, 2018 Budge Declaration at ¶ 3). Indeed, the most recent study cited in the “Therapeutic Interventions in Adults” section of the *New Atlantis* Article, was published in 2011, more than 7 years prior to Dr. Mayer’s expert report. (Sept. 9, 2018 Budge Declaration at ¶ 4).

In addition to being outdated, many of the studies cited in the *New Atlantis* Article are either flawed or misinterpreted by Dr. Mayer (or both). For example, the *New Atlantis* Article cites to a 2011 study comparing suicide rates for transgender people who received gender confirmation surgery to rates for the general

population, stating that the study “suggests that sex-reassignment surgery may not rectify the comparatively poor health outcomes associated with transgender populations in general.” (Dkt. # 90-4 at p. 11). However, the study has limited probative value, as it does not compare “transgender individuals who had gender confirmation surgeries with transgender individuals who did not have and wanted or did not have and did not want gender confirmation surgeries.” (Schechter Report at pg. 16 n.31). Further, the *New Atlantis* Article fails to address that more recent studies have compared transgender people who have had gender confirmation surgeries with transgender people who have not, and found that gender confirmation surgeries reduce suicidal ideation. (Budge Declaration at ¶ 9-10). Such “data cherry picking” is inherently unreliable and courts have unequivocally rejected experts who engage in this practice. *See, e.g., Barber v. United Airlines, Inc.*, 17 Fed. Appx. 433, 437 (7th Cir. 2001) (holding that “selective use of facts fails to satisfy the scientific method and *Daubert*”).

Given the innumerable flaws in the *New Atlantis* Article’s methodology and its utter rejection by the scientific community, it is no coincidence that it was not published in a peer-reviewed scientific journal—it could not have passed muster. The U.S. Supreme Court has recognized the importance of scientific scrutiny in ensuring “good science,” naming peer review as one of the enumerated factors that courts should consider when assessing the reliability of an expert:

*[S]ubmission to the scrutiny of the scientific community is a component of “good science,” in part because it increases the likelihood that substantive flaws in methodology will be detected.* The fact of publication (or lack thereof) in a peer reviewed journal thus will be a relevant, though not dispositive, consideration in assessing the scientific validity of a particular technique or methodology on which an opinion is premised.

*Daubert*, 509 U.S. at 593-94, (emphasis added) (internal citations omitted). Indeed, Dr. Mayer himself recognizes peer-reviewed journals as the “gold standard” in science. (Dkt. # 112 at 134:24-135-4).

The *New Atlantis* Article, which Dr. Mayer incorporates by reference in one of the only citations in his Report, fails each of the factors proscribed by Fed. R. Evid. 702 and *Daubert*. Indeed, it presents precisely the kind of dubious and unsubstantiated theories Fed. R. Evid. 702 was designed to exclude.

**C. The Amicus Brief Cited as Support in the Mayer Report Is Unreliable and at Odds with the Consensus Within the Scientific Community.**

The Mayer Report also cites to an amicus brief (the “Amicus Brief”) written by himself, Dr. Paul. R. McHugh (co-author of the *New Atlantis* Article), and Dr. Paul W. Hruz (Associate Professor of Pediatrics, Endocrinology, and Diabetes at Washington University in St. Louis School of Medicine, whose research centers on pediatric diabetes<sup>2</sup>) in the matter of *Gloucester County School Board v. G.G.*, then-pending before the U.S. Supreme Court, regarding a transgender high school student, Gavin Grimm, and his school’s discriminatory bathroom policy which prevented him from using the men’s bathroom in accordance with his gender

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<sup>2</sup> Ex. D, [http://research.peds.wustl.edu/faculty/hruz\\_paul\\_w](http://research.peds.wustl.edu/faculty/hruz_paul_w).

identity (Ex. E, Brief of Dr. Paul R. McHugh, Dr. Paul Hruz and Dr. Lawrence Mayer as Amici Curiae for Petitioner, *Gloucester Cnty. Sch. Bd. v. G.G.*, 136 S. Ct. 2442 (2016)). As with the *New Atlantis* Article, the Amicus Brief (and the theories proffered therein) contains none of the hallmarks of reliability—its theories have not been subjected to peer review and its methods have been wholly rejected by the relevant scientific community. *See Gopalratnam*, 877 F.3d at 779 (7th Cir. 2017).

The Amicus Brief overlaps significantly with the *New Atlantis* Article, meaning that it suffers from the same myriad of defects as does the *New Atlantis* Article—namely, data cherry-picking and interpretations far outside the mainstream scientific community. *See supra*. For instance, the Amicus Brief relies on a 1979 report (Jon K. Meyer and Donna J. Reter, *Sex Reassignment: Follow-up*, 36 Archives of Gen. Psychiatry 1010-15 (1979)) that is “extremely outdated by current standards but was even criticized at the time of publication because of serious methodological flaws.” (Schechter Report at p. 17). One such flaw is the “assignment of a negative value of minus one to persons who cohabitated with a person of ‘the non-gender appropriate sex’” when evaluating the efficacy of transition-related surgeries – *i.e.* that cohabitating with someone of “the non-gender appropriate sex” was deemed to indicate the surgery was ineffective. (Schechter Report at p. 17). Dr. Schechter states that “[i]t is unclear what such cohabitation was intended to imply and why it was given a negative value,” adding that there are numerous other examples of “value judgments and research bias that contaminate the findings.” (Schechter Report at p. 17).

Many of the flaws discussed above can be explained by anti-transgender animus, which may have clouded the authors' ability to view the scientific landscape with unbiased rigor. First, the Amicus Brief plainly reflects anti-transgender attitudes, consistently mis-gendering Mr. Grimm and demonstrating a profound misunderstanding of transgender people. For example, the Amicus Brief describes Mr. Grimm, a transgender boy, as “*a girl*, even though *she* feels the way *she* thinks a boy feels.” Amicus Brief at 10 (emphasis added). The Amicus Brief also dismisses transgender people as deluded by a “mistaken belief that is inconsistent with reality”:

Gender dysphoric boys subjectively feel as if they are girls, and gender dysphoric girls subjectively feel as if they are boys—according to their sense (at whatever stage of childhood they happen to be) of what that feeling of being a member of the opposite sex must be like. Yet those subjective feelings, strong as they may be, cannot and do not constitute (or transform) objective reality.

*Id.* at 9-11 (internal citations omitted).

Further, the Amicus Brief draws heavily on studies published by the American College of Pediatricians (the “ACP”), an organization classified by the Southern Poverty Law Center as an “anti-LGBT hate group.” (Ex. F, *Meet the Anti-LGBT Hate Group that Filed an Amicus Brief with the Alabama Supreme Court*, Southern Poverty Law Center (November 13, 2015), *available at* <https://www.splcenter.org/hatewatch/2015/11/13/meet-anti-lgbt-hate-group-filedamicus-brief-alabama-supreme-court>). In June 2016, the ACP issued a memorandum urging the Departments of Education and Justice to deny

transgender students the use of gender-appropriate restrooms and locker rooms and the right to compete on sports teams consistent with their gender identity. (Ex. G, Memorandum from the American College of Pediatricians, *A Medical Response to DOE & DOJ Guidance for Schools* (June 2016), available at <https://www.acped.org/wordpress/wp-content/uploads/5.26.17-a-medical-response-to-doe-and-doj-updated.pdf>). The memorandum goes on to deny the existence of transgender people as “fanciful”:

Despite the aforementioned scientific objections, one increasingly hears the fanciful claim that a child with gender dysphoria is born with a brain that is the opposite sex of his body. This is biologically impossible . . . . Children who identify as “feeling like the opposite sex” or “somewhere in between” do not comprise a third sex. They remain biological boys or biological girls.

*Id.* at 2-3. The ACP, which has approximately two hundred (200) to five hundred (500) members (Ex. H, Linda Keslar, *Crossing Over*, Proto Magazine (June 10, 2016), available at <http://protomag.com/articles/crossing-over>), was founded in 2002 in response to the American Academy of Pediatrics’ (the “AAP”) endorsement of same-sex adoption. (Ex. I, Nick Pinto, *University of Minnesota Professor’s Research Hijacked*, City Pages (May 26, 2010), available at <http://www.citypages.com/news/university-of-minnesota-professors-research-hijacked-6725473>). By contrast, the AAP has over sixty thousand (60,000) members. (<https://www.aap.org/en-us/Pages/become-Member.aspx>). The conclusions advanced by ACP and Dr. Mayer are contradicted by all major medical and psychiatric organizations; it cannot be plausibly disputed that transgender people exist and

that gender dysphoria is a real and serious medical condition. (Schechter Report at p. 9). Due to the lack of controls in the ACP studies—e.g. peer review—there is nothing to prevent the ACP’s plain anti-transgender animus from poisoning the results.

While the Amicus Brief’s methodological flaws are plain on its face, the clear anti-transgender animus motivating the Amicus Brief (and the studies upon which it relies) belies an important undercurrent of bias that precludes objective, scientific inquiry.

**D. The Centers for Medicare and Medicaid Services Study Cited as Support in the Mayer Report Does Not in Fact Support Dr. Mayer’s Opinion.**

Finally, the Mayer Report cites to a memorandum (Ex. J, “Memorandum”) issued by the Centers for Medicare and Medicaid Services (the “Centers”) to support the notion that there is only “inconclusive” evidence to support medical and surgical treatments as safe and effective for gender dysphoria. (Dkt. # 90, ¶ 20-21). But the Mayer Report misinterprets the findings discussed in the Memorandum.

The Memorandum announces the Centers’ decision to continue making coverage determinations for “gender reassignment surgery on a case-by-case basis,” finding that clinical evidence for “gender reassignment surgery for Medicare beneficiaries with gender dysphoria” is “*inconclusive for the Medicare population.*” (Memorandum at 2) (emphasis added). Dr. Mayer plucks the word “inconclusive” from the narrow context in which it is used, and represents that the Centers found

“inconclusive” clinical evidence regarding “gender reassignment surgery” with respect to children and adults of *any age or ability*:

A variety of medical and surgical procedures have been proposed for treating gender dysphoria. The evidence that these interventions are safe, effective, and optimal is minimal. The bases for this opinion with respect to both children and adults, along with the studies on which this opinion relies, can be found in both [the *New Atlantis* Article] and my amicus brief. *This opinion is supported by the Centers for Medicare and Medicaid Services . . . which review many available studies and found “inconclusive” clinical evidence regarding gender reassignment surgery.*

(Dkt. #90, ¶ 20-21 (internal citations omitted)). This is not so. The Memorandum expressly acknowledges that its finding regarding “gender reassignment surgery” is limited to the extremely narrow population of transgender Medicare beneficiaries with gender dysphoria:

*We acknowledge that GRS may be a reasonable and necessary service for certain beneficiaries with gender dysphoria. The current scientific information is not complete for CMS to make a NCD that identifies the precise patient population for whom the service would be reasonable and necessary.*

(Memorandum at 54) (emphasis added). The Memorandum notes that the Centers consider the Medicare population as distinct from the general population, which limits their ability to assess the safety and efficacy of these procedures for “the precise patient population” at issue:

*The Medicare population is different from the general population in age (65 years and older) and/or disability as defined by the Social Security Administration. Due to the biology of aging, older adults may respond to health care treatments differently than younger adults . . . . The disabled Medicare population, who are younger than age 65, is different from the general population and typical study populations due to the presence of the causes of disability such as psychiatric disorders, musculoskeletal health issues, and cardiovascular issues.*

(Memorandum at 57) (emphasis added).

Nowhere in the Memorandum do the Centers state or imply that medical or surgical treatments for gender dysphoria are not safe, effective, or optimal, as Dr. Mayer contends. On the contrary, the Centers specifically acknowledge that surgical treatment “may be a reasonable and necessary service for certain beneficiaries with gender dysphoria.” (Memorandum at 65). Indeed, despite the Centers’ narrow finding that there is inconclusive evidence regarding “gender reassignment surgery” for the transgender Medicare population, the Centers decided to continue to cover these procedures. (Memorandum at 2).

#### **IV. Dr. Mayer Is Unqualified to Make Clinical Recommendations.**

Dr. Mayer advances several clinical judgements for which he lacks the requisite expertise. Fed. R. Evid. 702 requires courts to examine an expert’s qualifications, and bars expert testimony unless the “expert’s scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.” *Daubert*, 509 U.S. at 597. As an initial matter, Dr. Mayer is not licensed to practice medicine and, indeed, has never practiced medicine

or otherwise treated patients other than as a student decades ago. (Dkt. # 112 at 7:5-6). Dr. Mayer has scant clinical experience, including only a year of clinical training in connection with his British MB degree and another year as an intern following completion of his degree. Dr. Mayer himself admits that he “would never hold [himself] out as an expert in clinical—clinical medicine. I saw a very limited number of patients.” (*Id.* at 9:23-10:1). He also admits that he has “no specific training in dealing with gender dysphoria,” though he considers himself “probably an expert in the epidemiology of gender dysphoria, having reviewed a tremendous amount of literature on what the science has to say.” (*Id.* at 32:25-33:3). Nevertheless, Dr. Mayer further affirms that he is not qualified to “run a study” because he is “not a clinician.” Indeed, Dr. Mayer conceded that if a psychiatrist and surgeon agreed that surgery was critical to resolve a patient’s gender dysphoria, he would not dispute that clinical assessment (*Id.* at 85:11-16; 86:4-13) and could not offer an opinion as to whether hormones or surgery were appropriate treatments for Plaintiffs’ gender dysphoria (*Id.* at 157:21-158:10).

Despite Dr. Mayer’s lack of clinical training and expertise, particularly in the field of gender dysphoria, he makes clinical judgments throughout his report which are both outside the scope of his qualifications and potentially misleading to the jury. For example, Dr. Mayer states that:

In body dysmorphic disorders, such as anorexia nervosa, we do not give patients interventions to alter their physical appearance. We treat the distress caused by the conflict between their perception of themselves and the reality of themselves. In other words, *treatment of the distress associated with the disorder is what is medically appropriate and medically necessary.*”

(Dkt. # 90, ¶ 24) (emphasis added). Dr. Mayer lacks the expertise required to know what is “medically appropriate and medically necessary,” particularly for any given person with gender dysphoria or body dysmorphic disorder. He has never treated patients—let alone patients with body dysmorphic disorders. Similarly, Dr. Mayer states that a hypothetical transgender woman and cis-gender woman seeking “feminization procedures to reduce her distress” are not “entitled to the procedure as a medical necessity.” (*Id.*, ¶ 25-6). Again, Dr. Mayer has never treated a single patient, much less a transgender patient suffering from gender dysphoria, and such a statement is wholly outside the scope of Dr. Mayer’s training, education, and expertise.

Case law similarly reflects that healthcare professionals may not offer expert testimony outside the scope of their qualifications. *See, e.g., Morin v. U.S.*, 534 F. Supp. 2d 1179 (D. Nev. 2005) (excluding testimony where the expert physician had expertise in toxicology and epidemiology with respect to diagnosis and treatment, but lacked expertise in identifying causal connections between jet fuel and tumors); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015) (excluding the testimony of a licensed Nurse Practitioner about whether the plaintiff was substantially limited in daily activity, because her primary expertise was in dermatology and she

lacked specialized training or knowledge in evaluating mobility). Accordingly, Dr. Mayer's testimony relating to clinically appropriate treatment should be excluded from the record.

### CONCLUSION

Dr. Mayer's testimony fails to meet the requirements for admissibility set forth in Fed. R. Evid. 702 and 403. In particular, Dr. Mayer's testimony about the strength of evidence regarding the safety and efficacy of certain treatments for gender dysphoria is irrelevant because it does not help the jury determine a fact in issue, and consequently carries a high risk of misleading or confusing the jury. Further, Dr. Mayer's testimony has not been subject to peer review, contains conclusory statements without analysis or support, and is based upon methods and principles that have been wholly rejected by the scientific community. Additionally, Dr. Mayer's testimony impermissibly includes clinical recommendations for which he lacks the requisite qualifications. Accordingly, the testimony of Dr. Mayer must be excluded under Fed. R. Evid. 702 and 403.

Dated this 7th day of September, 2018.

**HAWKS QUINDEL, S.C.**

*Counsel for Plaintiffs,*

By: /s/ Nicholas E. Fairweather

Nicholas E. Fairweather, State Bar No. 1036681

Email: nfairweather@hq-law.com

Caitlin Madden, State Bar No.

Email: cmadden@hq-law.com

Michael R. Godbe, State Bar No. 1104823

Email: mgodbe@hq-law.com

Amanda M. Kuklinski, State Bar No. 1090506

Email: akuklinski@hq-law.com

409 East Main Street

Post Office Box 2155

Madison, Wisconsin 53701-2155

Telephone: (608) 257-0040

Facsimile: (608) 256-0236

**AMERICAN CIVIL LIBERTIES UNION OF  
WISCONSIN FOUNDATION**

*Counsel for Plaintiffs,*

By: /s/ Laurence J. Dupuis

Laurence J. Dupuis, State Bar No. 1029261

Email: ldupuis@aclu-wi.org

Asma I. Kadri, VA State Bar No. 91290

Email: akadri@aclu-wi.org

ACLU of Wisconsin Foundation

207 East Buffalo Street, Suite 325

Milwaukee, Wisconsin 53202

Telephone: (414) 272-4032

**AMERICAN CIVIL LIBERTIES UNION  
FOUNDATION**

*Counsel for Plaintiffs,*

By: /s/ John A. Knight

John A. Knight

Email: jknight@aclu.org

Carolyn M. Wald

Email: cwald@aclu-il.org

ACLU Foundation

Lesbian Gay Bisexual Transgender Project

150 North Michigan Avenue, Suite 600

Chicago, Illinois 60601

Telephone: (312) 201-9740